ILLINOIS DEPARTMENT OF PUBLIC HEALTH
HEALTH FACILITIES AND SERVICES REVIEW BOARD
Tuesday, March 12, 2024
Bolingbrook, Illinois
10:00 a.m.

PHYSICALLY PRESENT:
DEBRA SAVAGE, Chairwoman
REX BUDDE
KENNETH BURNETT
GARY KAATZ
MONICA HENDRICKSON
DAVID FOX
DAVID KATZ
DR. AUDREY LYNN TANKSLEY
MONICA LeGrand
Ms. Antoinette Hardy-WALLER

ALSO PRESENT:
JOHN P. KNIERY, Administrator
MICHAEL CONSTANTINO, IDPH Staff
GEORGE ROATE, IDPH Staff
DON JONES, IDPH Staff
SHARIE RYAN, IDPH Staff
KENTON TILFORD, IDPH Staff

MAGNA LEGAL SERVICES
BY: Michael Marciniak, CER
Notary Public

P R O C E E D I N G S

CHAIRWOMAN SAVAGE: Pursuant to the Open Meetings Act section 7 we will have a member attending remotely via Webex. The meeting is not only recorded via the Court Reporter, but the entire Webex format will be recorded as required. Okay George, would you please call the roll.

MR. ROATE: Thank you, madam Chair. Rex Budde.

MR. BUDDE: Present.

MR. ROATE: Thank you. Kenneth Burnett.

MR. BURNETT: Present.

MR. ROATE: Thank you. David Fox.

MR. FOX: Present.

MR. ROATE: Thank you. Monica Hendrickson.

MS. HENDRICKSON: Present.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Present.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: Present.

MR. ROATE: Thank you. Monica LeGrand.

MS. LEGRAND: Present.

MR. ROATE: Thank you. Dr. Audrey Tanksley.

DR. TANKSLEY: Present.

MR. ROATE: Thank you.

Waller.

MS. HARDY-WALLER: Present.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Present.

MR. ROATE: Thank you. That's 10 in attendance.

CHAIRWOMAN SAVAGE: Thank you. Okay. Now, Blanca, would you like to say official words about thyself.

MS. DOMINGUEZ: Yes. Hi everyone, again Blanca Dominguez, I've been in this role now for a week, but I just want to say that I look forward to working with the board as well as all of you. And furthering the objectives of the board and help their, in general to all our communities so, looking forward to working with the review board.

CHAIRWOMAN SAVAGE: Thank you, and welcome again. May I have a motion to approve the March 12, 2024 meeting agenda as amended?

MS. LEGRAND: First.

MR. FOX: Second.

CHAIRWOMAN SAVAGE: Thank you. George, would you please call the roll.

MR. ROATE: Thank you, Madam Chair. Mr. Budde.

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Yes.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: Yes.

MR. ROATE: Thank you. Ms. LeGrand.

MS. LEGRAND: Yes.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: Yes.

MR. ROATE: Thank you. Ms. Hardy-Waller.

MS. HARDY-WALLER: Yes.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: Thank you. That's 10 votes in the affirmative.

CHAIRWOMAN SAVAGE: Okay. And just to note please limit all of our initial presentations that you'll be giving us to 10-15 minutes, and we thank you for that. Now, may I have motion to approve our December 5, 2024 meeting transcript.

MR. BUDDE: So, moved.

DR. TANKSLEY: Second.

CHAIRWOMAN SAVAGE: Any changes or comments to the transcripts?

(No verbal response)

CHAIRWOMAN SAVAGE: Okay. Hearing none, George if you could call the roll.

MR. ROATE: Mr. Budde.

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Yes.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: Yes.

MR. ROATE: Thank you. Ms. LeGrand.

MS. LEGRAND: Yes.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: Yes.

MR. ROATE: Thank you. Ms. Hardy-Waller.

MS. HARDY-WALLER: Yes.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: Thank you. That's 10 votes in the affirmative.

CHAIRWOMAN SAVAGE: Okay. So now we are going to move onto public participation. Don Jones if you would like to proceed.

MR. JONES: Thank you, Madam Chair. We have one individual who has registered to speak. That is Christopher Conrad, and he is speaking regarding project 23-042.

MR. CONRAD: Good morning, Madam Chairwoman, again my name is Chris Conrad I'm speaking for the city of Highland. I am here to speak on behalf of Well Care homes, project number 23-042. I know time is of the essence, so I'll be brief. There is really three issues I would like the board to consider, as they're taking up a decision on this application.

The first thing is the proximity of where we're located at. Highland is on the far southeastern corner of Madison county. We’re closer to the state border so it could be easy to shuffle the lines on a map and look at us from a Madison county perspective. But we're literally only three

miles from Clinton county lines, and we actually tend to draw much of our retail business from Clinton county. We also employ many people from Clinton county and so we tend to be a desirable place for people to, from those areas, to come towards us which is -- we're a little bit closer in proximity -- where we're at as you're headed east on 70 away from the metropolitan area.

It gets rural very quickly, as you head east toward Highland and the population tends to increase pretty quickly as you head east. The other issue is the project type, and so Dr. Usman when he approached the city with this project to have in-house dialysis out of the nursing home. Which is kind of unique for something that's in our area. And kind of goes at hand with some other issues that we're seeing in public health.

Which is EMS services are struggling vitally in our area, and to kind of let this board know effective May 1, we're actually going from two ambulances down to one. So, anything that can provide a little relief at the lower level. EMS transfers and hauls they needs to do, if they could keep some of the stuff they do in-house would be greatly appreciated.

The last thing is economic viability, Madison county is a kind of gated community, so this puts us in a unique

position where we're essentially a non for profit electric company. And so as -- the facility itself is roughly, ironically as I was walking around while we were waiting to start. Roughly the same size as this facility, as so these are very energy intensive buildings and they use a lot of electric. And so, one of the benefits to being in Highland is our rates are consistently about 2/3 the average of pretty much anywhere else in the state of Illinois.

And so, just from an economically viable standpoint for sustainability we think we can offer them some pretty nice incentives to be within the city. Just by using our utilities, so those were the three main points that I want to bring up. Does anyone, anyone on the board have any questions for me? Otherwise, I appreciate your time.

CHAIRWOMAN SAVAGE: Thank you so much. All right. So now, the following 20 items listed in the items below on your agenda have been approved that I have approved. So, please let the record note these items as approved.

Now, we'll begin with Permit renewal requests, we have three items. We'll start with DeKalb County Nursing and Rehab in DeKalb, Illinois; HSA-1 in Illinois. May I have a motion to approve the seven-month permit renewal of project 18-005. It is the third permit renewal request for

this project.

MR. BUDDE: So moved.

MR. FOX: Second.

CHAIRWOMAN SAVAGE: Thank you. Is there anyone here to present for the applicant? Please be seated, and if you could please introduce yourself and be sworn in.

MR. IRVINE: Good morning. My name is Brian Irvine, I am the county administrator for DeKalb, County.

THE REPORTER: Please raise your right hand.

(Whereupon:

BRIAN IRVINE

After being duly sworn, was examined and testified as follows:)

CHAIRWOMAN SAVAGE: Thank you. George, If you can please read the state board staff report.

` MR. ROATE: Thank you madam chair. On June 5th, 2018, the State Board approved project # 18-005. The permit authorized a modernization/expansion project at DeKalb County Rehabilitation & Nursing Center in DeKalb. The State Agency notes the project is obligated and the most recent project completion date was October 31, 2022. Project cost $16.9 million. The permit holders request a completion date of May 31, 2024. Extending the project's completion date 19 months, from October 31, 2022, to May

31, 2024. The three previous permit holders submitted the permit renewals were approved in succession. And the permit renewal request has no negative findings.

CHAIRWOMAN SAVAGE: Thank you, George. If you would like to Proceed.

MR. IRVINE: Just briefly today I'll give you a quick recap of how we got where we are today. I think this board is familiar and may have a lot on your plate. Just a refresher, So, back in 2018, DeKalb entered an expansion project, which essentially was established under the TCU unit for a rehab side. That was going to add 18 beds to 190 bed facility. In addition, there was some improvements that were some improvements that were being made; More cosmetic than anything to the existing facility.

That project moved along and during Covid, stopped and for those of you that still follow football analogies we were at the two yard line thereabout. About 99 percent completed and with Covid and obviously healthcare challenges that project was suspended. As we moved along, I actually came to the county shortly after March of 2021. We started to uncover some financial challenges that very quickly became very deep and then put the county off about $9.86M into the facility.

And county board in 2022, elected to sell the facility,

had a contract with a buyer who came to view it twice but there were some challenges in that process not with the board, but just with the buyer and the transaction. We got a lot more community input and ultimately the county board decided to retain the facility as a modified business plan that was put together by a company called Gordon Healthcare Group. One of the key components of that is changing our census to more Medicaid. There have been some recent changes in the law as far as how counties are reimbursed for Medicaid. Medicaid portion of that business plan goes up to about 71 percent. We're at roughly 16 percent Medicare with about half, yeah, a little more than half of that attributable to this TCU being in operation. So, the building is complete along the way as you're aware with a certificate of need to establish construction. And ultimately if there was to be a sale, a different certificate of need would be necessary. So, we initially were relinquishing the project at 18-005, but we've worked with staff, staff has been great to help us get this back on track.

We're hoping here to be open in the spring, and when we do -- once, you know, we're approved to move forward. We invite all of you to come out and celebrate together.

CHAIRWOMAN SAVAGE: Thank you. Do any board

members have questions for this applicant?

MR. KAATZ: Why were you not compliant with getting a timely communication to the staff board? I see you're being fined; this was a late communication?

MR. IRVINE: Yeah, and I'll tell you that -- my personal expertise is not in healthcare, in fact I don't know much about it. When I came to the county there was a project manager that the county had retained to oversee this. And they also had a relationship with who managed the facility, but given the challenges there was a parting of ways, and so we were left to sort of muddle through that.

So, through our errs and I'll take responsibility for that, we weren't necessarily understanding the process. That's why we reached out, it was after the fact but we were told that we couldn't have two CONs and so we were -- we were -- I think that's just a lack of experience.

MR. KAATZ: Thanks for the answer.

CHAIRWOMAN SAVAGE: Other questions?

(No verbal response)

CHAIRWOMAN SAVAGE: Hearing none, George if you could call the roll.

MR. ROATE: Thank you, madam chair. Motion made by Mr. Fox, seconded by Mr. Burnett, Mr. Budde:

MR. BUDDE: Yes. Based on the staff report and the conversation with the applicant.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes. Based on today's conversation.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Based on the information provided, yes.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Yes.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: Yes. Based on the staff report and today's testimony.

MR. ROATE: Thank you. Ms. LeGrand.

MS. LEGRAND: Yes. Based on the staff report and today's testimony.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: Yes. Based on the staff report and testimony.

MR. ROATE: Thank you. Ms. Hardy-Waller.

MS. HARDY-WALLER: Yes. Based on testimony.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes. Based on state board staff report and testimony today.

MR. ROATE: Thank you. That's 10 votes in the affirmative.

CHAIRWOMAN SAVAGE: So that vote is approved, permit rather. Okay, now we're going to move on to A-02 which is Winchester surgery center in Libertyville, Illinois; HSAV111. May I have a motion to approve the six-month permit renewal of project number 21-007, it is the fourth permit renewal for this project. May I have a motion.

MR. BURNETT: So, moved.

DR. TANKSLEY: Second.

CHAIRWOMAN SAVAGE: Thank you. There is someone here so if you could introduce yourself and be sworn in.

MS. FRIEDMAN: Hi. I'm Kara Friedman, counsel for the permit holder.

(Whereupon:

KARA FRIEDMAN

After being duly sworn, was examined and testified as follows:)

CHAIRWOMAN SAVAGE: Thank you. George, if you could please call the state board staff report.

MR. ROATE: Thank you, madam chair. On September

14 the state board approved project 21-007 authorizing the establishment of a single specialty ambulatory surgery center treatment center in Libertyville. The project is obligated, and the current project completion date was December 31, 2023. Project cost of approximately $950,000.

The permit holders request a project completion date of June 30, 2024 extending the projects completion date by six months. There were three previous permit renewal requests ranging from one year to six months. Thank you, madam chair.

CHAIRWOMAN SAVAGE: Thank you. If you would like to proceed.

MS. FRIEDMAN: Thank you. Again, my name is Kara Friedman, that's K-A-R-A F-R-I-E-D-M-A-N, counsel for Winchester ambulatory surgery center. As you can see from the report, the estimated completion date for the project was December 31. That date was based on the provider determining it would submit a request for survey and the nursing component licensure in November.

That survey was scheduled for December 19, which was in advance of the planned completion date. And no permit renewal was requested in the middle of November because that date had been scheduled. At the time of the IDPH survey, everything was in order for licensure with the

exception that the hospital medical staff privileges of the division were inactive. While their practicing administrator was under the impression that this reactivation could be done at the press of a button so to speak.

They soon learned that they would have to start the process from the beginning. Not knowing exactly how long that process would take, the permit request we're now seeking is to change the completion date to June 30. I do understand that there is a hospital committee meeting this Thursday. So, they should be able to satisfy their deficiency with activation very shortly. And I'm happy to answer any questions.

CHAIRWOMAN SAVAGE: So, one question is why weren't the two physicians that were referring patients to this facility not currently practicing or were they?

MS. FRIEDMAN: No one is referring cases yet, the surgery center is not open yet. But as I understand it, a lot of physicians do not admit patients to hospitals that they pretty much are in an outpatient setting. And so there was no need for them to have privileges, but they learned that they need them. And they do have a signed transfer agreement for any emergency cases.

CHAIRWOMAN SAVAGE: Other questions?

MR. CONSTANTINO: Yeah, madam chairwoman, I would like to know why the applicant isn't here.

MS. FRIEDMAN: I did connect with the administrator before the last hearing when they were planning to come. And I guess I was under the impression that since it was just a technical issue with their credentialing that they did not need to appear so I apologize if there was a misunderstanding that they should be here.

MR. CONSTANTINO: Yeah, that's for renewals, permit requests for renewals and they're not here to explain why.

MS. FRIEDMAN: Well, I think --

MR. CONSTANTINO: I think they ought to come back when we deny the referral.

MS. FRIEDMAN: Can you say that again?

MR. CONSTANTINO: I said, I think we ought to deny the referral.

MS. FRIEDMAN: Okay. Well, I'm sorry that they scheduled all their cases for the day with the understanding that I could explain the situation. Which I have done, and I can further answer questions I am under oath and I have received information about their credentialing as recently as the end of last week.

CHAIRWOMAN SAVAGE: Other questions by the board or board members?

MR. FOX: So, the last piece of the puzzle was scheduled for December 19, right?

MS. FRIEDMAN: Correct.

MR. KATZ: And supposed to wrap up by December 31, was that reasonable and put my question in context. We're going to hear a lot today about coming back and coming back and coming back. Spent an hour and a half waiting for the court reporter; this is a colossal inefficient use of time. There is 100 people in this room, we're just re-debating the same topic, so my question is specifically for this, is 12 days a customary amount of time from when you would have received approval - was it a glitch or was it just poor planning?

MS. FRIEDMAN: I'm not completely sure what you're asking, could you restate that question?

MR. KATZ: Sure.

MS. FRIEDMAN: Are you talking about the difference between the 11 days, the 19th and the 31st?

MR. KATZ: Did you wait until the end and make an unrealistic, poorly planned out process? Or was this normal that they should have been 99 percent approved and there was no buffer needed. The problem is, and I

apologize for going off on a rant this early in the morning. But if, when people plan poorly and end up appearing before this board, multiple times, it's a waste of time. I'm trying to understand what happened here.

MS. FRIEDMAN: Okay. So, I think that in mid-November, I'm not exactly sure of the date that IDPH confirmed the date. Once they learned that the date was going to be higher than December 31 to December 19, they believed that would be adequate 'cause they would receive their license on the 19th of December.

MR. KATZ: And in your capacity as their counsel, did you also believe that was an adequate amount of time?

MS. FRIEDMAN: As long as they don't have deficiencies.

MR. KATZ: That's the point -- that's the point.

MS. FRIEDMAN: And I can't anticipate -- and I can't say often there are deficiencies in initial survey so that was probably their error.

MR. KATZ: Thanks.

CHAIRWOMAN SAVAGE: And it was only on the 19th of December when you understood that the physicians needed hospital privileges?

MS. FRIEDMAN: Right, and we did file the permit renewal request before December 31 and paid the extra

$500.

MR. KAATZ: I see -- I'm concerned also that this is the fourth renewal request. So, I'm inclined to say maybe we should just wait and chalkboard it back and do another one. Second point is, I thought there was some interesting points in the staff report about communication and utilization services. As presented in one of the earlier submissions, I see you registered your submission for CON on this project -- and Mike, did you share this with me am I reading it wrong?

MS. FRIEDMAN: All these are all cases, the cases that are going to be completed, this surgery center has cases where the physicians are already doing - are already admitting patients. The building was actually an ASTC center a few years ago, so they're re-using a building that was designed to do endoscopy. And it's across the street from their office; not even the street, across the parking lot from their office. IDPH required it to be licensed 'cause it's not adjacent.

MR. BUDDE: If I may, Ms. Friedman and I did communicate about the January meeting. My apologies I did not know that was completed before today. So, I'll take the responsibility on that one. But also, if Ms. Karen Singer from the licensure and she had wanted to chime in

as well. There is a process, once we approve it and the applicant bills it, it then needs to go through the licensure approval process for nursing survey and lifesaving survey; it's a two-part survey. And I think that's where it got caught up.

MS. FRIEDMAN: Correct. The life safety survey they didn't test before the nursing survey.

MR. BUDDE: So, let me just make sure Karen wanted to add anything to the conversation.

MS. SINGER: This is Karen Singer, can you hear me, yes. I mean the nursing survey was scheduled as soon as we were able to based on our workload. We knew that there was a deadline, that's why we tried to get it as far away from the December 31st, date. But we had a short staff, so we scheduled it as soon as we were able to get it in.

CHAIRWOMAN SAVAGE: Other questions?

MS. FRIEDMAN: I don’t think we'll need until June 30th, that’s the date that we submitted. But I'm hoping that we'll be able to square everything up with IDPH in the next week or so.

CHAIRWOMAN SAVAGE: Thank you. Okay. George, if you could call the roll.

MR. ROATE: Thank you, madam chair, Motion made

by Mr. Burnett seconded by Dr. Tanksley. Mr. Budde:

MR. BUDDE: I appreciate staff comments about the applicants not being in the room. I will vote yes on the extension.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: I vote no.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: I'm going to vote yes reluctantly, and I'd like to communicate a message to the consultants in the room. For a project like this which has come before the board so many times. I think it's an expected courtesy that members of the ownership would show up as well.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Based on the conversations and similar to Mr. Fox, reluctantly yes.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Philosophically I share the concerns as I articulated. I also believe that reluctant folks who said yes would have those same messages so I'm going to vote no.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: I will vote no also because I'm concerned about four renewals. And I also share the concern expressed earlier about the lack of nursing here.

So I vote no.

MR. ROATE: Thank you. Ms. LeGrand.

MS. LEGRAND: I also share the concerns of my fellow members here. But I reluctantly will vote yes.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: Thank you. I share the concerns with my colleagues that the clients are not present and really am not as clear as I think I want to be on the deficiency and would like to ask for them to elaborate on it in a sense. And I just kind of want to pause here to say because it's about credentials correct?

MS. FRIEDMAN: Yes.

DR. TANKSLEY: And I find it challenging to understand how physicians are not aware that they need to be credentialed at a hospital. No matter what the sub specialty is, it's like standard so I'm going to vote no.

MS. FRIEDMAN: Can we pause the vote and I can ask if we can defer because I can certainly ask the permit holder to come. It's a misunderstanding I thought that we definitely had an understanding that they would not need to appear.

CHAIRWOMAN SAVAGE: So, may I have a motion to rescind all the active votes currently.

MR. BUDDE: I'll make that motion.

DR. TANKSLEY: Second.

CHAIRWOMAN SAVAGE: George if you could please call the roll.

MR. ROATE: Motion made by Mr. Budde seconded by Dr. Tanksley. Mr. Budde.

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: No.

MR. ROATE: Thank you. David Katz.

MR. KATZ: No.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: No.

MR. ROATE: Thank you. Monica LeGrand.

MS. LEGRAND: Yes.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: Yes.

MR. ROATE: Thank you. Ms. Hardy-Waller.

MS. HARDY-WALLER: I vote no. I don't know how that is going to substantially change the testimony today.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: I vote Yes.

MR. ROATE: Thank you. That's six votes in the affirmative four votes in the negative.

MS. FRIEDMAN: So we will come back at the next meeting to present with the permit holder?

CHAIRWOMAN SAVAGE: Okay. So now may I have a motion to defer until the next meeting, this project.

DR. TANKSLEY: So moved.

MR. BURNETT: Second.

MR. ROATE: Motion made by Dr. Tanksley seconded by Mr. Burnett.

MR. KATZ: I'm sorry, what's the alternative you said the motion is to defer.

CHAIRWOMAN SAVAGE: Until the next meeting.

MR. KATZ: And if that didn't carry.

CHAIRWOMAN SAVAGE: Than we would go back to the votes.

MR. KATZ: So I'm not sure what voting will accomplish, like there a bunch of people that are coupled with, you're smiling, what would be helpful.

MS. FRIEDMAN: I know that there has been statements made that there is additional information you might want to hear from the permit holders and physicians themselves. And I'm really regretful that there has been this

misunderstanding with me and the administrator because the general idea was that they were going to have to cancel their full day of cases in clinic. And so, I really hate to have that be a meeting that they could have canceled their cases today and shown up. But I'm willing to have them come.

MR. KATZ: Right. I get it I get it. Thank.

MR. ROATE: Mr. Budde.

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Monica Hendrickson.

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Yes.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: Yes.

MR. ROATE: Thank you. Ms. LeGrand.

MS. LEGRAND: Yes.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: Yes.

MR. ROATE: Thank you. Ms. Hardy-Waller.

MS. HARDY-WALLER: Yes.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: Thank you. That's ten votes in the affirmative to defer.

CHAIRWOMAN SAVAGE: So now deferral is approved for the next meeting.

MS. FRIEDMAN: And I will coordinate with Mr. Kinery and Ms. Singer about submitting the documentation that they've satisfied the deficiencies.

CHAIRWOMAN SAVAGE: Thank you. Okay. So, now we are going to move onto A-03 TARGET health cooperative MOB, in Chicago Illinois HSA6. So now may I have a motion to approve the 12-month permit renewal of project 22-007 it is the second permit renewal for this project.

MR. KATZ: So moved

MR. BURNETT: Second.

CHAIRWOMAN SAVAGE: Okay. If you could each introduce yourselves, spell your names for the court reporter, and then be sworn in.

MS. PRENDERGAS: Good morning. Dr. Heather Prendergas, social dean, clinical affairs, executive director of physicians group.

MS. MCCULLOUGH: Hi. I'm Sandra McCullough, I'm a

senior clinical director at the clinic.

MR. AXEL: Matt Axel with Axel and associates. I'm the consultant with the project.

CHAIRWOMAN SAVAGE: Thank you. George if you could please give us your state board staff report.

MR. ROATE: Thank you, madam chair. On March 15, 2022 the state board approved project 22-007 authorizing the establishment of a three-story medical office building in Chicago. The board -- state board staff notes the project is obligated and the current project completion date was March 1, 2024. Project cost was approximately $19.8 million. This is the permit holders second request and they are asking for an additional 12 months from March 1, 2024 to March 1, 2025.

CHAIRWOMAN SAVAGE: Thank you. If you would like to proceed. Oh, please do that.

(Whereupon:

HEATHER PRENDERGAS

SANDRA MCCULLOUGH

MATT AXEL

After being duly sworn, were examined and testified as follows:)

CHAIRWOMAN SAVAGE: Thank you. If you would like to proceed.

MS. PRENDERGAS: Good morning again, I'll just start by giving just a brief overview about the project. So, target health was established as part of the healthcare transformational board. It was established in 2021 -- sorry in 2022, and it's in the University of Illinois' five organizations that have come together to provide healthcare, unprecedented access to specialty care in advanced diagnostics for the community of West Elston and Gage Park. Members of the collaborative include University of Illinois hospital, Grand Health, Miles square, Frank Health, and Allevio medical center, the UIC college of applied health sciences, and the office of community engagement and input partnerships.

As part of the award from the state we acquired the building 55th and Pulaski. I should point out that this building was previously occupied by Mercy hospital when they closed and left the community. When we acquired the building, it had been abandoned, we - you know, started seeing patients there. It is an old building, and we uncovered a lot of additional work that needed to be done.

But yet, we have started providing services since opening on February 22, 2022. We have provided care to over 22,000 patients in the community and surrounding communities; 10,000 of that has been directly specialty

care; about 5,000 has been advanced diagnostics, our colleagues from Frank health are providing immediate care and behavioral health. And that's about almost 8,000 visits and our UIC college of applied health sciences just started providing PT.

We continue to add services on, because there were -- it is an old building we needed to make improvements, it really had not been maintained well. We had to install a life safety system, we have had a number of other issues that have been unexpected, and there have been supply delays. That is why we're here requesting this extension.

MS. MCCULLOUGH: I just have one thing to say about the dental, we have completed everything else. So, that's just the last piece of this project that we're just waiting to complete. And again, have found some deficiencies with the building that we had been addressing.

CHAIRWOMAN SAVAGE: Okay. Mr. Axel.

(No verbal response)

CHAIRWOMAN SAVAGE: Any of our members have questions for this applicant?

MS. HENDRICKSON: Just a point of clarification, in terms of being approximately at your 90 percent completion, is that based on the day they submitted or had that been updated since this report has been submitted to

the board. Were you still at 90 percent?

MR. AXEL: No, we're sill behind.

CHAIRWOMAN SAVAGE: Other questions? Go ahead.

MR. FOX: Do you think a year gives you enough time.

MS. PRENDERGAS: Yes.

MS. MCCULLOUGH: Yes. Just based off of our, what we've accomplished so far.

CHAIRWOMAN SAVAGE: Other questions? Mr. Katz.

MR. KATZ: Are you pleased with how far you've come.

MS. PRENDERGAS: Absolutely.

MR. KATZ: What is your biggest concern or issue?

MS. MCCULLOUGH: I think because the building is old, I feel like we've taken a few steps forward and then we would find something else that we would critically need to fix. But I think that's always been the challenge, but we have been able to over accomplish.

MR. KATZ: Community feels good about it.

MS. PRENDERGAS: Since July of 2023 we just kind of exploded. And not only with patient visits but also we're hosting community classes, community meds, and it's been really embraced. And we're offering things in Spanish and English. It's been a really great experience. The

community is really happy to be back, having someone back in that community 'cause Mercy that was there previously also, and then with them leaving. So the community has been engaged and happy that we are there.

MR. KATZ: Thanks.

CHAIRWOMAN SAVAGE: I think 22,000 patients is something to be proud of so that's great. Other questions? All right George if you could call the roll. One second.

MS. HENDRICKSON: I will just note for the record that Dr. Tanksley is recusing herself from this matter. Due to a relationship with the applicant.

CHAIRWOMAN SAVAGE: Now, George.

MR. ROATE: Thank you, Madam Chair. Motion made by Gary Katz, seconded by Mr. Burnett; Mr. Budde.

MR. BUDDE: Yes. Based on conversations with the applicant.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes. Based upon today's testimony and staff report.

MR. ROATE: Thank you. David Fox.

MR. FOX: Yes. Based on testimony.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Based on the information provided, yes.

MR. ROATE: Thank you. David Katz.

MR. KATZ: I vote yes and I commend you on what you're doing. It's complex, and I appreciate how thoughtful you've been with regard to the situation and appreciate how straightforward you've been. Thank you.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: Yes. Due to the enthusiasm when she answered my question.

MR. ROATE: Thank you. Ms. LeGrand.

MS. LEGRAND: I also vote yes, based on 22,000 patients; that's great.

MR. ROATE: Thank you. Ms. Hardy-Waller.

MS. HARDY-WALLER: I also vote yes and commend you on bringing services to a health desert in our communities where it is much needed so again thank you.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: And I too vote yes based on the state board staff report and testimony today and concur with my colleagues. Good job. Yes.

MR. ROATE: Thank you. That's nine votes in the affirmative and one vote of recusal.

CHAIRWOMAN SAVAGE: And that vote -- permit is approved. We are going to take a five-minute break, and then we'll be right back.

(Recess)

CHAIRWOMAN SAVAGE: Next up is going to be A-04 Fairfield Memorial Hospital in Fairfield, Illinois. May I have a motion to approve the four-month permit renewal of project 18-029; It is the second permit renewal request.

MS. HARDY-WALLER: Motion.

MR. BURNETT: Second.

CHAIRWOMAN SAVAGE: Thank you. George, if you could call the roll.

MR. ROATE: Thank you, Madam Chair. On October 30th, 2018 the state board approved project 18-029 authorizing the addition of a three story wing to Fairfield Memorial Hospital, to include the modernization of the surgery department. State agency staff notes the project is obligated and the most recent project completion date was July 1st, 2021. The original project cost was approximately $25 million. This is the permit for -- this is the permit holder's second request or fourth request for a permit for renewal. And they're asking for a project completion date of June 1st, 2024. Extending the existing permit five months. Thank you, Madam chair.

CHAIRWOMAN SAVAGE: Thank you. Okay. if you'd like to please state your names, spell your names for the court reporter, and then he will swear you in.

MS. TAYLOR: Dana Taylor. Interim CEO. D-A-N-A T-A-Y-L-O-R.

MS. BOLDT: Kristen Boldt, K-R-I-S-T-I-N B-O-L-D-T. I'm interim CFO.

THE REPORTER: Ms. Taylor and Ms. Boldt, please raise your right hand.

(Whereupon:

DANA TAYLOR

KRISTIN BOLDT

After being duly sworn were examined and testified as follows:)

THE REPORTER: You may proceed.

CHAIRWOMAN SAVAGE: Thank you. If you'd like to proceed.

MS. TAYLOR: Okay. we have found ourselves in a very unique situation in our organization. Both of you, both of us, as you heard, are interim. And so with this, we found out on February 12th that we were delinquent, or not compliant with meeting the final project report. With that, I immediately contacted the representative for the board. And what we learned was that we were, this, the report was due. We had been constantly working on HVAC issues that have not been rectified in between the contractor and the subcontractor.

There have been intermittent moisture issues and so we were working on that. However, I do believe with the extension that we can rectify this and have this put to bed. And then we will be able to release the retainage for that. In regard to the overages, we do recognize that the facility has went over in cost; This has been due to a couple different things.

One was the cost of the exam lines, which was not included in the original listing. That listing was argued between the contractors, but since it was actually signed off by the facility it was felt that it was our responsibility. So that was around $24,000 of overages. In addition to that, there was additional overages with the clean suite in the OR. So, in our previous roles, we were not privy to a lot of this information. So we have been trying to diligently gather this information in a short amount of time, go back and look at the financial data and get things brought up to speed.

Our desire is to be compliant with the board, and to make sure that this organization is in good standing and that we do get this construction project completed as soon as possible.

CHAIRWOMAN SAVAGE: Okay. Does anyone on the board have any questions? Mr. Katz.

MR. KATZ: Could you please tell me exactly where you are today with the project?

MS. BOLDT: So we are really 99 percent done. We believe all the arrangements that need to be made for the HVAC are done. I just want to hold out and make sure that I'm not signing off on something, because the problems have been intermittent. We pretty much have changed out the whole components of the HVAC system. So really it's just making sure that there isn't anything else that I'm signing off on before it's before it's, yeah.

MR. KATZ: Are you comfortable giving yourself enough time to get through that, 'cause those things can be messy.

MS. BOLDT: I do believe that extra month will be sufficient.

CHAIRWOMAN SAVAGE: Okay. Other questions?

(No verbal response)

CHAIRWOMAN SAVAGE: All right. Hearing none, George, if you could please call the roll.

MR. ROATE: Thank you, Madam Chair. If I may correct myself, I initially mentioned this was a fourth renewal. This is actually the second renewal request; my apologies. Motion made by Ms. Hardy Waller, seconded by Mr. Burnett.

MR. ROATE: Mr. Budde.

MR. BUDDE: Based on the conversation today, I vote yes.

MR. ROATE: Thank you. Mr. Burnett?

MR. BURNETT: Yes. Based upon today's testimony.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes. Based on today's testimony.

MR. ROATE: Thank you. Ms. Hendrickson?

MS. HENDRICKSON: Based on today's testimony, and I'd also compliment you guys for being interims. You can handled yourselves really well, so thank you. I approve.

MR. ROATE: Thank you. Mr. Katz?

MR. KATZ: Yes.

MR. ROATE: Thank you. Mr. Gary Kaatz.

MR. KAATZ: Yes. Based on testimony.

MR. ROATE: Thank you. Ms. LeGrand.

MS. LEGRAND: I also vote yes, based on today's testimony.

MR. ROATE: Thank. You. Dr. Tanksley.

DR. TANKSLEY: Yes. Based on today's testimony. And I echo my colleague that it is hard being interim. So, thank you for what you're doing.

MR. ROATE: Thank you. Ms. Hardy-Wallen

MS. HARDY-WALLEN: Yes.

MR. ROATE: Thank you. Chairwoman Savage?

CHAIRWOMAN SAVAGE: Yes. Based on the State board Staff report and testimony today.

MR. ROATE: Thank you. That's ten votes in the affirmative.

CHAIRWOMAN SAVAGE: So that permit is approved. Okay. So now you will stay with us for alteration requests. So D-01. Also Fairfield Memorial Hospital in Fairfield, Illinois. May I have a motion to approve the project cost increase to project 18-029, it is the second permit renewal request for this project.

MS. LEGRAND: So moved.

DR. TANKSLEY: Second.

CHAIRWOMAN SAVAGE: Okay. George, if you could give us our state board staff report.

MR. ROATE: Thank you, Madam Chair. The permit holders the, the alteration request was submitted on, on March 1st, 2024. And the permit holders are requesting to increase the overall project cost. On October of 2018, the permit holder was approved for a modernization expansion project on the campus of Fairfield Memorial Hospital. The cost of the project was $24.8 million with an initial

project completion date of July 1st, 2021.

The permit holders have since received an approval for their permit renewal. The alteration to the permit is asking for an increase of $80,526 an increase of 0.3 percent, which is within the state's standard. The applicants are -- the applicants cite some unforeseen costs in finishing up the project as being reason for those requests.

CHAIRWOMAN SAVAGE: Thank you. You may proceed.

MS. BOLDT: Okay, sure. Thank you so much. I'd like to go over a few of the overages that we have, sort of a key note. Dana mentioned earlier about our exam lights having to be added. In addition to the cost of those lights, it was roughly just shy of $68,000 for the installation of them. Also, from the time of the bid to whenever the project started, steel had increased, we had an additional $103,000 just in the cost of steel. We also did choose, kind of seeing where some things were at for us whenever the pandemic hit. We had only one negative air pressure room in our hospital.

So in this new expansion, we did add four exam rooms that did have the negative air pressure for patient safety; that was in the tune of a little over $21,000. So the total amount of overages, as you mentioned, $80,526.45

cents. And we would like to request that. We are a rural critical access hospital a little over four hours south of here. We serve about 60 percent of our patients are Medicare and or Medicaid. Some of those patients that now with these new OR rooms and the services we can offer, were previously traveling 70 miles to Indiana.

I know the health systems accept Illinois Medicaid, but there are a few of the independent practitioners and surgeons that did not accept Illinois Medicaid plus the transportation. So this, this building has been amazing for our community. So thank you.

CHAIRWOMAN SAVAGE: Any questions for this applicant?

(No verbal response)

CHAIRWOMAN SAVAGE: Okay. I think you gave a very thorough presentation. George, if you could please call the role.

MR. ROATE: Thank you, Madam Chair. A motion made by Ms. Legrand, seconded by Dr. Tanksley. Mr. Budde.

MR. BUDDE: Yes. Based upon today's testimony and explanation.

MR. ROATE: Thank you. Mr. Burnett?

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson?

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. David. Katz?

MR. KATZ: I vote yes. I would just add to the lawyers and other consultants out here be helpful when you put these proposals together, if you could put a little padding in the timing. You know, put a padding on the budget; be ready to come in under budget. Because the fact that we are here talking about a $25M project that, you know, one percent of the HVAC, .03 percent of the cost overages. It's just not a good use of time for a committee whose charter is really to make sure there is access, make sure there is financial viability for a few other things. We've completely lost sight of what we're trying to do here. So, that's not fair I'm taking it out on you guys, at all but I would ask all of us in the room to think about that. I do vote yes though.

MR. ROATE: Thank you. Mr. Gary Kaatz.

MR. KAATZ: I vote yes, based on testimony.

MR. ROATE: Thank you. Ms. LeGrand.

MS. LEGRAND: I also vote yes.

MR. ROATE: Thank. You. Dr. Tanksley.

DR. TANKSLEY: I vote yes. Based on the

state board review and the testimony.

MR. ROATE: Thank you. Ms. Hardy-Wallen

MS. HARDY-WALLEN: Yes. Based on the explanation.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes. Based on the State board Staff report and testimony today.

MR. ROATE: Thank you. That's ten votes in the affirmative.

CHAIRWOMAN SAVAGE: So that permit is approved. Thank you. Okay, so now we're going to move on to application subsequent to initial review. H-01 is our first Pain and Spine Institute in Joliet, Illinois. May I have a motion to approve project 23-033 for the establishment of a surgery center for pain management.

MS. LEGRAND: So moved.

CHAIRWOMAN SAVAGE: May I have a second?

DR. TANKSLEY: Second.

CHAIRWOMAN SAVAGE: Thank you. Let's, when you all sit, if you could share your names and spell them for the court reporter and then he will swear you in.

MR. SHARMA: Samir Sharma co-founder of Pain and Spine Institute, S-A-M-I-R. Last name is S-H-A-R-M-A,

MR. H PATEL: Hudet Patel, P-A-T-E-L. I'm also co-

founder of Pain and spine

MR. J PATEL: Jignesh Patel. Practice Administrator. J-I-G-N-E-S-H Patel, P-A-T-E-L.

MS. COOPER: Ann Cooper attorney for the Applicants, A-N-N-E C-O-O-P-E-R.

MS. FRIEDMAN: Kara Friedman, counsel for the applicants.

THE REPORTER: Ms. Friedman, Mr. Sharma, Mr. And Mr. Patel, and Ms. Cooper, please raise your right hand.

(WHEREUPON:

SAMIR SHARMA

HUDET PATEL

JIGNESH PATEL

ANNE COOPER

KARA FRIEDMAN

After being duly sworn were examined and testified as follows:)

CHAIRWOMAN SAVAGE: George, if you could give us the state board staff report.

MR. ROATE: Thank you, Madam Chair. The applicants propose to establish a single specialty ambulatory surgical treatment center. Providing pain management surgery services located at 756 Essington Road, Joliet, Illinois. Project cost is $2.42 million. The project

completion date is December 31st, 2025. There were no requests for public hearing and there were four negative findings.

CHAIRWOMAN SAVAGE: Thank you. If you'd like to proceed and please be sure to speak into the microphone.

MR. SHARMA: Good morning. So thank you board for giving us this opportunity to present our plans for an unopposed single specialty, ASTC in Joliet, Illinois in Interventional Pain Management. I also wanted to take a few minutes to thank our letters of support from our local firefighters, teachers, police officers, physicians, Dr. Carrie Temple, who was an orthopedic spine surgeon with Illinois Bone and Joint, and JT McNaughton, who is a village board trustee of Homer Glen; All of which have been patients for Pain & Spine Institute over the last several years, and taken the time to author letters of support for our project. And lastly, I wanted to thank Ms. Sean Maconey for her letter of support, who is the executive director of Will County Medical Clinic who's located in Joliet, Illinois, who provides pro bono primary care healthcare services to the uninsured, underinsured and patients with insurance but lack access to the residents of both Will County and Grundee County, which comprises over 750,000 people.

Will County Medical Clinic recently received expansion money funding their expansion or capital expenditures and expansion of their services. And continuation of excellence of care, which actually opened up opportunities for Pain and Spine Institute to partner with Will County Medical Clinic in 2023. As the only physician specialty providers in interventional pain management, treating patients of pain of Will County Medical Clinic pro bono or free of charge.

So now, Dr. Patel and I started pain and Spine Institute in 2007 with one primary process, or one primary principal in place. To provide advanced interventional pain management care within 48 hours of when a patient calls to when a patient is seen in office by a pain and spine provider. A concept of accessibility that is lost in healthcare today. Little bit of background. So I myself was born in Joliet, Illinois. When I came out of training, I joined a 50-person anesthesiology group in the northern suburbs of Chicago.

Being one of three interventional pain management providers, of which my obligations were split between anesthesiology and pain management, which is still a very normal landscape throughout today's environment in terms of hospital contracted anesthesiology groups. The

consequence of which, however, created substantial delays lack of access of care days delays in terms of patient care from a pain management standpoint, from when they called to when they were seen by a pain management provider of several weeks or even months at times to get in and see one of myself or one of my partners at the time.

Now, someone in a debilitating, painful condition, you know, one to two days is absorbent amount of time, let alone weeks to months to see Medicare health. And people will do what they need to do to try to get themselves out of pain. And so when we decided to start pain and spine institute in 2007, I had a two year, 250 mile clause from Arlington Heights, which opened up the opportunity to come back to Joliet to provide healthcare services to a community I was born and raised in.

Where Dr. Patel and I, with our first office, physically with our own two hands built out our office setting. Fast forward to today in 2023 pain Spine Institute had provided pain management care to over 20,000 patients in pain, still holding up core principles in place of expedited interventional pain management care within 48 hours of when a patient calls to when a patient is seen providing the accessibility that we started with.

So now pain is a, is an enormous healthcare burden in the United States today, and we've all known or heard of some of the prevalence and occurrences or statistics of people with back pain, opioid abuse, as well as opioid fatalities. And this is real, and this is something that the two of us deal with on a day to day basis. One in three people in the United States that's over a hundred million residents, sometimes in their lifetime will experience a chronic debilitating, painful condition.

We know chronic pain leads to accelerated neurodegenerative conditions such as dementia, chronic depression, suicidal ideation, opioid dependence, and opioid addiction, leading to over $600 million, $600 billion of healthcare costs than most productivity, which is more than treatments for cardiovascular disease, diabetes, cancer treatment; putting unneeded stresses on Medicare services as well as Social Security disability. So now in 2019, the US Department of Health and Human Services, along with Department of Defense, veterans Affairs and Office of national Drug Policy, created the best practices guidelines for all physicians to follow in light of the opioid epidemic that is occurring across the country.

And it's summarized in the three primary products:

1.) Utilizing restorative therapies including physical therapy, chiropractic therapy, massage, and ultrasound.

2.) Incorporating cognitive or behavioral therapies for patient care.

3.) Minimization of narcotic prescriptions and utilizing interventional pain management as an intermediary between conservative treatment and open surgical treatments.

As we know that the open surgical counterparts a lot of times, require chronic narcotic usages, which is forefront going into opioid addiction. Now, pain and spine from our onset has been utilizing best practices guidelines, collaborating with our healthcare providers, our primary and specialty surgeons and physicians to provide expedited accessibility care to these patients where we get them in, evaluate, diagnose, and treat, bringing them back to a normal functional physical demand level, eliminating narcotic usages in majority of these cases.

Now, diving back into specifically our practice itself and why we're here today, and some of the requirements that we see that we need to continue to provide at a high level of care of healthcare to the patients that we see in the communities. As mentioned of over the 20,000 patients that we do see on an annualized basis, 75 percent of these patients are treated conservatively again utilizing

physical therapy, chiropractic therapy, both of which we implement within our office-based locations. A lot of the non-narcotic physical pharmacotherapies in accordance with the best practice guidelines.

However, it is a 25 percent of patients that do not respond to these conservative treatments where our field of interventional pain management comes to the forefront. Dr. Patel and I would be the first to advocate that a number of the common procedures that we perform for soft tissue, muscle, ligament, tendon, joint, extra spinal treatment can be in, and have been safely performed in an office space setting for years, if not decades safely. At a substantial cost benefit ratios when compared to being performed in a outpatient hospital setting of over 90 to 95 percent.

However, it's the advances tech technological advances in our field of interventional pain management over the last several years that have now brought patients options of minimally invasive spinal procedures or surgery as an alternative to major open surgical procedures that have provided substantial patient benefit, comparable effectiveness, add significant cost benefit ratios when performed in a licensed data compared to a hospital based setting.

However, because of the complexity of these procedures, they have both procedural requirements as well as patient safety requirements that go above and beyond what's available in an office space setting. From a patient standpoint, some of the benefits include elimination of open surgical risk hospital stay. So again minimizing the risk of postoperative or hospital required infection. Number two, these are all minimum invasive procedures where these patients are home within a few hours of the procedures, back to a normal functional demand level within a few days, substantially eliminating the narcotic need to a few days from several weeks to months in the open surgical counterparts.

And again, when performed in a licensed ASTC compared to a hospital based setting cost savings of 70 to 75 percent, to insurance companies. Now from a structural standpoint of both requirements to be able to do the procedures within standard of care, as well as providing for patient intraoperative and postoperative safety, there are requirements that go above and beyond what is available in an office based setting of what we're talking about.

So from a patient standpoint, dedicated anesthesiologist as well as recovery room staff to provide

for both intraoperative and postoperative patient safety, and then large enough recovery rooms and operating rooms to accommodate these specialty equipment. As well as providing a negative pressure line for the procedures that we do to, again, minimize any risk of postoperative infection.

In our field of interventional pain management. Of all of these spectrum of treatment options that we have for patients, there's over one third of these procedures are these minimally invasive surgical procedures that have FDA approval for the devices as well as CMS approval for the procedures with national coverage determination. However, because the complexities are not allowed to be performed in an office-based setting and required to be performed in a licensed ASTC is to see or a licensed hospital based setting. I believe we provided a number of CTP codes or CBT codes of these procedures, and they essentially focus around spine related injuries. So spinal cord injuries, spinal nerve, and peripheral nerve injuries, and the whole spectrum of spine related pathologies including disc herniations, spinal stenosis, instabilities, and spinal fractures.

In our 10-mile service area from our Joliet location of where we are presenting to have our single specialty

office location, there's been four identified licensed ASTCs or hospital based settings that have pain management procedures; that was identified in the state board review. Two of the hospitals or one hospital, including the hospital and the surgery center, both Silver Cross Hospital and Silver Cross Surgery Center has an exclusivity clause with their staff contracted anesthesiology group. So Silver Cross Hospital and Silver Cross Surgery Center do not allow pain and spine Institute physicians to have privileges at that facility unless we're employed directly through the Department of Anesthesiology.

The third location would be AmSurg, which I believe there was data that was provided in terms of utilization in 2021, over in 2022 Midwest Orthopedics at Rush established a Joliet location within the facility or within the Joliet area, taking a majority ownership within the Amsurg facility, significantly increasing utilization at that location. We have as Pain Spine Institute have a working relationship with Midwest Orthopedics at Rush, where they utilize our facilities to provide expedited pain management care as their own pain physician scheduled four to six weeks out to be able to perform procedures at the AMSURG location.

And then the last location identified was an extension or presence in Saint Joe's Medical Center of which both Dr. Patel and I have been staff physicians here for over 10 years, and have only been allowed to be credentialed for one of the minimum invasive surgical procedures. All other surgical procedures fall under exclusively clauses of either staff neurosurgery or staff interventional radiology. So restricting pain and spine physicians being able to provide these procedures at that location.

With the one procedure that we are able to perform, there's significant work flow difficulties as we are required to follow staff general surgery, neurosurgery, orthopedic surgery, and understand these physicians have complex cases and they a lot of times go above and beyond dedicated or allocated time frame requiring our cases to follow those cases, creating substantial delays for patient accommodation and physician schedules.

And secondarily the contracted anesthesiology group preferentially does not schedule elective cases past 3:00 PM not allowing our physicians to perform these cases in the evening or weekend hours, again to accommodate patient and physician scheduling. This entirety of what we have to deal with limits the type of quality care that we are able to provide in our Joliet location for our patients. We do

have staff privileges at outside surgical centers, located in Oakbrook, Orland Park, as well as Chicago, which would require us to take these patients to those locations to be able to provide the care of the procedures that are not available in the 10 miles service area.

I think by having a licensed single specialty, ASTC in Joliet, Illinois would allow us to provide high level physician care from a cost effective standpoint and keeping that treatment option in the community that we practice.

MR. PATEL: Good Morning board I'll be very quick and I don't want to go over a lot of the same things again, so this way you just get an idea to talk to me and you can hear me out as well. Okay. So in 2007 when we first started you know, we've known each other since 1993, so we're like, one day we're going to start a pain clinic together, or a medical practice together, and we ended up doing it. So 2007 we'd go up and we actually did put up the cabinets in our walls ourselves. They were crooked, but we managed to get that done, you know, at that point.

But we've grown since then. When we first started a pain clinic down the street from us that went under, they were very heavy on medication use, we'd had patients that show up saying, I got a day left of my meds. And they're

on astronomical doses where scared us, being trained to do, to do all this stuff. Patients with morphine vials coming in saying, you need to build this in my pump. And to deal with these patients is we were able to do targeted injections to find the source of their pain that minimize their pain and actually wean them down off their medications.

And part of these patients that are on opiates, they require us to be there with them to talk to them. It's just not only to do a procedure, they feel better and it's done. Part of this is, you know, make sure we hold their hands and say, you're going to get through this. They might need extra visits, meaning that we need to be able to staff the offices that we're at. And it's important just to be in the office. And at the same token going up what Dr. Sharma said, we strive to get patients in within 48 hours.

There's multiple times throughout the month that we get a patient from a orthopedic surgeon, neurosurgeon, a primary care doctor saying, this patient needs to have surgery, this patient's going to go to the ER, can you help us out? And we're like, sure. Have them come over now or have them over tomorrow morning. We make sure that we service the office to get these patients to reduce

hospital visits that prevent them from going to the ER. Treat them, keep them off the high dose medications where they could get to see a spine surgeon. And at the same token, we've developed these good connections with our doctors and surgeons where we could say, you know what, I think this patient's going to need surgery. They can't wait three months because they're going to be ramped up on meds. And we're able to provide that treatment for them as well.

You know, to, to tie things in pain management has grown a lot and there's certain procedures and injections that we could do that weren't available when we first started. And with these new procedures, we could actually postpone surgery or even avoid major operations, but we have to be able to do those in our clinics. So we still staff our patients and still provide the care that we've always provided to our patients around that area. And to be able to do so, having that ASTC located right there, we'll able to staff it based on the number of staff members who are able to get patients in right away, don't have to worry about our case getting postponed, pushed up or bumped for something else. I think we'd be able to provide better quality of care to our patients if we had that there. Thank you very much. I'll give time for

questions.

CHAIRWOMAN SAVAGE: Thank you. Do our board members have questions for this applicant?

MR. KAATZ: So where it says in the report, 4,537 referrals come, I guess it's through your practice into the surgery center, is that correct?

MR. PATEL: Yes. So those referrals come from all the spine surgeons, the primary care physicians that are in the local area.

MR. KAATZ: Okay. Where do those procedures get physically done now?

MR. PATEL: They get done in our office.

MR. KAATZ: Okay, so all the 4,500 are done in, in your office now?

MR. PATEL: Not all of them. Most of them, the ones that require a higher level like a spinal cord stem implant, they need to get done somewhere else.

MR. KAATZ: Okay. What, what percentage is that?

MR. SHARMA: So, so the specialty procedures of the minimal advanced surgical procedures, we take the outside surgery centers or try to do it within the hospital. I'd say currently it's probably less than 15 percent because of the lack availability. Patients don't want to, you know, the dynamics change, you know, post

Covid with, with how patients perceive hospitals. Hospitals are now thought of being as, as that's where you go if you're sick. So patients don't want to go to a hospital. A lot of patients don't want to travel up to Chicago to be able to have these procedures. We work with our, you know, surgical colleagues and the fight is to minimize the risk of utilization of narcotics, which a lot of times that's what patients ask for. Can't I just get on a pain killer and kind of get through passed this?

MR. KAATZ: So 600 or so other procedures or things that need to be done in a surgical suite based on 15 percent of the 4,500 and the rest, you're doing the injections and stuff in your office now?

MR. SHARMA: Yeah, I would say a minimum of 600. So there, there's a number that, you know, the adoption is just dropped. Okay. Either the patient just doesn't want to go down that route 'cause they don't want to travel nowhere. We want to see in orthopedic or a neurosurgical spine surgeon to go through a, a larger procedure from that standpoint.

MR. PATEL: So I think that what Dr. Sharma is trying to say is that we could provide these other more invasive things if we ever have the ASTC, 'cause the patients don't want either travel far to go get it done.

They're like, well, if you can't offer it, offer it to me here. I'd just rather not get it done.

MR. KAATZ: Okay. Okay. All right, thank you. You, you make reference to single specialty, help me, is it anesthesiology or is it orthopedic spine? What's the single specialty?

MR. SHARMA: So pain management.

MR. KAATZ: Pain management. And is all of your pain management done by anesthesiologists?

MR. SHARMA: Correct. We're both board certified fellowship trained in anesthesiologist and pain management.

MR. KAATZ: Thanks.

DR. TANKSLEY: I wanted to ask a question just kind of about the, the concept of, of the pain management that you do. You mentioned the opioid crisis and addiction a number of times and, and I went through all of your support letters and I'm trying to find the support from your primary care providers, those folks that often get tasked with writing those prescriptions when the pain specialists aren't able or aren't willing to write those prescriptions. So I want to, so I agree with you that and I appreciate what you guys are doing in providing alternatives to medication.

I want to be mindful that there are times that people require medications, and I just want to know how do you guys address that and, you know, and how do you work with your, your non-pay specialty colleagues in assisting in that sometimes burdensome area of providing that level of chronic pain management as a non-specialist?

MR. PATEL: Yeah, absolutely. And you're right. I mean, I could give you an example from yesterday; I saw a patient, she was 85 years old. Great lady, grandmother, you know, she's had multiple operations. She's not going to tolerate a lot of injection procedures. She's on one or two pain pills every couple days to maintain her pain. That's reasonable. There's no reason for her to go invasive procedures that she's maintaining and she's doing well.

So what we tell our primary care doctors to do is one, they just refer them to us and we'll take over that point and then we'll discuss options with the patients. And most of the times our primary cares are fine with that. They're like, I'd rather you deal with it. I'd rather see them for the other issues that I gotta deal with. Because you guys have a list of like 18 different things to deal with in a very short period of time. So they're like, they're happy to do it.

Some of the primary care doctors are like, would you mind seeing them once every six months or once every three months or once a year? Whatever is good for them, we're open to, so we leave it up to them. So we're, we'll see him more often or if you want to see them, we'll just approve things and we'll do it that way. But we do like to see them at least once a year so we can see if there's any new techniques or anything that's there available to help bring them down that we offer that to them.

MR. SHARMA: Yeah, I think a another aspect is that we commonly, when we started a large part, again, there was not a lot of minimal invasive surgical procedures out there. So a lot of the surgical colleagues that we worked with did the operation. These patients were still on 2, 3, 400 milligrams of morphine equivalents narcotic. And they're like, all right, well I'm done with what I'm doing. Can you guys help out? And we took them and we're like, yeah, we'll help you out. So I, I didn't want to come across as that we're absolutely against it. I think absolutely there's a role to it, but I think how was, you know, obviously it was prescribed or how do physicians that utilize it was just as complicit in terms of the opioid problem that we see. And that's, that's kind of where our role is, is to

try to educate, to kind of say, Hey, these are what we can do. You don't have to go down this route. You know, if we could get involved in, you know, you know, kind of minimize that or eliminate that out of the equation in its entirety.

And that's all I'm sure you deal with this on a day to day basis.

DR. TANKSLEY: And I probably, I just had a couple follow up today because that, so one, I guess, so even more concrete, my question is do you have relationships, MOUs, whatever, some type of formal type of relationships with addiction medicine specialists, with, with other individuals that can, that care for the things that you aren't able to care for?

MR. SHARMA: Absolutely.

DR. TANKSLEY: Then another follow up is, what is the clinics or you know, the entities stance or policy on cannabis as a use for -- medicinal cannabis for chronic pain in the state of Illinois?

MR. PATEL: We Okay. Yeah. I'll, I'll answer. It's a, it's a gray area 'cause our licenses are DEAs a, it is a federal license and state wise, it's legal for recreational use and some medication use.

DR. TANKSLEY: So it's a qualifying condition for

correct use.

MR. PATEL: And I tell patients, I'm honest with them; in med school, we didn't learn that can do, you know, there's a system out there that there's not taught in medical school, you know, I mean, other countries not in this country. And I tell them, I go, I just don't know enough to tell you that it's okay for you to have Oxycontin with cannabis. I go, I'm okay with it, but you have to pick one or the other.

And if you do this, we're going to send you to a doctor that knows how to use it Right. And prescribe it. I, it's not like you go to the counter say, gimme two joints and I'm good, good to go Like that. There's certain techniques and ways to use it the right way, especially if you don't want to have the THC where you don't want to get the, the psychoactive effects. And there's CBD, CBG, CVN that are effective as well.

So we incorporate the use of other doctors as well and we tell them when there's opiate use and THC, we like to split those up so we have to pick one or the other.

MR. SHARMA: So we're, we're actually just to add briefly, we're, we're working with a trauma surgeon out of Christ Hospital and a, a pharm D of Christ hospital that they opened up a compounding pharmacy for cannabis. And

they're creating a, a database of trauma patients of, of full spectrum of trauma patients and trying to identify what combinations between CBD and THC are, are best for certain types of debilitating, you know, chronic painful conditions.

So we're -- we've implemented with that research going on. So we're advocates for it done in the right way.

DR. TANKSLEY: Well, I just want to make sure you guys are at least thinking of the conversation. 'cause I know that comes up quite a bit with, with patients with chronic pain and, and often they're turned away from pain facilities 'cause of their medicinal use of the substance in the state. That's true. Thank you for exploring and having those conversations with the specialists in that area.

MS. LEGRAND: Yeah. So I, I find ASTC is fascinating in general. My question really comes when you talked about the cost saving. I would like to understand what you expect your payer mix to be in your a your in your ambulatory surgical treatment center. And the reason why is, as you mentioned, there is a concern about individuals going into the hospital. There is also concern of overly burdening our hospital systems with non-private pay patients. And so what would you expect your payer mix

to be if you operational?

MR. SHARMA: So our current payer mix and correct me if I'm, I'm off. So I would say you know, we, we do have staff privileges that's mentioned at, at St. Joe's Medical Center and St. Mary's Medical Center in Kankakee. So we see their patients that we are consulted on at our facilities. And then we do work with Medical Clinic. So I think that brings our uninsured patient below, just below 5 percent. Medicare would be a large majority, probably another 45 percent. And then we see commercial would probably be in the, in the ballpark of 30 percent. And then we do some expert work litigation work for you know, work related injuries we call third party things of that sort, which probably be in the 15, 20 percent range.

MS. LEGRAND: So just to clarify, you're expecting that your current payer mix will transfer into your new setting and not necessarily change once you enter into this new setting?

Dr. SHARMA: Oh, Absolutely. That's correct.

MS. HARDY-WALLER: Thank you for your testimony, and I really appreciate the level of detail you went in talking about the interventional pain management services that you provide and also would really like to applaud you for the sort of above and beyond that you do with the one-

on-one patient support to expand quality of life for those patients. One of the areas of nonconformance was duplication and certainly again appreciate the detail of the work that you do, but can you help me understand and maybe justify, given the, given the fact that there is capacity within the market to do similar or same service, how does your work differ from those hospitals or facilities within the market around the practice that you're talking about Doing?

MR. SHARMA: Yeah, sure. Something jump under that. So within the 10 mile service area, I believe the board identified there were four locations that had utilization access for pain management. As I mentioned, two of them silver cross hospitals, silver cross surgery center are strictly closed to outside pain management procedures or outside pain management physicians that are not employed through their contracted anesthesiology group. Those two hospitals or the hospital and surgery center don't perform the procedures that we indicate.

They do have Parkview Orthopedics at Rush Midwest Orthopedics at Rush has staff privileges within the silver Cross location and increasing utilization from that standpoint. But the fact that we are not allowed privileges at two of those facilities, that becomes, it's

not even an option for us to, we've been trying to for probably five or six years.

We submitted applications there probably in within 2022, 2023. And of all that came back is you have to apply through to the Department of Health that's addressing those two locations. Amsurg is only a mile away from our location. And I believe the, the state board reviewed identified utilization data from 2021, and that was prior to Midwest Orthopedics coming into Joliet in 2022 and take majority ownership of substantially increasing utilization 2022 through 2023. And in 2024, they're implementing a total joint replacement outpatient program at AmSurg as well.

Their current position. So they do provide interventional pain management are scheduling out four to six weeks at that facility 'cause of their other orthopedic surgeons. And hence they use our facility to expedite or provide accessibility to their patients and expedite care from that standpoint. And then the last component is Saint Joe's Medical Center, which has utilization however, restricts us to only one of the minimally invasive surgical procedures that we are asking for.

I think we submitted CPD codes for over 10 or 11 of

them. All those other procedures are not approved because as a result of credentialing committee, including staff neurosurgery that sits on the credentialing board that they fall into any further interventional or open surgical care falls under neurosurgery, spine neurosurgery or on actual care or spine technologies fall under interventional radiology as exclusivity. So they only have one of the advanced procedures that we are requesting privileges.

MS. HARDY-WALLER: So just for clarification, the two hospitals that have the exclusivity for physician privileges, are you saying that none of those physicians who have those privileges provide the same procedures that you do?

MR. SHARMA: At all four locations, they don't have any, any compliment trained pain management physician, ESEC Valley trained, fellowship trained that are doing any of those procedures in any of those four locations.

MR. KATZ: Thanks. I want to try to ask the question maybe a little differently 'cause what I'm trying to understand is who loses. I understand this is great for you and I understand it's great for a number of your patients. Probably all the patients, right? 'cause Some

have access to procedures they couldn't otherwise get, others get more choice of who they want to get treated by. Who, where does it, who loses who, who's taking the other side of this and saying, boy, this is the last thing we need is for these guys to come up and open a, you know, interventional pain management.

MR. SHARMA: So I think we work collaboratively. So I brought information in regards to the primary orthopedic spine surgeon at St. Joe's and the primary orthopedic spine surgeon at Silver Cross, both advocating doing over 200 procedures at either hospital individually, as well as referring over 400 patients a year from one of them over 500 patients a year to, from another one to us because of the fact of lack of availability or accessibility for patients.

So I think there, there's always going to be a place. So we're not, we can't replace all orthopedic spine or neuro spine surgical procedures. However, just in all disciplines in medicine, you know, the treatment of medicine is going from major open surgical procedures where patients have to say for days, weeks, in and months, they now be an outpatient. And that's kind of where the technology is, is transitioning to the procedures that we had indicated.

They, they fit specific indications. So it's not all encompassing. So we're not, I think the, the pie is, has grown big enough so we're not taking part of the pie at the same size pie. The pie is becoming big enough. You, you anecdotally you see this as well as statistically a lot of physicians are not accepting Medicare or not operating on Medicare, not rendering treatment on Medicare patients.

A lot of these patients have nowhere further to go. So I think our experience in, in terms of our facilities is, and with the collaborating physicians that we work with, is that they're doing procedures that they feel comfortable with doing the procedures that they do not feel comfortable with doing. Whether it's someone that's elderly or someone under a Medicaid insurance or someone has Medicaid insurance or uninsured falls into the hospital setting of interventional pain management where we can help these patients. And not you know, allow them to be just restricted to be medically managed with either cannabis or a narcotic.

MR. KATZ: Yeah, I'm not, that's helpful. I guess philosophically I think I'm less sensitive to for-profit surgery centers that are competing for business with you or you with them. That's the way the market works and

should work. I guess I'm more sensitive to whether this just increases the burden. I think this is where someone was going. I think you were going earlier on hospitals. And I, I don't know if our, if you guys have spent a lot of time, more time than we have with this.

Does staff have a view on you know, it's great to talk about capacity and market demand, but do we have a view is this, does opening this down the road create undue or unusual burdens for some of the providers that are already out there? Projections? I, I, and, and you may not have looked at it, I'm just trying to understand it.

MR. ROATE: I collectively by nature, the, the referral process takes from other healthcare facilities. So naturally they will take from a outpatient surgery centers will draw from hospitals, and it's, and our referral actually state that these referrals must be to IDPH approved facilities, which either fall under ASTCs or other hospitals. So by design, they will take from the other facilities. But the true question is, does it take to a point to where it causes capacity issues or you get you should get you, you should get objections from the hospitals where the facilities are taken from. And periodically we do get those letters.

MR. KATZ: But I mean, it doesn't, you, you've

talked a lot today about procedures that aren't being done elsewhere. Right, right. So that isn't by definition taking from other providers.

MR. SHARMA: Right.

MS. FRIEDMAN: I will point out the leadership of health systems carefully monitor what's going on in this board. So we're sure that hospitals are aware of this project and there has not been opposition. You've been, you know, we've had other people present before you that do see that opposition.

MR. KATZ: Yeah, that's a fair point. Thank you.

MR. FOX: You talked a little bit answering the question about payer mix, but what is the commitment of the group to, you know, the charity care and Medicaid patients? Because that's one of the things that I'm concerned about in this theme about if, if all we leave the hospitals with is payers who don't pay anything, when are we going to damage services at the hospital? And this board has seen a number of requests from hospitals 'cause of the financial pressure with increasing costs to get rid of services like mental health services and OB services and things like that. And so what's your commitment to, you know, if Medicaid patients and things like that? My background is hospitals and physician groups, and I

always had a rule that if you won't take my poor patients, you don't get my good patients.

MR. SHARMA: So interestingly, when we started,

MR. KATZ: let me, let me say good payer patients, not good patients. Lemme clean that up.

MR. SHARMA: Interestingly, in 2007 when we started, you know, we, if you tried to look us up or anything, it was a pain clinic. And the connotation and, and especially, and we were in network with Medicaid at the time, the connotation was, Hey, this is where I can go to get narcotics. So overwhelming majority of patients that came to us at that point were saying, Hey, I got this backache, we're do an MRI and I'm look pristine better than mine. And they're like, I need four or five Norco. And that was flooding in. And, you know, and I'm, you know, we're not trying to, you know, stereotype or anything that sort, but anecdotally that's what we experienced; So we came out of Medicaid. At that time, however, we never stopped treating Medicaid as part of our staff obligations with the hospital. So physicians, patients that had legitimate pathology, all our physicians that we're on staff with at St. Joe's, at St. Mary's, all of our spine surgical physicians, all our specialty physicians are clinical psychologists and psychiatrists

that we work with understand that if they have a patient and it is Medicaid, we will take them. We do it pro bono. And we have been doing pro bono work for 17 years, or I guess 15.

We're in network for, we're in network for two years. For 15 years we've been doing pro bono Medicaid work. Not for the fact of, you know, we, part of it, you know, we're not, you know, in incorporating any, any further healthcare costs to the state. Still providing within our care of communities instead providing within our credentialing guidelines of being hospital physicians.

DR. TANKSLEY: I have a follow up that I'd like to, so when you described your payer mix would you then say that the Medicaid population fit into that less than 5 percent uninsured that you mentioned? Or where would they fall percentage wise?

MR. SHARMA: Yeah, that would be uninsured. Uninsured.

DR. TANKSLEY: Right. But you didn't, and, and I get it, you didn't mention Medicaid, they were insured Not in, you don't, that's not a part of your standard payer mix. So what percentage would you say of pro bono work for Medicaid patients do you provide?

MR. SHARMA: I'd say probably comparable. So

probably in that 5 percent range or so. So less than 10 percent would be the collaboration of uninsured and Medicaid.

DR. TANKSLEY: And where in Joliet do those patients go then to receive their care? Not You not Sure.

MR. SHARMA: Well, no, we know. So, so they, there's no accessibility. So patients have to go to Cook County or Mount Sinai or UIC or things that we have as mentioned, we have or maybe I didn't, but there's a, one of the program directors for pain management is, does work with us a few days out of the month. And that's, that's a big patient population that they can't find accessibility. You know, they have insurance, but who takes it? Especially in the, in the specialty world

DR. TANKSLEY: Especially, I would, so in Joliet, 'cause that's a pretty good distance from Chicago, especially in a population of people who are probably experiencing other social determinants like transportation. So how would they, like, do you guys have any insight into what, what services exist or resources to help them get

MR. SHARMA: To Chicago?

DR. TANKSLEY: Or get the care that they, they also deserve?

MR. SHARMA: So what run the medical clinic is established just for that.

DR. TANKSLEY: What's your safety net system?

MR. SHARMA: So the, so the Will-Grundee medical clinic that we collaborate with is established just for that, a primary concern to be able to provide care within the community of the uninsured patients or underinsured or --

DR. TANKSLEY: And that's the housing support letter that you gave?

MR. SHARMA: Correct. Yes. and that's, that's all that's available here. But you, you're right, it's, there's a lack of resources. They can take public transportation. They, you know, there are these hospitals that now spread out into the community, but Rush is in the community. They don't take Medicaid at the rush location. University of Chicago, Northwestern, they all come out into the suburbs. They're not seeing Medicaid in the, in the suburban locations at their primary hospital locations.

DR. TANKSLEY: Yes. Yeah, I think that's a shame. I want to say that on the record. I think that's a shame. Okay. Thank you.

CHAIRWOMAN SAVAGE: Other questions? I think from

a perspective of family that has pain issues, you know, there is a long wait. Even if you have Medicare Advantage kind of plans as well as Medicare and insurance. So I think there they explain that well. Okay. So if there's no other questions, then George, if you could call the roll.

MR. ROATE: Thank you, Madam Chair. Motion made by Ms. Legrand, seconded by Dr. Tanksley.

MR. ROATE: MR. BUDDE.

MR. BUDDE: I appreciate the conversation today. It's helpful. I'm still real concerned with the, the lack of care for the poor and practice, if I understood correctly, does not participate in Medicaid. We just do it on the side kind of thing. I have to vote no.

MR. ROATE: Thank you, Mr. Burnett.

MR. BURNETT: Yes, based upon today's testimony.

MR. ROATE: Thank you, Mr. Fox.

MR. FOX: I'm going to vote. Yes. I'd like to compliment the applicant further, their commitment to providing advanced and I would say very patient friendly access for pain services. This is an area which is just burgeoning as the population gets older. And I think you'll provide a, a valuable service to the community.

MR. ROATE: Thank you. Ms. Hendrickson?

MS. HENDRICKSON: I will vote yes, based on today's testimony.

MR. ROATE: Thank you. David Katz.

MR. KATZ: I'm going to vote an enthusiastic Yes, I, I really appreciate the I, I kind of echo David's comments and, and the where the field's going. And I also appreciate the way you approached the testimony, which was not just a, answering the questions, but answering the questions. We may not have been smart enough to ask, but we're really trying to understand. So thank you.

MR. ROATE: Thank you, Gary Kaatz.

MR. KAATZ: I will vote yes based on the testimony. And as I understand it, there are not a lot of fellowship trained pain specialists. And I admire the fact that you, in your presentation, did not defer to the fact that most, in a lot of communities, there are physicians practicing pain management. And hopefully you'll do a good job with your community connections and get those patients to be referred to your program. So I vote Yes.

MR. ROATE: Thank you. Ms. Legrand.

MS. LEGRAND: I also vote Yes.

MR. ROATE: Thank you, Dr. Tanksley.

DR. TANKSLEY: I vote no. I, I would agree that I am challenged by the fact that there is, is not a,

a significant plan for the patients who do not have access to insurance. Or, let me, let me take that back. 'cause You do have a plan for your uninsured. So I, I want to stand corrected in that I am challenged by the lack of access for patients with Medicaid.

MR. ROATE: Thank you, Ms. Hardy-Waller.

MS. HARRY-WALLER: I would vote yes based on your testimony and also echo my colleague David's comments as well. But particularly your attention to addictive, the very high risk of addictive behavior of patients seeking pain management. I think that's extremely important given the opioid problem that we have. So, thank you.

MR. ROATE: Thank you. Chairwoman Savage?

CHAIRWOMAN SAVAGE: I vote yes based on the state board staff report and the testimony today. And I think as my colleagues have said, I mean, there's a ways to go for all providers to increase services to the Medicare population, or Medicaid population especially, and the underinsured. But, you know, I think there's such a need for this 'cause there are very, very long waits here in Will county and DuPage County. So I thank you for what you do.

MR. ROATE: Thank you Madam Chair that take votes in the affirmative two votes in the negative.

CHAIRWOMAN SAVAGE: So that permit is approved. Thank you.

DR. SHARMA: Thank you.

DR. PATEL: Thank you.

CHAIRWOMAN SAVAGE: Okay. So up next is H-02 Chicago Children's Surgery Center in Chicago, Illinois. May I have a motion to approve project 23-034 for the establishment of the surgery center for dentistry?

MS. HENDRICKSON: So moved.

DR. TANKSLEY: Second.

CHAIRWOMAN SAVAGE: Okay. When you all are seated, if you could please introduce yourselves, spell your name for the court reporter, and then he will swear you in.

MR. MORADO: Juan Morado Jr. J-U-A-N M-O-R-A-D-O-J-R

MR. WHEELER: Jeff Wheeler. J-E-F-F W-H-E-E-L-E-R.

MR. WELCH: Kyle Welch, K-Y-L-E W-E-L-C-H.

MR. SILVERMAN: Mark Silberman, M-A-R-K S-I-L-B as in boy, E-R-M-A-N.

THE REPORTER: Mr. Morado, Mr. Wheeler, Mr. Welch, and Mr. Silberman, please raise your right.

(Whereupon:

MAGNA LEGAL SERVICES

JEFF WHEELER

KYLE WELCH

MARK SILBERMAN

After being duly sworn were examined and testified as follows:)

CHAIRWOMAN SAVAGE: Thank you. Mike or George, if you could give us our state board staff report.

MR. CONSTANTINO: The applicant's proposed to establish an ASTC providing pediatric general dentistry and oral maxillofacial surgical services in approximately 14,600 gross square feet of space at a cost of $9.2 million. The completion date is July 1st, 2024. We did have findings on this application. There was no public hearing and no letters of support or opposition to proceed. Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you. If you'd like to proceed.

MR. MORADO: Good morning members of the board, very pleased to be before you today with a different kind of project. And frankly an exciting one, one that we hope will certainly aim to disrupt the status quo. This project doesn't conform to what you're usually seeing, it's a result of years of planning and it's built on the foundation of success that the application that the

applicants at the table have had another part of the country.

And that we hope to repeat that success here in the great state of Illinois. With me today, I have the co-founders of NewCor Health, Jeff Wheeler and Kyle Welch, along with my partner Mark Silberman. We'd like to thank the staff for all their hard work on this project and its report and for meeting with us. Before we even filed the application to discuss the concept and how to approach the application process, we would note that there was no opposition to this project, nor was there a request for public hearing.

And I think just one correction to the record. There were multiple letters of support that were submitted and are available online for the project. One of the things you should know is that we did approach county health departments for this project. We received letters of support from two Will and Lake County. We also reached out to Cook County and had not yet heard back for with a letter of support. We've also approached FQHCs and associations, and there's a letter of support from an association in the area as well.

Today you're going to hear from Mr. Welch who's going to discuss the founding of Care NewCor and how these

gentlemen came to get into this line of business, the mission of their organization, and what happens to the patients who need this treatment. Right now, Mr. Wheeler is going to discuss the planning work and who the facility intends to treat.

And finally, my partner Mark will address the criteria which were nonconformance. Members of the board. This project creates access where none currently exists. We've been fortunate to file applications for ASCs that accept Medicaid patients for treatment at their facility. But as you know, that's not always the case. Too often ASCs in this state will not accept Medicaid patients, and I want you to understand that this as SC is actually designed to primarily treat Medicaid patient population. And while that may not seem believable, as is described in your state board staff report, we can assure you that these patients exist.

`And you only need to look at your facility profiles to see that there are not many ASCs that are focusing on dental related procedures. And certainly there are none in the geographic service area. There are 3.9 million Medicaid patients in the state of Illinois, 1.5 of which are pediatric, and 250 of those are adults with developmental disabilities.

These people exist and their options for care are limited. The proposed facility is designed to treat these very patients, pediatric patients, and those developmentally disabled individuals who require sedation for dental care. We're hopeful that this first proposal in Illinois will be successful, and I will tell you right now that it's our expectation that we will be back before you with another project for another part of our state. While it's the first here in Illinois, this model's worked in Baltimore, it's worked in DC, it's worked in Detroit, and we believe it can work here as well. And with that, I'm going to turn it over to Kyle.

MR. WELCH: Thanks. before I talk about how we got started, I want to tell a story that I didn't know about until we started doing research. And it's about a child from where our current location was in that community. His name's Demote driver. If you were in dental school before 2008 or during 2008, you would know this name. Demonte driver had an abscessed tooth. This is like a $50 procedure, $80 procedure, nothing. And he could not find access to care in the state of Maryland. And this tooth went with its abscess for a period of time and eventually infected his bloodstream. He ended up having to get three brain surgeries and passed away for not getting access to

care associated with dental and an abscess tooth.

So let me start off by telling you a little about Jeff and I. We met in school around 2010 or 2011. And we knew we wanted to do something in healthcare. And if you look at the stack of cases in healthcare at the high end of the stack you find orthopedics, heart surgery, brain surgery, and you will find no shortage of hospitals that want to do these procedures. Everybody wants to do these procedures. And then if you go down a little bit, you'll find endoscopy where you find some people that are willing to do these procedures. Below that are the procedures nobody is willing to do, nobody wants to do.

And when people hear you're doing it, they say, why are you doing it? That's where dental is. Dental has been a walled garden in kind of medical care for their own purposes in some ways. And in this case, it's created problems because it's discounted for the need. So what type of procedures are these? These are procedures where pediatric patients, usually pediatrics, sometimes adults with special needs, but usually pediatric patients between the ages of two and seven or so have so much extensive dental work that they need to be put under general anesthesia for the work to be done appropriately.

So what does that mean, a tube goes in their nose down

their throat, in their lungs, and an anesthesiologist is keeping them alive as a dentist performs this work. This is the proper way to do it for a number of long-term reasons. When this care is not provided in this way, the alternative ways that this care is provided is sometimes what's called a papoose board, where they take the child, they strap the child down with Velcro straps, including their head and do the work on the child.

The problem is, and this is the problem in providing that care that way, is we see those children showing up to our facility when they're 17 and 18 with 30 teeth that need to be extracted because they are afraid of going to the dentist because they, when they were five or six, were strapped down to a table and treated in this way.

And so what made us take this approach is to providing care in this space as Jeff and I were in school. And when you can solve the problem of providing access to people that don't have another place to go, you solve actually one of the biggest problems in running an organization. And that is customers. Our customers are Medicaid state insured. We have some private pay, but we, we target these and we focus on these customers 'cause that's where our need is. And that's the base, that's what we see.

As far as how we're able to do this, this might be a

question that comes up. Well, hospitals might be doing this. Why are you doing this? Hospitals, these are usually the first cases to be furloughed at the hospital. So if you're scheduled and you have a stack they prioritize certain cases.

These are always the ones that get bumped. These are ones that don't get scheduled and it's hard to get privileges for. If they do a day, they usually see between three and four cases in a day. That's typical of a hospital. If you ask pediatric dentists what we do is we provide efficiencies because this is the only thing we do. We're able to see twice as many patients in a day than a hospital does. And what that does is it makes seeing Medicaid patients not like, go from like a non-profit center to something that actually works. The system works.

So what are some of the things we do? We have, instead of one dental assistant, we have three dental assistants in the room to make sure we optimize time. We have an anesthesia check to make sure the tech, to make sure that the ORs are turned over more efficiently. We invest in making sure these procedures are done super efficiently. And so much so that my two kids actually needed work. They needed general anesthesia for orthodontic work. And I've had two of my kids seen at our facilities, the quality of

care is top notch and providers that come to our facility and pediatric providers that come in, they see it, they see how we do it, they say, this is how it should be done everywhere, and no one's going to be doing it. So that's all I have. Thank you for your time.

MR. WHEELER: As you've heard, this is a, as you've heard, this is a non-traditional project. And so you may wonder why are we treating so many Medicaid patients? Is this really a needed service? And why did we pick this location in Illinois? Our current patients that are other facilities are disproportionately covered by Medicaid. They are, depending on the facility, it's about 89 to 99 percent Medicaid. And that is a, a very big focus and area, a concerted effort on our part is to increase access to care for these patients.

There's a huge need for these services. There's not a lot of good data on this. Two states that do publish data are California and Maryland. And the data that they have published indicates that there's, for every million pop inhabitants of a state, there are about 2000 cases using those same using those same estimates in the city of Chicago, greater metro area of about 9.5 million people, there would be about 19,000 Medicaid cases alone.

Not to mention non-Medicaid cases would increase that

to potentially 25,000 to 30,000. These patients are disproportionately covered by Medicaid because the types of services and situations that end up in is correlated with families. The very challenging lives that the families live for these patients. And they're not getting served because the hospitals, as Kyle mentioned the hospitals are allocating the resources elsewhere and it makes sense. There are limited resources in terms of, OR time in terms of anesthesia coverage and they do not choose persistent.

Dental care or care is not a priority and so there aren't many alternatives. UIC has a clinic that does these cases, but the wait time that UIC is over two years currently. We did research on the state of Illinois and on Chicago we, we spoke to there are 554 dental offices that accept Medicaid in the greater Chicago metro area.

We talked to 53 of those dental offices and seven of them said that they sent to UIC 24 of them say that when they see these cases, they tell their patients to call their insurance company and ask where they can go. 10 of them said they send people to Google and tell them to Google where they can go. And 12 of them said they have nowhere to send patients. There's a relatively low proportion of pediatric dentists in the state of Chicago,

I'm sorry, in the city of Chicago.

For instance there is a rate of 15 pediatric dentists per million population as opposed to, for instance, Washington DC has 35 per million. So it's less than half as many pediatric dentists per capita, which makes it harder to combat to resolve this issue. And mean that there's not access to care.

And there's especially a lot of need on the south side of Chicago where we have decided to place our facility. We have four other facilities. It typically takes about 12 to 24 months to, to hit profitability. As Kyle mentioned, we are able to see a lot more patients per day. And we believe very much in something that we call a triple win. It's gotta be a win for the patient. It's gotta be a win for the providers and it's gotta be a win for our staff in order to make, make the facilities sustainable.

And what we've seen is that typically our facilities have somewhere between a 4.6 and a 5.0 reviews in terms of their Google reviews because the patients love our staff, they love our triple win and they have a very delightful experience. And we have clinical safety and quality as Kyle mentioned. So I'm going to, that's my portion. I'm going to turn the time over, mark.

MR. SILBERMAN: So this project has the potential

to be a game changer. It is designed as Juan said, to disrupt the status quo by creating necessary healthcare where shamefully, there has been none. Consider the staff's observation that the average commitment to Medicaid for an Illinois ASTC is about 4 percent. This project is proposing 85 percent Medicaid and the only reason that number's not higher than 85 percent is because there's a portion of the patient population with special needs with developmental disabilities who also need this care. And while often they're insured, they don't have access to the facilities that have this specialized care. Now your staff in the staff report presented its conclusion that this commitment to Medicaid was not believable. And while certainly from a for-profit, ASTC, but Jeff and Kyle are here to demonstrate to you and to prove based on their experience that it is, and this isn't just good business as they've mentioned, it's doing good. There is a need here. Jeff and Kyle have already demonstrated their proof of concept in Baltimore, in Washington DC, in Detroit.

And as Juan mentioned, we want to be clear, we're convinced that the need for these services that going to far exceed a single ASTC with a single operating room. But we also appreciate that asking you to approve this project

requires a leap of faith. And Jeff and Kyle are here to take that leap with you. They're prepared to demonstrate the need and the viability of this project and only then return before you for approval to expand this facility. That can only happen however, if the board is willing to utilize the discretion that's afforded to it and to balance the value of this project and what it is designed to accomplish against the staff's findings. So to that end, I want to take a look at the findings of non-compliance, or candidly as I hope you will look at them today. Findings of non-conformance. Now there's seven findings, but realistically there's three issues. Size and cost, existing capacity and referrals with regards to size and cost.

The findings that the applicants found a space that's too big and they're spending too much money to develop it. Generally, this is not a complaint you hear regarding a Medicaid driven project. And there was another site that was less expensive but it was out in Plainfield. And candidly there's another option just across the border into Indiana where the applicants could just bypass the CON PRO requirements. But the issue is that's not where the patients are who need this care. Patients shouldn't have to travel 30 miles out to Plainfield to get this care

and they certainly should not have to leave the state of Illinois to get this care.

So rather than continue the trend of designing healthcare, being littered with unnecessary barriers to access this project is trying to minimize as many as it can. Hence the decision to locate this facility on the south side of Chicago, even though the result was costs and that in size that exceed the established standards of the board with regards to existing capacity of other ASTCs. Yes, there are ASTCs that show capacity, but none of these facilities are approved for, are appropriate for or are interested in providing pediatric dental care and certainly not to Medicaid beneficiaries, none have the dedicated staff the equipment necessary to provide this care or are interested in providing the care to the level that the need exists.

So that leaves us with the elephant in the room, which is the question of the referrals. I want to start with the most important points. The inability to provide referrals to meet the board's requirement is not an affront to the board's rules. It is not an affront to the board's process. When we had a technical assistance meeting with this board before even filing the project, we identified this as a challenge. We knew about going in the

applicant's not unwilling to meet the board's requirements.

It is literally unable to comply with the board's standards. And we want to explain why it's a byproduct of this board's need methodology being based on historical utilization. This board evaluates future need based on a demonstration of historical care where it was provided, who provided it. And it evaluates who will be a set impacted by any proposed project. The requirements for referrals are the same. And generally this works well. It certainly is the established standard. We're not challenging the board's findings, but it doesn't apply well to the introduction and to access to care where none exists.

Juan and I first experienced this when we appeared before you seeking regulatory approval to establish a post-acute care rehabilitation hospital in Illinois. Illinois's healthcare delivery system had been functioning for years without a delivery model that most of the rest of the country employed Illinois patients to get their rehab care were either staying too long in hospitals or were being discharged into nursing homes potentially too early to obtain the rehab care they needed. The concern that drove that project was that the care wasn't being

provided in the setting most beneficial to the patients. And in that instance, even though we knew exactly where the patients were and were getting care, there was an absolute inability to give referral letters. If you can imagine asking a hospital to document the fact that they were potentially holding onto patients longer than they should or going to a nursing home and asking them to certify the idea that perhaps they took a patient on before they were appropriate for skilled nursing care.

Instead with those applications, what happened is the applicant relied on first a statistical demonstration of the need for care, evidence of support for the project, confirmation of the utilization elsewhere in the country, and the lack of any opposition to the idea. And that project was approved and paved the way for the now several rehabilitation hospitals that exist and are serving Illinois residents.

We followed that same model here. Jeff and Kyle have demonstrated the statistical need for this care, demonstrated that their support for this project demonstrated the success they've had in other metropolitan communities with underserved Medicaid populations. And there has been absolutely no opposition or objection to this proposed project. But here in this situation,

demonstrating where the care is being provided is simply impossible because this is care that's just not being provided.

These are children who are generally going without care. Children simply suffer until teeth are lost or the circumstances because some so emergent that their families end up having to turn to the emergency room. And as you've heard, children can and do die because they lack access to this care. UIC, which is the only hospital that is routinely providing this care, has approximately a two year waiting period. And the statistics that Jeff mentioned in 2023, you had a 1.5 million children, 250,000 adults with disabilities, 3.9 million total Medicare patients. And when you compare that to states like Maryland, California, what they've seen there, this yields over 2,000 dental procedures per 1 million residents.

If you consider the need in the Chicago area, it's overwhelming. And these patients need somewhere to go. Children should not end up in the emergency room just to obtain care like this. Now we're not asking this board to be cavalier with its application and its rules. You're given discretion for a reason. There are times where healthcare delivery models will develop faster than regulations can be updated. And sometimes someone proposes

a project that is effectively a square peg in a round hole.

This is such a project and the best evidence we'll give you of that is simply asking, have you ever seen another project like this? There's a reason that you're in power with the authority that you have. So ultimately what we want you to consider is this, what are the consequences of your decision today? Both approving this and not. If you approve this and the need is not as great as Jeff and Kyle have experienced elsewhere, they risk losing some money. But this approving this project is not going to adversely affect anyone because no one else is providing this care and no one else is demonstrating any interest to.

But if you deny this project and what is proven to be true in Baltimore, in Washington, and Detroit proves true here, children who are dependent on Medicaid and who need this care will continue to go without.

This is a project that's inspired by providing necessary care that's simply not being provided at proving this project. At worst, we'll provide access to care for underserved children who need it. And candidly, at best, it has the ability to inspire a change in our healthcare delivery model by demonstrating that a commitment to Medicaid population is a viable business model.

This is the exact type of project for which this board was given discretion. And with that, we're happy to address any questions you have that will help you utilize your discretion to evaluate and hopefully approve this project.

CHAIRWOMAN SAVAGE: Any questions?

MR. KAATZ: How first off, everything you said about access and stuff is true based on my, I live on the other end of the state and things that go on to get people cared for and stuff is amazingly difficult. How does the reimbursement rates, which are never great for Medicaid, but how do they in Illinois compare to the other where your centers are?

MR. WELCH: The reimbursement rates are a bit lower than in Michigan and probably significantly lower than they are in Washington DC but they're still sufficient to be able to run a sustainable business. Okay.

MS. LEGRAND: I have the pleasure of operating local health department that does have a dental clinic in it in central Illinois. So I can attest to similarly to my colleague, everything you've said in terms of wait times and access. My question though is related to kind of the reimbursement structure in Illinois, and maybe you can speak to your other states that you've worked in for

dental referrals into your program. Are they coming primarily from the best way to describe it is a dental box company so to speak, or are they coming from government or FQHC type services?

MR. WHEELER: So it depends on the clinic, but typically what we see is our ASCs the largest referral providers are usually community clinics that are meeting that need. The box dental that you say also send 'cause they have the same problem. I think academics, they say about 11 percent of p pediatric dental is going to be needing this type of work. And so we receive from all types. It's just that usually the community clinics see more patients in, in the areas that we've benefit. So one thing I noticed, I, I forgot to left. I left out, we were actually deciding on where to put our first facility. We looked at a map and we just said, okay, where is, where are there no pediatric dentists?

And we just picked a spot based on that. We said, let's look in there. And our facility that we, our first facility ended up being across the street from where the Monte driver went to school. Which was, I wish it was planned that way, but it wasn't, it was coincidence just because we went to where there was need. And so, yeah.

DR. TANKSLEY: I have a, a question. I unlike my

colleague had the pleasure of living in this neighborhood, and so I would like to know, I did get a chance to look at your letters of support and I'm, I'm just interested in knowing why none of them are from the area in the sense that the ones that I was able to see, and please correct me if I don't have all of them, is from Will county, from Lake County and from the south, Southland, south suburbs, Tinley Park, and this, the service, at least this area. So I, I'd like to know more about your service area as well. 'cause This is in Chicago proper. This is and, and who you've talked to in Chicago proper that I, I want to make sure that about, you know, bringing this service and, and, and I agree. I mean, I think it's, I'm not going to say I agree, but I, I, I think that what you guys are doing is a, is a, you know, is commendable. I think it's, you know, great to think about this population. I'd just like to know who you guys are working with and

MR. WHEELER: Yeah, I'll start off and I'll let Jeff talk a little bit more about the specific efforts. But I think the letters that you saw are a reflection of where they were looking initially. So Mark talked a little bit about playing field. I think that's why you see that one letter that's kind of a little bit further out there. One of the other things that we've learned from coming

before this board is that there is a desire that we reach out to the public health departments to see where they think there's a, an identified need. And so you see that reflected in the letters from both Will and Lake County. There's outreach to cook, but it's a, a bigger system and maybe they are not willing to write a letter quite yet. And then I want to let Jeff talk a little bit more about ongoing efforts because they did this survey that you've heard a little bit about, but I don't I don't think they've certainly gotten anywhere near starting to what they hope to accomplish on some of the marketing that I think you're, you're thinking about.

MR. SILBERMAN: And if I'm correct, there's also outreach to a number of FQHCs that I'll, could you describe that as well?

MR. WELCH: Yeah, so we, we reached out to a number of FQHCs as, as Kyle mentioned, working with community clinics and being able to serve those patients that is a very big priority for us. We, we did speak to 53 dental offices in the Chicago metro area. Tried to find a representative sample to understand what the market would look like and, and what sort of need there was. And we honestly, we, we asked a number of them for letters of support. They being dentists are not familiar, as familiar

with the traditional healthcare medical care side of the, the equation. And so they some of them said that they were not comfortable writing those recommendation because they didn't want to go on public record. They didn't know what it meant. They didn't know the implications. And I think it was just a lack of understanding. And but they, they, they were very enthusiastic about the project.

MR. WHEELER: So the other thing I would say is I mentioned Demonte Driver in Maryland. In the state they had, if you look at pew, they had, they did research and Maryland had the lowest reimbursement rates for pediatric dental at the time of his death in passing. And it was a wake up call. 'cause This made national news. And within three years they changed a lot of the rates and got things in line. And pediatric dentists were there. If you had gone to that community and asked for letters of support, you wouldn't have been able to find them. 'cause No pediatric dentists were there to provide the letters of support. That's the situation. What happened after that was not only rates went up in Maryland, there's a CON process there. They have one exception in that process, pediatric dental, and it was 'cause of Demonte driver and his passing that all changed for that state.

DR. TANKSLEY: Are you saying there's no pediatric

dentist on the south side of Chicago?

MR. WHEELER: No, no, I'm not. No, I'm not. That's not what I'm saying. Okay. I'm saying that there is need. Okay. I don't live in this state, I live in Virginia. And so trying to get, like, I, if you know some people I'd like to make some friends, right. You know what I mean? So like, like let's hit, let's hook up afterwards. But, but for me, like I can just tell you from my lived experience doing this in other communities at different points in time, you'll see the need sometimes.

MR. SILBERMAN: And if I can address to that point before we address any of the marketing ideas, then what's been discussed and what's been envisioned is this if approved, one of the first things that they want to do is to meet with, with Medicaid to find out where they see the need, where they see the opportunity.

And the reality is that when we talk about who will be the strategic partners, the answer's going to be anyone and everyone who will get the word out, who will get the opportunities for this to be known, for these services to be utilized. Because at the end of the day, and I'll acknowledge both sides of it, the laudable side is the fact that this is care that's needed, that's not being provided. So there needs to be an effort to make sure that

people know it's there. But then also from the business model side, you need the expertise, the volume, and the effort to be able to make the, the sustainable model. So the idea is that legitimately there is no one who they will not look at as a as a strategic partner. And with regards to having an outreach to the FQHC, I think the findings were the same, which was there was excitement, there was support. We had a discussion with HFS before the application was filed to avoid ex parte. Again, same thing, but there just wasn't a willingness to submit letters. To that end,

DR. TANKSLEY: Just a follow up, I think I would look broader than just that FQHCs, there's a number of the safety net in general, given the population you're looking at, there's there are resources on the south side of Chicago that also reflected,

MR. BURNETT: Yeah, I just want to piggyback on what my colleague is sharing in terms of working with to qualify as a, you know, in the state of Illinois FQAC served over 1.3 million patients on the south side of Chicago, which is a very large landscape actually landscape on the south side of Chicago equal the west side and north side of Chicago. So the landscape is pretty large in your efforts to do your due diligence and your

commitment to work with the Medicaid health plan, working with community health centers and reaching out to 53 dental providers, at any point did you consider reaching out to the Illinois Primary Healthcare Association, which overseas or is the, were all of the FQs are members of in, in every state you have a piece, a PS PCA did you work with your in Delaware or the other states that you had to identify a resource in Illinois to foster that relationship or connect with the trade association so that you can reach out to the number of community health centers and on the south side of Chicago? Because I'm sure the service that you are identified is a need. However, in terms of the due diligence I would strongly recommend fault and leadership and understanding the Medicaid health plans as well as working and knowing who the main players are on the outside Chicago.

MR. SILBERMAN: And one thing I'll add before, if they have an answer to, to address that is this, we're more than happy to, whether it's just a commitment or even as a condition to continue to follow up. I mean, we are, how long out from operational is 18 to 24 months? Yeah, so the idea is there's still a lot of the effort to be done to make this a success after the approval. And so what I'm saying is we're more than willing to not only collect and

to coordinate with staff, but to take on ideas and to commit to reporting back to the information we're finding. I think the primary focus for today's hurdle was candidly to make sure we explain to the board both the need for the services, the commitment, and the viability. Because I think when we saw in the staff report a concern of whether or not an 85 percent Medicaid committed facility could be viable or was realistic, the answer is candidly, if it weren't for the commitment to the special needs patients, you said you're upwards of 89 to 99 percent Medicaid in other communities.

MR. BURNETT: To understand your performer based upon your performer looking at working primarily with Medicaid. You feel strongly that your operation be sustained.

MR. WHEELER: Yeah. Yes, absolutely. And that's what we love about what we do in every location, like Jeff and I were just sitting listening to and hearing about like the needs and oh, 5 percent of Medicaid things like this. These are, these are our customers, these are the people we want to serve. And the fact that this is like, that's our, this is our target. Absolutely. Absolutely.

CHAIRWOMAN SAVAGE: Dr. Beedle.

DR. BEEDLE: Yes, I, I represent DHS as a non-

voting member. But I'm also the medical director of the Division of Developmental Disabilities. And I also and the chair of the Mortality review team. So in Illinois, there is a critical shortage of dentistry that can support individuals with developmental disabilities. And because they don't get dental care what happens is people become endentulous. There's behavioral problems related to pain syndrome, to under treated dental disease. And ultimately there's increased mortality in people with intellectual and developmental disabilities because of choking. Because, and for special diets, which occasionally will get messed up and, and people die from essentially being edentulous later in life. There are two other players that I know about at Illinois. One is Illinois Masonic, which has a dental fellowship specifically for people that have intellectual and developmental disabilities and graduates like six people, six dentists a year.

So there are essentially you know, people educated in this in Illinois, but there's the other place besides Illinois. Masonic is a clinic called Millstone in Rockford. And I do confer with the applicant that there is the need in other parts of the state. People drive hundreds of miles to Illinois, especially from the southern part of, in central part of the state to come to

Chicago, just to go to Illinois Masonic and also to Millstone, which is in Rockford. So this is, is something that I, I, I had an interest in for several years, and I think that the proposal would really be a service to people in Illinois.

And if, if the presenters would like to reach out to me to discuss contacts, I can certainly do that. But I, I would encourage the voting members of the board when they consider the proposal that there is a desperate shortage. Not getting appropriate care as a child leads to all kinds of dental issues and health issues and premature death. And this proposal would serve the citizens well, in my opinion.

CHAIRWOMAN SAVAGE: Thank you, Dr. Beedle.

MR. KATZ: I commend you on finding a way to serve a, a really underserved population. Help me a little bit with the, the numbers. So this would be about $9 million, is that right?

MR. WELCH: That's right.

MR. KATZ: And how do you, where's that funding coming from?

MR. WELCH: So the $9 million, the way that the board application is structured, that includes the lease. And off the top of my head, I don't remember, but I think

that's --

MR. KATZ: so you kind of capitalized the lease, so it's like three to four of equity. Is that the right way to think about it?

MR. WELCH: Yeah, so 4.1 million of, of that is the lease, and then there's about 5 million of direct costs. And that is coming from a combination of tenant improvement allowance from the landlord and equity from the company.

MR. KATZ: And so equity is in the three to four range?

MR. WELCH: Yeah.

MR. KATZ: And the equity is personal money, is it institutional money, It's combination of both.

MR. WELCH: It's personal money.

MR. KATZ: Okay. I, I tip my hat to you on this. I, I just, again, help me on the P&L. So I'm looking at the projections, and this is year one. Whenever year one is, you're showing kind of a $400,000 after tax, throw in 400 for interest, gives you 800, throw in a hundred for taxes, gets you to 900, throw in 200 for depreciation, gets to 1,100,000. So kind of poor man's estimate for cash flow is about 1,100,000 in year one on about 3 million of equity, three and a half million equity. So I say that not

to, not to I I'm beyond impressed. I mean that you've taken a, a population that needs service in arguably other than the uninsured most challenging payer landscape. And, you know, mark has come in and kind of begged for, I mean, I think what's really going on, and this is a message that those of us sitting up here, there's not an institutional investor that I know of that wouldn't be dying to give money to this.

This is like, this is called creativity. And I, I well done creativity, find it a different way to serve a need. And I look at that and I say, hallelujah. Not these guys are making too much. And by the way, my 35 percent cash on cash return doesn't include the management fee you're taking. Hallelujah. I mean, that, that's, you're working within the, the construct and the constraints to deliver quality service in a, in a way that isn't being done. And so kind of to all of us up here, I'd be happy to have this discussion off line. I'm suspecting at least some of us hadn't really been thinking about this. This is a gold mine and it's a gold mine. That's all being done for the purpose of, you know, return on capital, but also to serve patients. So, hallelujah.

CHAIRWOMAN SAVAGE: Other questions, Mr. Kaatz?

MR. KAATZ: I'd like to just ask you a couple

questions if I may please, and thank you for your presentation. First one is, I, I when I was working, I ran a health system in Rockford and we did a lot of work with Milestone in this area. And we were able to get a philanthropist that bought us a bus and we souped it up for dental, and we found a dentist in Rockford that was a great guy, generous guy, give us time to go out and in, in, in our area, would see tons of patients that had never been to a dentist before. Just as a perspective, the demand is incredible. You might, after you get yourself settled, you might want to think about your business model, including transportation outside of your brick and mortar, because there are people from all over the state that will come and, and, and obtain your services.

So I'm, I'm sold on your model and the access service, everything that my colleagues have commented on, I can't believe you can do those financials at the, at the Medicaid rates in the state of Illinois. I just can't, I'm sitting here, I I'm buying everything that you're saying, and then I'm thinking about, you know, what else I know about this and it's a slam dunk, but I cannot, I just cannot figure out how you're going to do this with Illinois Medicaid rates. And not just the rates, but their payment, they don't pay quickly. So cash flow is really,

really important here. And but I'm, I'm dying to get a reaction from you on the Medicaid rates. 'cause You know, Michigan, Maryland, DC you're, you're in some states that are pretty nice with regard to Medicaid. I don't think we've had an increase in Illinois Medicaid since 1993. Yes. so I don't want to do, say anymore. I'll discourage you, but tell me how you're going to do this.

MR. MORADO: I'm going to go ahead and let gentleman speak a little bit more to how they're going to do it. But it's interesting, one of the points you raised was the payment turnaround. I got a message from Jeff, probably, I don't know, two, three months ago, where he found a article from the a previous inhabitant of the governor's office where we didn't have a budget for a number of years here in the state. And as you all well know, the payment time lagged quite a bit. We're talking a year, year and a half. I think more recent reports out of the comptroller's office shows that they're turning around payments anywhere between two to four weeks now. So we're very happy to see that happen.

MR. WELCH: So just sort of two parts to my response. The first is when other providers are seeing something like 5 percent of their patients are Medicaid then it is all Medicaid is challenging enough to deal with

that. It's better to serve them for free than it is to be in network and deal with Medicaid. For us, because it is 90 percent or more we have to deal with Medicaid and we have to develop a, a good relationship with Medicaid. And so I, I know and talk to the head of Medicaid in several of the states we work with. They're very familiar with us and our model. And when we get into a cadence of submitting claims initially in Maryland, I'm not going to lie, they were 18 months behind in paying us. And it took some, some work to get that process going and to get things running smoothly.

But now we're getting paid in about two weeks in Maryland. And in some part the like a lot of insurance payers I don't know if Mark warn me not to say anything too, too crazy. There I can see that we're in short circuit when I'm talking to them because it's, you know, we use the word dental, but it's a medical facility and it's just sort of something that nobody's ever seen or dealt with before. And so it's sort of a question of first impression every time I talk to a payer. And so when I'm talking to negotiating with contracting with payers, I have to go through a very lengthy education process on what it is we do, how it is we get paid. And I've done this with dozens of payers and Medicaid in, in five or six

states, including DC and Virginia.

That, that sort of surround the our facilities in Maryland. And the fact that our business is built on Medicaid means that we don't have the same issues that other people have because we have that relationship and we know how to submit the claims and get paid. As for the, the payment amounts we need to be really efficient and we are able to turn over ORs in five to 10 minutes. We're able to see eight to 10 patients a day where the hospitals are seeing three or four. And all of that is essential to us keeping our lights on. And to being able to provide a delightful triple win experience for the staff, the providers, and the patients.

MR. KAATZ: You know, I'm drawing a correlation, Madam Chairman, if I, can I continue with another question please? I'm drawing a correlation to how Illinois handles their perinatal network and their level three perinatal centers. They have a differential payment. That's why perinatal centers in Illinois do so well. And I'm, I'm, I'm wondering if you have been able to see anything like that in Michigan or Maryland or DC you, you're going to be a monopolist basically, right? And there's an oligopoly position with the state. It's interesting. And, and you guys might get a differential payment. I, we don't ever,

we've never had that. I don't think we ever, well, so

MR. WELCH: so this is a national, so this issue, it's not just Illinois, it's not, Illinois's not the only place where there are problems with access to care. It is a national issue. CMS recently passed created a new code because previously it was really unclear how to build these cases. It's sort of different in every state. And so CMS recently created code for surgery centers in our, and they also set a CMS rate, which creates some guidance. And states across the board have been, have had problems with access to care. And so most states have increased reimbursement rates for these procedures in the course of the last two or three years because it is such a dire need.

MR. KAATZ: You do this well, you are going to be incredibly busy.

DR. TANKSLEY: Thank you. Again, thank you. And I agree with my colleagues. I think this is innovative. I think that you guys, and, and I have no issue with whether or not you can make this work. 'cause I see the passion in you for doing this and, and believe that if you need to pull the money out of your pockets to make this work, you would do that. So I, I get that. You didn't have to convince us that there's a need or, or there's an issue

with access fundamentally. That's why we're all sitting here because we know there isn't indeed a need. And so I'll cut right to the chase and say two things. One is clearly we know that the population you're targeting are underserved, primarily people of color who are disadvantaged when it comes to wraparound healthcare services. Understand that your focus here is dental. But coupled with that, we understand that there is a full array of medical service that services that will be required for this population.

And so when we talk about, or we think about sort of your due diligence that you've done to bring that project here to Illinois, I think there's opportunity for more work. I think that there's opportunity for other providers in the area who may not be providing the service at the level that you are, but are doing that. And because they're here in Illinois and have worked here in Illinois for years and years and years, may have some sense of the, the population and the access and the other issues that go along with that. An instance, St. Bernard Hospital does something very similar. They have two ORs that they're providing the service for, for specialty needs clientèles. And so question becomes, have you had a conversation with them? Is there a possibility to do some collaborative work

with them? When you can't get a letter of support from a Cook county? And I understand they're large and they got a lot going on, it's kind of telling to me. But you did get it from, from other counties when you're going to be sitting in the middle of Cook County. I think that's critical.

That, that there is some communication, some collaboration, some partnering there as well. And then I'll end by saying, you know, we have a lot of people come to Illinois to develop a service to do work here. And it, it shouldn't rest on you lightly. And I'm sure it hasn't, that Illinois is a rare bird. And so developing those relationships with the state to do this kind of work is going to be critical to the sustainability. But given that i because of your passion, I'm almost certain that you'll figure it out.

There's other organizations that have been able to figure that out. But what I'd like to see in a comeback in terms of your due diligence is again, how have we looked at truly partnering with those other organizations within the area where we're going to provide the services? What kinds of relationships or conversations have we had with the state around reimbursement and what that looks like here? 'cause It is very different than any other state.

And I think lastly, how are we going to wrap services around this population? I mean, we, we get the kids, we fix their teeth, but then they have 15 other kinds of things going on in families where there's a significant number of determinants of health.

They can't get to you or they can't get back, they can't get to the pharmacy, they can't get their medication. There's just an array of things that, you know, you can't answer obviously. But you certainly can at least have an understanding of how to address them into the future. And I don't think that I've heard that. I've heard what your focus is. I think it's great. I agree. It is such a need. We know that I live that every day. But how do you make a business model out of that is not only going to be financially successful and feasible, but really meet the needs of this population

MR. SILBERMAN: And member Waller had that point to, to a couple points on that. One is there was a degree of communication with HFS in advance of the filing. Once we filed the application, we had to sort of cease those because even though Dr. Beedle is a non-voting, ex-officio, we didn't feel comfortable having ongoing discussions with HFS while the application was pending. I can say without hesitation or without limitation after the

decision on this, the, the intention is absolutely to start this meeting with HFS.

And we would love the opportunity to identify with whom and various people we can coordinate. I know there has been the discussion in, in other communities, anyone who's already providing this care facilities, their facilities can become great opportunities for training. So if they're doing the fellowship somewhere, they can collaborate and coordinate the ideas. They just want to make sure they maintain the control and the commitment.

And then with regards to the greater community, part of this project is designed to inspire. Part of this is to be able to demonstrate that a commitment to this population of commitment to the in which they reside. That's part of the reason that not doing it in Plainfield, not doing it in Indiana was important. So that is something I think Jeff can address.

MR. WELCH: Yeah. being a partner with the local community is absolutely essential. Our, our mission is to increase access to care and to help these patients. And just doing their dental surgery and then sending them home isn't the complete story. We want to partner with the local hospitals, local community clinics, local, local dentists. We want to do everything we can to be able to

increase access to care and help those patients across the board. We're, we're very cognizant of the very challenging lives that our patients lead and the many needs that they have and want to be able to help them as much as possible across the board.

MR. WHEELER: There's, there's an interesting thing here with timing. 'cause I, I hear your point on this and absolutely being in the community is critical. We don't, we don't survive unless we're in the community. When we start talking to people and saying we're building a facility, they think next month or three months, they don't realize it's going to take 12 months to 18 months. And so having the appropriate timing of this, of, of when we approach specifically people that are dealing with this problem and saying, Hey, we're here. Let us in it. Like, let's, let's work together. That's a critical factor of this. What we found is that when we get a little bit too excited ahead of our skis on stuff, we end up getting referrals before we can serve them because our facility's not done. And that burns people to work. All these guys are whatever.

And so it's important to get the timing right on this. I can tell you and I can promise you, every community we've been in with their fans you share the first name

with one of the providers at our first facility Dr. Wilson. And we didn't, she wasn't there on the first day. She was somebody in the community actually doing this work, serving these patients at different, at hospitals and other places. And, and she came after we had opened, and she's one of the, our, our favorite doctors. She's her favorite partner in our facilities. And so I agree getting the timing right is on this. And our, maybe a little bit of it is too, is that we just don't want to let people down in case we don't get approved for a board for a certificate of need on something like this. And then we've wasted their time. So there's that too.

MR. KAATZ: So in Illinois, and I'll be brief with this question, we used to have a lot of medical dental schools. I think we're down to two, maybe three. Do you, are you comfortable with the challenge of recruiting and retaining pediatric dentists?

MR. WHEELER: This will be a challenge. This is actually one of the bigger questions for us that is important, is that how are you unifying providers to do this work? And we confident, based on a market success.

MS. HENDRICKSON: So kind of on Mr. Kaatz's claim, what kind of staffing do you have at these facilities? If we were to approve this, what are your goals? How many,

you know, physicians do you plan? Do you have nurses, the dental tech? What, what do you plan on having there?

MR. WHEELER: So first off for each OR there'll be an anesthesiologist providing anesthesia care and a dentist within that, or there is usually two to three dental assistants assisting in the process, in turning over the OR providing care during the case. 'cause The most important thing of this care and this treatment is minimizing time under general anesthesia. A kid goes under general anesthesia for more than two to three hours. They start, there's academic studies that show cognitive function. So cases usually done within an hour or so. We try to do as much as we can, minimize that. It also just happens to help with efficiency in OR terms. And so the OR is as the patient leaves, they go to a pacu. Usually the PACU has you know, nurses that either have PACU experiences or NICU experience to help assist in the care and make sure the airways and the wake ups fine.

As far as the design goes for this the pediatric facilities having done this for so long and having five kids when kids cry, I don't, I don't get bothered as much. It's a sign of life, right? I just, you hear them breathing, right? But what happens is this kids wake up from anesthesia and it hurts. It's bad. So you'll see from

the flow that we have in the design is that the important aspect of the flow is to make sure that patients that are about to go back don't see patients that are coming out. Because there's often tears when they're coming out.

And so we try to design it so it has a proper patient flow to carefully the patient as they're receiving care and as they're leaving. So they'll usually be depending on the number of ORs, at least two, and sometimes more nurses and then multiple nurses assistants. And then there's a whole call center associated with making sure every patient that shows up and the parent that shows up is ready for procedures that day. 'cause There are so many different things that show that happen with this that make it complicated.

People think they're showing up for a dental office appointment. It's not that you have to show up having not eaten food or drink for the last 24 hours, or, or sorry, 12 hours. And so you have to make sure the parent knows what that means and that there, that doesn't mean like sneaking something sometimes, some other time. And so those, it's, there's a lot to making sure the patients show up and ready to go. All that.

CHAIRWOMAN SAVAGE: Any other questions? Okay. George, if you could call the roll.

MR. ROATE: Thank you, Madam Chair. Motion made by Ms. LeGrand, seconded by Ms. Hardy-Waller. Mr. Budde

MR. BUDDE: Great conversation. Applaud what you're doing. I vote Yes.

MR. ROATE: Thank you, Mr. Burnett.

MR. BURNETT: Yes. Based on today's testimony.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: I vote yes, when I was reading the staff report beforehand, I was somewhat skeptical, but knowing that you've done this three times before in three different states, and given the, the passion and the commitment and the inspiration that you presented today I, I wish you the best.

MR. ROATE: Thank you, Ms. Hendrickson.

MS. HENDRICKSON: I, I approve you're definitely providing a critical need, our community, and I hope eventually you may turn to adults as well.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Yeah, no, I'm, I'm supportive. I think there's a case study here, alma mater in this company's future. So we'll, we'll see how that progresses.

MR. ROATE: Thank you, Gary Kaatz.

MR. KAATZ: Before I declare my vote, I have to say that I have, since I've been on this board, I've been dying to be able to adjudicate a proposal where I have to say, you need to find more private paying patients, and it'll never happen again after this. I applaud your efforts, of course, I vote yes. And reach out. 'cause You're going to be a real successive if you do things right. And I think you're going to do things right, you know what you're doing, and you're enthusiastic. Big opportunity. Thank you for doing it. Thank you.

MR. ROATE: Thank you, Ms. Legrand

MS. LEGRAND: I will also vote yes because I do have a handicapped sister. Understand where you guys are coming from. So that's why I had to ask my question. Thank you.

MR. ROATE: Thank you, Dr. Tanksley.

DR. TANKSLEY: I will also vote yes. I am, I would also just really emphasize that there are, there's a lot of work to do in the community on the south side of Chicago to get to meet the people that are already there doing some work that may very much compliment and or do, you know, kind of underpin what you're doing. Thank you.

MR. ROATE: Thank you, Ms. Hardy-Waller.

MS. HARDY-WALLEN: Again, I applaud

everything that you're doing. It's not a no but it's a deferral. I would like to have the vote, a deferral to come back with that information that we talked about. I, I have no doubt that you guys are going to do a phenomenal job. And clearly I'm probably the only one to say, not now. But I do think that there's a huge opportunity to come back with more information about how you're going to partner on this in the communities, because what people do is come into our communities, start services, and there's no collaboration within the community for the patient population. And that's where my advocacy, and I just didn't hear enough of that in your report. But again, thank you for your service.

MR. ROATE: Ms. Hardy Waller, are you abstaining then?

MS. HARDY-WALLER: Is that what that would be? And I, I, okay, then I'll abstain.

MR. ROATE: Okay. Thank you, chairwoman Savage.

CHAIRWOMAN SAVAGE: And I vote an enthusiastic yes. I, I share my colleagues. I'm sure you'll do your due diligence or you wouldn't be doing this, and that you will be in the community in the south side. And I appreciate your triple win commitment. Having

had a lot of dental work in my time, I, I was afforded the luxury of being put to sleep for some of mine. And it's, it's really quite something. Yes, you wake up in pain but you know, you get better quickly. So thank you for all you're doing and wishing you the best success.

MR. ROATE: Thank you. That's nine votes in the affirmative one vote absentia.

CHAIRWOMAN SAVAGE: Thank you. And that permit is approved. Thank you. Thank you. Okay, we're going to do one more before lunch. We're going to do H-03. NANI vascular north ASTC in Addison, Illinois. May I have a motion to approve project 23-036 for the establishment of a surgical center for vascular access?

MR. FOX: So moved

MS. LEGRAND: Second.

CHAIRWOMAN SAVAGE: Thank you. When you folks arrive, if you could please introduce yourselves for those who haven't already, spell your names for the court reporter and be sworn in.

MR. MORADO: Juan Morado Jr. J-U-A-N M-O-R-A-D-O-J-R.

MR. RAHMAN: Dr. Mohammed Rahman. M-O-H-A-M-M-E-D R-A-H-M-A-N.

MR. DEJESUS: Ernesto Dejesus, E-R-N-E-S-T-O D-E-

J-E-S-U-S

MR. SILBERMAN: Mark Silberman, SILB as in boy, E-R-M-A-N.

MR. O'DEA: Brian O'dea, B-R-I-A-N O-D-E-A.

THE REPORTER: Mr. Morado, Mr. Rahman, Mr.

THE REPORTER: Mr. Morado, Mr. Dejesus, Mr. Silberman, and Mr. O'dea, please raise your right hand.

(Whereupon:

JUAN MORADO

MOHAMMED RAHMAN

ERNESTO DEJESUS

MARK SILBERMAN

BRIAN O'DEA

After being duly sworn, were examined and testified as follows:)

CHAIRWOMAN SAVAGE: Thank you. Mike or George, if you could share the state board staff report.

MR. CONSTANTINO: Thank you, Madam Chair. The applicants are proposing to establish a single specialty ASTC in Addison, Illinois. Project cost is approximately $3.8 million, and the completion date is July 1st, 2025. The proposed facility will be a single specialty ASTC with two operating rooms and focus on vascular access and maintenance for ESRD patients. This project was formally

approved by the state board in April of 2018 as permit number 17-072; The Illinois vascular care in Algonquin. However, that permit was relinquished due to issues with the landlord. The applicant's failed to meet five criteria:

1. Projected utilization
2. Service demand
3. Treatment room need assessment
4. Service accessibility
5. Unnecessary duplication of service.

Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you Mike. If you'd like to proceed.

MR. SILBERMAN: Thank you. We're pleased to appear before you today to present a project and establish an ASTC that is focused on a single specialty and is candidly driven by the ability to establish, to maintain and to preserve vascular access for end stage renal dialysis patients. As will explain vascular access is quite literally the lifeline for these individuals. Before discussing the project in detail, I want to introduce everyone that I have at the table with me. To my left, I have Brian O'Dea, chief Executive Officer of NANI, Dr. Mohammed Rahman and Dr. Ernesto Dejesus, who are going to

describe for you the facility and its purpose and its operation. And my partner Juan Morado, Jr. We want to thank staff for a generally positive staff report. We're pleased that there's no opposition.

There was not a request for a public hearing. NANI has been committed to providing kidney care in and around the Chicago area since 1968, and they have remained committed to this patient population. And in fact, they've been very committed to this project for a significant period of time. As Mike mentioned, NANI previously filed a project to establish an ASTC to serve this community.

They appeared before the board, they presented the project to the prior complement of this board, and that project was approved. So what happened with the project in April, 2018, the project was presented, project 17-072. It was approved, and NANI began its process of completing the project as described. NANI set forth to complete the project consistent with what the board project had been designed and is described.

But ultimately, unexpected challenges arose with the landlord, issues that were entirely outside of NANI's control. Effectively, the issues were that the landlord proved unwilling to provide the long-term commitment that the lease originally had envisioned. And since then, we

think we have a good understanding of why that location has now been developed into condominiums.

As a result, NANI informed the board of these challenges. We coordinated with the board staff and everyone agreed that the most appropriate course of action would be to relinquish the permit consistent with the board's rules. But even in that notice, which included NANI's intention to continue serving the patient population, was its commitment to find a suitable location to establish this ASTC.

Well, that notice was filed on December 31st, 2019, and we all know what happened next, which was Covid. NANI physicians continued to provide care to this patient population throughout the pandemic, but also continued in their efforts to identify and secure the right location. And we appear before you today confident that we found that location and are excited at the prospects of this project, once again being approved. And with that, I'm going to turn things over to Brian O'Dea, who can fill you in on a little bit about NANI, for those of you who aren't familiar with it.

MR. O'DEA: Thank you, Mark. NANI was started in 1968. We were the first off hospital premise nephrology practice in Illinois we're pioneers in dialysis, but

please don't think that we're a dialysis company. Some of our patients choose to get renal replacement therapy at a Fresenius or DTA, but we are an independent physician-owned medical practice, the largest independent nephrology practice in the country. We were started by a surgeon Dr. Robert Murky, who's still famous in the medical books for first describing Murky lines. We started early when we first put a dialysis machine in the basement of a church because the parishioner's wife was willing to learn how to run the machine.

There was a member of the church who needed the therapy, and pretty soon we had Cathedral Center on Ashland Avenue in, in Jackson Park. And that was before we were being paid, when it was experimental. I tell you that story, not to brag, but to say that we've always done the right thing for the patient. And that's always been our guiding light. Since we started the nephrology practices starting in the West suburban Hospital.

We started the practice of Jackson Park, Silver Cross, St. Bernard, South Shore. We've always gone where the need is and what the patients need us. And this, I'm really pleased that you're taking time to hear our requests today because this service is needed by our patients. This is not a new service. We're doing this right now in the OBL

setting, but CMS has sent a strong message that they want us to continue the service in an ASTC setting. And that's why we're here in front of you today making this request. Thank you.

DR. RAHMEN: I am a practicing nephrologist with NANI. I have been in practice for over 30 years. In the last 15 years, I focus my service to the patient who required vascular access procedure. Dialysis patients require presence of graft or fistula to perform dialysis. If the graft or fistula is clotted, it's considered an emergency and it has to be cleared as soon as possible. And this graft or fistula is considered a lifeline for the patient. At the same time, the patient requires maintenance procedures to keep this axis open and prevent it from clotting in the future, you know, many don't realize the value of the vascular access.

And we opened our first access center in 2005. This access center was opened as an extension of the practice. And 2018, I came here before the board, you know, with the same project and we're thankful that it was approved. But as Mark mentioned, as you probably know, out of our control all this, we couldn't proceed with the project, and then pandemic developed. The ASTC will really offer us a value to provide more care for our patients.

With the ASTC, we can provide more tools like a drug coated balloon, which can release anti-proliferative drugs into the vessel wall. Those drugs, we cannot use it on our current practice. In the ASTC there's a new innovative procedure that came approved by the Medicare that we can use in the ASTC. We can perform the, create the access into vascular without traditional surgery in the hospital.

As much as possible, we try to keep our patients outside the hospital for a couple of reasons. In the hospital, the expense is much more expensive. Our patients, due to the hospital busy schedule, they always wait all day to get the procedure done. At the same time, at the ASTC, we can get the patient registered, map their veins, and do the procedure within an hour. Patients can go back to the dialysis without missing a single session of dialysis treatment. So this project is very vital to our patients, and we are thankful that you approved it before, and I hope you can see the value and approve it again. Thank you.

MR. DEJESUS: Morning. my name's Ernesto, and I've been a nephrologist with NANI since 2005. Unlike Dr. Rahmen, this is my first time presenting to the board. But our patients have very similar issues that I've been seeing since I've been practicing. As you already heard

Dr. Rahmen talk about some of the other procedures we can perform, but I just want to drive home the point about how important these having access to an ASTC that's focused on interventions such as these is important. Patients who undergo dialysis, they generally undergo dialysis by having a catheter or arm access, such as a fistula or graft.

Studies have shown that patients that dialyze with the fistula or graft have 50 percent of the mortality compared to patients who dialyze chronically with a catheter. In addition, other studies have shown that patients who dialyze with the catheter are hospitalized three times as much as patients who dialyze with an arm axis, such as fistula or graft. So it's for optimal patient outcomes, it's crucial to keep these dialysis fistulas and grafts open and for patients as this is their lifeline to this life sustained treatment. You might be asking, why don't we just let hospitals take care of these dialysis access issues? And Dr. Rahmen already alluded to the fact that, you know, it's not an uncommon scenario to send a patient to the hospital.

They wait around in the emergency room for a long time and end up getting a catheter placed instead of having the fistula worked on. Unfortunately not all physicians

understand that the importance of the arm access the fistula and the graft and how it's their lifeline. And in addition, when you have a clotted fistula the quicker you deal with it, the quicker you intervene on it, the higher the success rate to open it up. And so the typical scenario at our office based location that we've been open since 2007 a dialysis unit will refer a patient with a clotted fistula graft.

We'll get them in same day again, directly back to their dialysis unit. But they don't miss a treatment at all Dr. Rahmen had said. And so we've really done a better job keeping the fistulas open, maintaining them, dealing with them when they're clotted, and really optimizing patient outcomes. In addition, there's been a movement towards value-based care in dialysis patients. The goal of value-based care is to increase the efficiency in the delivery of the care by decreasing ER visits, decreasing hospitalizations.

And our organization has fully embraced this by opening up an office-based lab, and to deal with these dialysis access issues on an outpatient basis. Interventional nephrologists, such as Dr. Rahmen and myself, have proved that we can provide excellent care. Studies have shown that patients treated in a free standing outpatient center

have better outcomes, fewer hospitalizations, fewer access related infections, and lower mortality rates than those treated in the hospital setting.

As you know, dialysis is literally a life sustaining treatment. It is of the utmost importance to ensure that our patients have timely care, higher satisfaction, and to minimize delays of dialysis treatments. Simply put, this facility will allow our practice to better serve our patients. And with that, I'll turn it over to Mr. Morado.

MR. MORADO: Thank you, Dr. Dejesus members of the board. As you've heard throughout this presentation, we do appreciate your approval of this project a couple of years ago. And this really seems to be a circumstance where the relinquishment of that permit ended up being beneficial for the application that's before you now. The project before you was reimagined and refiled with additional support from Dr. Dejesus, the findings of nonconformance fall into two categories.

Three of the findings deals specifically with proposed referrals for the facility. Your rules only allow for referrals to be counted if the procedures were performed at an existing hospital or an ASTC. in this case, we have documented thousands of procedures that both Dr. Rahman and Dr. Dejesus have performed in the last year, but they

were performed in an office-based lab site. And as you've heard from Dr. Rahman and Dr. Dejesus, there are very real access issues that have prevented them from being able to utilize hospitals or other ASTCs in order to ensure that their patients had access to this treatment.

They had been performing them in an office-based setting, but this had its limits. And as you heard CMS for a variety of reasons, seemed to be pushing these procedures to be performed in an ASTC setting. We believe that among those reasons, is the increased patient safety measures available in an ASTC setting. And CMS is encouraging this change through their reimbursement of vascular access procedures. Additionally, at the state level, what you see is a number of different processes that people have to go through, which we've talked a little bit about today.

The fact that you have a design safety construction survey and then subsequently a licensure survey. Additional safeguards do we believe increase patient safety. Since 2017, Folks who are following this industry noted that over a hundred office-based labs have closed office-based labs that are dedicated solely to vascular access procedures are not even breaking even. And often they're losing money, which is why so many are closing.

This is the reason why we were unable to provide the referrals from an existing hospital or ASTC. But as you could see in the application, there is ample patient volume for this growing practice. Coupled with the applicant's desire to have an open staff policy, the applicants intend to take the same approach they do with their other ASTCs in Justice, Illinois, which is to perform these life sustaining procedures for their patients. And importantly, to offer access to other surgeons who have nephrology practices in the community.

Table four of your state board staff report shows that the proposed referrals to this facility will result in over 2000 hours of surgery, certainly justifying two operating rooms that we're seeking approval for today. The other finding of non-conformance is a common one, one that this board's seen before. And it deals with the concept that under your rules, there's available capacity in operating rooms in the geographic service area. But if you'll allow me to dig a little bit deeper and analyze that data with you, I'd like to talk about the fact that four of those facilities are hospitals.

And we've talked about some of the challenges with getting these procedures in those hospital surgical suites. 10 of those facilities are ASTCs in the geographic

service area. Now you've heard why they're not being performed. These procedures aren't being performed in hospitals. So let's talk about the ASTCs and the GSA of the seven facilities listed in the state board staff report, not one specializes in vascular access procedures. Midwest Day, Ophthalmology Surgery Center of Illinois, Aiden center for day Surgery Center, Innovia don't even offer general surgery, which is where we're seeking approval for today.

Loyola's ASTC serves as an outlet for the Loyola Medical Center. The DuPage Medical Group surgery center is dedicated to that practice's patient base. And finally, you have the Aiden center for day surgery, which if you look at the facility profiles over the last several years, seems to barely be operating. And if you look at their patient base and payer mix, it's 98 percent private pay and private insurance.

The proposed facility would grant one of the state's Premier nephrology practices the necessary tools needed to carry out their mission, which is to treat patients by ensuring they're able to receive life sustaining dialysis treatment and to ensure that their vascular access problems are addressed. And with that, I'd like to thank the board for your attention and we'd be happy to answer

any questions. You may have

CHAIRWOMAN SAVAGE: Questions by board members.

MR. FOX: What's the payer mix now in the practice?

`MR. O'DEA: We're 78 percent Medicare and Medicaid, probably about 9 percent Medicaid.

CHAIRWOMAN SAVAGE: Other questions?

MS. HENDRICKSON: Just a point of clarification. When you were describing on the, the table four

MR. O'DEA: Yes.

MS. HENDRICKSON: The Aiden Center for day surgery. So can you clarify again your comment? You're saying that they are operational

MR. O'DEA: No, it's, it's an interesting one. So they have four operating rooms and you look at their, their profiles 'cause this, every facility in the state has to submit these profiles. If you look at it for the last several years, they're not doing many procedures at all. They did eight general surgery procedures in 20 -- 2022. And if you look at their payer mix, it is 98 percent private insurance and private pay. So I guess the point that I'm trying to make with Member Hendrickson is that we're seeing a completely different kind of patient, one and two. Most importantly, we're not going to have a

negative impact on them.

MR. SILBERMAN: Just so the record is clear, that was table five.

MS. HENDRICKSON: But maybe to clarify if in, in terms of not being competitive against the number of patients there is physical space though, in that site.

MR. MORADO: At the Aiden day surgery center

MR. SILBERMAN: there is, but there isn't a demonstrated willingness to commit to this patient population or to exceed the type of control. The biggest issue when you fracture, so one of the challenges that we talked about the last time this project was up, is that if you're reliant on the available space within a service area, you end up having to fracture the patient population. You end up having to go not where is best interest of the patient, or you have the dedicated staff, the experienced staff, and the control over it. But you have to go to wherever there happens to be space. And in a situation like this what you have is you also have to have a facility that is willing to commit itself to a primarily government payer mix. As Brian mentioned, the commitment to Medicare Medicaid is, I think you said about 70 percent, 70, 78. So those are the challenges with looking to utilize existing facilities. The other challenge that

you have is that when it comes to a facility that tends to rely primarily on private insurance, you end up with some of the same challenges that you have with regards to prioritization of procedures.

Where these procedures are of a high priority based on the fact that they're of great need to the patient and to their welfare, but they aren't high reimbursement. And so you end up with some of the challenges where opportunities or block time things get blocked or don't even don't have the opportunity. So that's why this wasn't looked at as a viable alternative to the consideration or to the establishment of this facility. Because historically, and I think the doctors can speak to this, they've had notable challenges getting access to existing facilities.

MR. DEJESUS: Not only that, that one other thing that might address this is, you know our nurses that are office based lab, they're former dialysis nurses, they know dialysis patients and they know how to take care of dialysis patients. They know how important it is. You know that they get their treatments, that they know what labs to look at to see if it's safe to undergo the procedure. Is their potassium too high? Are their weight gains too high? And so it, it's invaluable to have those nurses who have that dialysis experience to be helping us take care

of these patients in the current office based lab. And it would be those nurses helping us in this proposed ASTC as well.

CHAIRWOMAN SAVAGE: Other questions? Concerns?

(No verbal response)

CHAIRWOMAN SAVAGE: Okay, George, if you could please call our roll.

MR. ROATE: Thank You, Madam Chair. Motion made by Mr. Fox. Seconded by Ms. LeGrand. MR. Budde.

MR. BUDDE: Yeah. Based on the staff report and the conversation. Yes.

MR. ROATE: Thank you. Mr. Burnett?

MR. BURNETT: Yes. Based on today's Testimony.

MR. ROATE: Thank you. Mr. Fox?

MR. FOX: yes, based on the applicant's testimony.

MR. ROATE: Thank you. Ms. Hendrickson?

MS. HENDRICKSON: Yes. Based on information provided.

MR. ROATE: Thank you. David Katz?

MR. KATZ: Yes. Also based on the information provided.

MR. ROATE: Thank you. Gary Kaatz?

MR. KAATZ: Yes, based on the staff report and the testimony.

MR. ROATE: Thank you. Ms. LeGrand.

MS. LEGRAND: I also vote yes, based on the staff report.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: I'll vote yes based on the staff report.

MR. ROATE: Thank you. Ms. Hardy-Waller?

MS. HARDY-WALLER: Yes.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes, based on the state board staff report and testimony today.

MR. ROATE: Thank you. That's 10 votes in the Affirmative.

CHAIRWOMAN SAVAGE: Thank you. That permit is approved. And now we are going to lunch for about 45 minutes.

(Recess)

CHAIRWOMAN SAVAGE: Back to order so we can get going. So welcome back everybody. We're going to start with H-04 Cardiovascular Institute, ASTC in Naperville, Illinois. May I now have a motion to approve project 23-040 for the establishment of a surgery center for cardiac

cath.

MS. HENDRICKSON: So moved.

MR. KATZ: Second.

CHAIRWOMAN SAVAGE: And as you folks come up, if you could state your name, spell your name for the court reporter, and then be sworn in.

MS. FRIEDMAN: Hi, Kara Friedman.

MS. ECK: Hi, Cheryl Eck, C-H-E-R-Y-L, last name E-C-K, and I am a Vice President of Strategy with Endeavor Health.

MS. SABA: Yvette Saba, Y-V-E-T-T-E. Last name Saba, S-A-B-A, president of Edward Hospital.

MS. SMITH: Catherine Smith, C-A-T-H-E-R-I-N-E S-M-I-T-H. And I am Vice President of Cardiovascular Institute, Endeavor Health.

MR. HOFFMAN: And good afternoon, Mark Hoffman, M-A-R-K H-O-F-F-M-A-N, south Region Director for Real Estate and Development Endeavor Health.

THE REPORTER: Thank you so much. Ms. Friedman, Ms. Eck, Ms. Saba, Ms. Smith and Mr. Hoffman, please raise your right hand.

(Whereupon:

KARA FRIEDMAN

CHERYL ECK

YVETTE SABA
CATHERINE SMITH
MARK HOFFMAN

After being duly sworn, were examined and testified as follows:)

CHAIRWOMAN SAVAGE: George, if you could give us our state board staff report.

MR. CONSTANTINO: Thank you, Madam Chair. The applicant's propose to establish an ambulatory surgical treatment center performing cardio cardiovascular catheterization service in Naperville, Illinois. The proposed ASTC will have two labs total, capital cost for this project is approximately $26.9 million. The expected completion date is September 30th, 2025. The applicants did not meet the service to area residence and the movable equipment standard of the state board. There was no public hearing and no letters of support or opposition were received. Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you, Mike, if you'd like to proceed.

MS. SABA: Sure. Thank you. I'll get started with my testimony. Good afternoon, Madam Chair and members of the board. I'm Yvette Saba, president of Edward Hospital in Naperville, Illinois. With me are Kathy Smith, vice

president of our Cardiovascular Institute, Mark Hoffman, director of Ambulatory Operations and real estate, Cheryl Eck, vice President of Strategy Planning and Business Development, and Kara Friedman our legal counsel.

First, I would like to thank the board staff for the comprehensive and generally favorable summary report describing our project. We are expanding our existing cardiovascular care service line to a new ambulatory program adjacent to the hospital in a new cardiovascular institute outpatient center. This outpatient center building was approved by this board last year and is currently under construction. Because our plan that this new program is limited to shifting some of our current cardiac catheterization caseload from our hospital department to alleviate high utilization.

This project will not affect other providers in the area and is unopposed. The cardiovascular institute Outpatient center will also house the offices of cardiovascular disease specialists locating these specialists in the same building will create a specialty medical home for cardiology patients who have ongoing supervision and treatment needs for their heart and vascular care. It will also improve physician efficiencies for the procedurals who will care for the patients in the

new cath labs. Physician efficiency has become essential to maximizing the time of these important physician resources as we and our physician partners continuously improved to and retain physician talent.

As you may know, Edward Hospital is a leader in cardiovascular care in the state. We are the largest non-academic provider of heart care in Illinois. With over 45,000 heart and vascular patients treated annually among Illinois providers of heart care, we are ranked number two in the state with the number of specialized cardiac interventional procedures.

Cardiovascular disease is the leading cause of chronic disease, morbidity, and mortality in the United States and globally, cardiovascular disease affects one to two percent of the US population and the disease burden worsens as the population ages. The American College of Cardiology Board of Trustees workforce Task force has estimated that deaths from heart disease will more than double between 2000 and 2050. Today we are consistently striving in our outpatient clinics to improve cardiovascular health.

Our clinicians, both in our primary care offices and cardiovascular clinics work every day to lessen this disease burden and for many individual patients even

prevent their cardiovascular events. These interventions are first focused on lifestyle choices and with medication management when needed, the most important lifestyle tricks that work for our patients to achieve our smoking cessation and adapting a healthier diet and active lifestyle. We have web-based tools to provide day-to-Day support in these efforts and help put patients in the driver's seat in improving their risk profile for CPT Medication management to keep an individual's blood pressure, cholesterol, weight, kidney function, and blood sugar levels normal, are tools that earlier generations did not have. Now there are tools to extend our patient's life and wellness. Just over 20 years ago, we opened our heart hospital on the campus of Edward Hospital and this committed program has placed our institution as a national leader in cardiovascular care. In a moment, I'll transfer this presentation to Kathy to discuss our current program in more detail. As one of the top health systems in the state for cardiovascular care, patients in the west and southwest Chicago suburbs consistently choose our health system for expert, innovative, nationally recognized care close to home.

Patients do sometimes travel more than 10 miles for our services. Generally, travel times for our patients are

reasonable and still reflect a draw from nearby areas. So we do not believe this will be a concern for the board. Thank you for your time and attention. I would like now like to turn it over to Kathy Smith, who will discuss the clinical aspects of this project for more detail. Thank you.

MS. SMITH: Thank you Yvette. And good afternoon, Madam Chair and all board members. Again, my name is Kathy Smith. I'm the Vice President of the Cardiovascular Institute at Endeavor Health. Not only because of my role in our health system, but because of my own personal experience as a patient in our heart hospital. I am in a unique position to present to you our expansion plans. I am here with you today because of the interventions that modern technology, that modern technology cardiology now offers. My grand, excuse me, my grandmother and all seven of her siblings passed because of heart disease. And my mother's life was tragically cut short by a massive heart attack.

Knowing my risk profile, I was motivated to take preventive measures as Yvette has described, to ensure that I was not struck by the same fate. 12 years ago, I had no noticeable indications of heart issues, but given my family history, I did do a screening test, a coronary

calcium scan. I failed it and was soon after diagnosed with aggressive cardiovascular disease. Despite the severity of my disease with the availability of percutaneous coronary intervention or PCI, open heart surgery was not necessary at that time.

Instead, I underwent a minimally invasive surgery and had two stents placed to open the blockages and I was quickly on the road to full recovery. I have always felt that Edward's cardiovascular team, doctors, nurses, and staff excelled in the care that they provided to their patients and families. And when I experienced this for myself firsthand, I found it true every step of the way from diagnosis to recovery.

As the primary intervention for serious CPT has dramatically shifted, we appreciate the board's recent focus on cardiology services to assess the potential rule changes. Cardiac catheterization procedures have been revolutionary. This care is one of the most important and minimally invasive medical miracles that we have today. Minimally invasive, therapies are fundamental to a quick return to independent living and wellness.

I can attest both professionally and personally to the capability of this intervention to provide just that. This expansion of Edward aims to guarantee that patients

depending on our health system, receive the appropriate care properly when identified, leading to the reduction of cost, of more expensive interventions and associated hospitalizations relative to these cases. Taking place in ASTC, you may be aware that CMS has added heart diagnostic, heart catheterizations, and PCI to the ASTC covered procedures list in 2020.

With this update along with careful patient selection based on the American College of Cardiology guidelines, there has been an accelerated migration of this care to an ASTC setting to ensure patient safety. Patients with higher risk profiles will continue to have their care within the hospital. Notably, this program will be located adjacent to Edward Hospital. In a rare case, as such an adverse event, the patient requiring hospitalization will be properly transported next door. Our hospital program is operating at a high level of utilization approaching its capacity.

Instead of investing in costly hospital grade cath labs for cases suitable for external settings, we proposed the establishment of an ASTC to cater to these elective cases. Elective cases will be separated and this additional lab space will ensure that urgent and emergency cardiac catheterizations and procedures at the hospital can be

promptly performed at all hours of the day without creating delay in our scheduled elective cases.

Finally, I would like to address one part of 1120 finding in our board report, namely the state standard of freestanding surgery center equipment, which was established without taking into account the specialization of a surgery center such as ours. And therefore our equipment budget deviates from the standard in the case of cardiac catheterization services. Those cases require advanced imaging equipment in each lab. And the cost of this equipment is the same as if we were expanding it, expanding the service within the hospital.

We will furnish our labs with equipment that is clinically necessary to perform the procedures. And in reviewing the standard at issue, it doesn't contemplate the program's use of this advanced imaging equipment within every case, but it is imperative, part of the OR equipment. All other costs of the project are within state standards and we believe that the cost of the equipment and the project cost overall is reasonable and this project represents the best approach in expanding our cardiac catheterization capabilities. Thank you for your attention and we are now happy to answer any questions.

CHAIRWOMAN SAVAGE: Any questions for this

applicant? Well, hearing none I want to tell you, you guys saved my mother's life. One of your doctors did, and I thank you very much for that. So understand where you're from. So we have no questions. You do. Okay.

MR. BUDDE: Just Make sure I understand the, so you're doing these procedures right now within the hospital, right? You're going to basically take the, the portion, the high percentage of those procedures that are appropriate for an ASTC, moving to your new facility. Yes. That simple, right?

MS. SMITH: Yes.

MR. BUDDE: And it'll give you more capacity 'cause of the hospital; You're not closing down beds in the hospital; Correct?

MS. FRIEDMAN: We are at your capacity in our existing labs within the hospital, it's very expensive to build a lab and the incremental lab within the hospital constraints. So building in the outpatient center will shift the lower acuity cases that are currently being done in the hospital.

MS. LEGRAND: I have one question. So since it will be a freestanding building, if you have an emergency there, will you have the ambulance to run them across or is there a, or how will you get that patient across the

parking lot to the, to the hospital?

MS. SABA: We'll have an ambulance available. We have one on site for Edward Hospital with our current ambulance provider and we would call 911 and they would come around the block, get the patient and take them to the entrance.

MR. FOX: Are there procedures that you will be performing in the outpatient setting? That well, let me rephrase the question. Are there procedures that you will not be doing in an outpatient basis to your facility? In other words, the, the sicker patients will be continued to be done in the hospital. The transaortic valve replacements, obviously that's a hospital. Only is there a particular type of patient that you would focus on for this, this new remote setting?

MS. SABA: Not necessarily a particular patient. It would be basically their, their disease process. So within the ASTC setting, we can only do PCI on single vessel. So if there was someone that actually needed multi-vessel intervention, PCI stents, those would still be done in the hospital. Okay.

CHAIRWOMAN SAVAGE: Other questions?

(No verbal response)

CHAIRWOMAN SAVAGE: Hearing none, George, if you

could please call the roll.

MR. ROATE: Thank you Madam Chair. Motion made by Ms. LeGrand. Seconded by Mr. Katz. MR. Budde.

MR. BUDDE: Yeah. Based on the staff report. I will vote yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes. Based upon the state staff report and today's testimony.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes, based on the staff report and applicant testimony.

MR. ROATE: Thank you. Ms. Hendrickson?

MS. HENDRICKSON: Yes. Based on the information provided today.

MR. ROATE: Thank you. David Katz?

MR. KATZ: Yes, based on the testimony.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: Yes, based on the staff report.

MR. ROATE: Thank you. Ms. LeGrand?

MS. LEGRAND: Yes. Based on the staff Report and the testimony.

MR. ROATE: Thank you Dr. Tanksley?

DR. TANKSLEY: Yes. Based on the state board staff report.

MR. ROATE: Thank you. Ms. Hardy-Wallen?

MS. HARDY-WALLEN: Yes. Based on testimony.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes. Based on the testimony and state board staff report.

MR. ROATE: Thank you. That's 10 votes in the affirmative.

CHAIRWOMAN SAVAGE: And that permit is approved. Thank you very much. Try to build it a little quicker. Now up next is Advocate Condell, ASTC in Libertyville, Illinois. May I have a motion to approve project 23-041 for the expansion of pain management to the existing surgery center?

MR. FOX: So moved.

MS. HENDRICKSON: Second.

CHAIRWOMAN SAVAGE: And we are going to remind all of our presenters in the room that we would like to stay between 10 to 15 minutes if at all possible; 20 on the outset. Thank you. If you could introduce yourself, spell your name for the court reporter, the new person, and then we will proceed.

MR. MICHAL: Hello, it's Dean Michal; D-E-A-N M-I-C-H-A-L.

THE REPORTER: Gentlemen, can you please raise

your right hand?

(Whereupon:

DAN MICHAL

After being duly sworn, was examined and testified as follows:)

CHAIRWOMAN SAVAGE: Okay. Mike or George, if you could give the state board staff report.

MR. CONSTANTINO: Thank you Madam Chair. The applicant's propose to add pain management surgical services to an existing multi-specialty ASTC located in Libertyville, Illinois. There is no cost to this project, and the expected completion date is March 1st, 2024. The applicant's failed to meet: projected utilization, treatment room need assessment, and unnecessary duplication of service. There was no public hearing, no letters of support or opposition were received.

CHAIRWOMAN SAVAGE: Thank you Mike. If you'd like to proceed.

MR. SILBERMAN: Thank you. We're pleased to appear before you today with an application that is driven by ensuring better utilization of an existing facility and meeting commitments that were made when this first project came before you. The Advocate Condell Surgery Center is a joint venture involving the Advocate Condell Medical

Center and individual physicians for multiple specialties. This application is before you to add pain management to that compliment of services available at the facility. The purpose is both to improve the utilization of the existing facility and equally importantly, to address issues related to access for the patients in the community that they and their physicians are experiencing.

Overall, this is one of the more straightforward projects you'll have the opportunity to review. Before I discuss the project in any detail, I just want to introduce who I have with me at the table. I have Dean Michal, who's the Chief Executive Officer of the ASTC and my partner Juan Morado. We want to thank the staff of the Positive Staff report. Once again, there was no public hearing requested, no opposition to this project. I'll describe why the project is before you. Dean is going to discuss both the successes and the challenges that the facility has faced and why adding pain management from both an administrative and a, you know, patient need perspective is important to both to the patients, the physicians, and the facility.

And then finally Juan will address the three criteria for which this project was found not to be in conformance. This facility serves as an outlet for the Advocate Condell

Medical Center, which is the largest healthcare provider in Lake County and has the only level one trauma center in the county. The surgery center is currently approved for seven categories of service. In recent years, the utilization of Advocate Condell Medical Center as it has risen utilization of the ASTC has also increased.

And just two years ago, the facility was operating two ORs and had a utilization rate of 86 percent well above the state's target utilization. As a result, they appeared before you and the facility expanded and added a third operating room so as to better manage patient flow and account for the addition of the podiatric category of service at that time. Now we're here before you to add pain management.

Ultimately the goal of this project is to better meet the needs of the patient population that this facility serves, in particular patients that are reliant upon the Advocate Physician Partners program. And as such, they are facing challenges in finding access to care at other facilities. And we want to ensure that this facility can maximize its utilization, which as you know, is one of the primary tenants of the CON program.

Your state board staff report does accurately reflect that there are six ASTCs in the area with three hospitals.

But as you evaluate this project, please consider of those ASCs, two of them are dedicated entirely to endoscopy. One is Lurie children ASTC, which would not be performing these procedures. One supports Northwestern Lake Forest and one of the other two is well above the state target utilization and the other has access issues, which we'll discuss with you. So with that, I will pass it over to Dean who will explain to you the purposes of this project.

MR. MICHAL: Good afternoon. My name is Dean Michal and I'm the Chief Executive Officer for Advocate Condell Surgery Center. I've, I've had, I have had the pleasure of serving in this role at Condell Surgery Center for just under two years and managed the facility through the end of the height of the Covid Pandemic and oversaw growth in the last couple of years of the facility. Like all healthcare facilities in the country, this facility and its patients are facing challenges. We treat a large number of Advocate patients at the facility and often serve as a relief valve for the over capacity hospital surgical suites. The number of parties, the number of patients we are seeing at the surgery center continues to increase and there's no reason to believe that this trend is going to change.

The reasons for this growth are pretty simple ASTCs

offer the ability to get surgical procedures done safely, efficiently, and cheaper than surgery in a hospital. As we look at strategic planning, we've had active discussions around the state of healthcare delivery in Lake County, but the issues at Vista and Lake County, there's a disruption in the available service providers that requires a proactive evaluation of where those needs can be met. We have already seen and expect to and expect increased patient volumes at Advocate Condell Medical Center. And I know for a fact that the medical center is trying to address these issues because the president of Advocate Medical Center is on my board of directors. So we've discussed this.

While we are not at target utilization now, I can tell you why I am confident that our numbers are going to continue to increase. We have four pending applications for credentials at our facility, including three podiatric surgeons and one orthopedic surgeon who happens to be a VA doctor, orthopedic surgeon who's contacted us directly. We did not contact him trying to find access to surgical time.

Insurance providers are encouraging both patients and physicians to utilize surgery centers when it's appropriate. Another factor at play is value-based care

and management of defined populations of patients. At Advocate Condell Surgery Center, we often see patients who are treated by physicians who are part of the APP or Advocate Physician Partners ACO. APP brings together more than 5,000 physicians who are committed to improving health outcomes for divine defined patient population in the community at large. It's because of our physician partners who are apart of APP that we discovered an access issue that we hope to solve with today's application.

There have been multiple physicians who perform pain management procedures, who have approached our facility about performing procedures at our surgery center. With an open staff model, available surgery time, and importantly the ability to cover the insurance of those APP patients; This facility makes a lot of sense. Physicians who wrote letters for our application perform some of these procedures at another surgery center, Hawthorne Surgery Center.

Currently they are now running into significant roadblocks because that facility does not accept APP patients. This forces those APP patients into deciding among a number of less than ideal options. A patient could try to schedule surgery in the hospital or they could seek out an APP approved ASTC in another community much further

from their home, or they could seek treatment at another ASTC and just pay increased cost for their treatment. For many, this simply is not an option.

The hospital is often not the best location for patients 'cause these procedures are outpatient cases and do not need to be in the hospital. These patients are suffering from either acute or chronic pain and require immediate care. With Advocate Condell Medical Center being a level one trauma center, there are often many types of cases that come into the facility which warrant bumping pain management to much later in the day, if at all. This is not just a big inconvenience to the patients and physicians, it's much more.

It often means that patients with chronic pain conditions have to make their way through the hospitals, often wait hours for an available surgical suite, and the cost of performing these procedures in a hospital surgical suite are often more than they would be if they were performed, were performed in an ASTC.

I think this category of service to our facility solves this access issue and we expect that our pain management physicians will be able to perform everything from injections, spinal cord transmitter procedures, nerve ablations, and implant decompression spacers for spinal

stenosis. There are other surgeons with privileges at Hawthorne who utilize our facility for the APP patients already. And we would ask this board to approve this project because it provides access for patients who live in the community, better utilizes our facility, and it makes sense for the patients who need these services. With that, I'll turn it over to Juan.

MR. MORADO: And I'll cut this down for the members of the board so we can keep it moving. Thank you very much, Dean, members of the board, as you just heard, there is actually a real need to add this category of service to this existing ASTC. The staff report was overwhelmingly favorable for this project and the findings that you see are the usual suspects when it comes to ASTCs.

While we have a great respect for the rules, there is no reason to use your discretion to approve this project. Two of the findings deal with project utilization of the existing facility. And this is a bit of a catch 22 situation because the purpose of this application is to better utilize an existing healthcare facility, which is in complete alignment with your mission and your goals. But here we have a finding because even with the addition of the pain management procedures, it's not going to get

the facility the full utilization, but it will improve access to care.

Your state board staff report correctly points out that with the additional pain management procedures, the facility is going to be performing just over 2,500 hours of surgery, which under your rules is just, is below the state's target utilization rate for an ASTC with three rooms. Three years ago, the facility saw a need for podiatry to be added to the facility and sought approval from this board since that approval utilization has risen, and the need for an additional facility and the need for an additional operating room to perform pediatric procedures was met without negative impact to area facilities.

Adding pain management will result in an overall increase in the number of procedures performed at the facility and an increase to its utilization. As Mark mentioned, the facility just added that third room and as it tries to accommodate increased patient loads and importantly plans for continued growth. We believe it would be an appropriate use of this board's jurisdiction to approve this project, increase access at an existing facility, and allow for better utilization of it.

The last finding that I want to touch on deals with

unnecessary duplication of services. Mark touched on a little bit, but I just want to remind you about some of the specifics. We've already discussed why the hospital is not the best site for these pain management procedures. So let's dig into the ASTCs a little bit more. To begin, there was no opposition to this project from any area ASTC facility. Two of the facilities are dedicated to endoscopic procedures only. One is Lurie children's performing procedure specific to their patient base. And the other is Northwestern Lake Forest Hospital, which supports that facility.

Vernon Square Surgery Center focuses primarily on plastic surgery. They have a utilization currently of 105 percent, which leaves Hawthorne as the only other facility that performs the pain management procedures. However, you heard a little bit about the access issues when it comes to Advocate patient partner patients who need to be seen at Hawthorne facility. Hawthorne is also a multi-specialty, ASTC that performed 4,900 hours of surgery last year and pain management only took up 136 of those hours or just about two percent.

The patients that were going to be proposed to be moved over to this facility don't even make up the entirety of the pain management end. So we believe that the impact, if

any, to Hawthorn will be minimal and they'll be able to use that additional surgery time for the other categories of service of which they're approved. Importantly, there is an access issue this project hopes to cure. Hawthorn doesn't accept these patients who are in the ACO and thus a restriction on access for a significant patient population in this community exists. And we hope to address it with the approval of this application. I'd like to thank you for your attention and consideration of the project.

CHAIRWOMAN SAVAGE: Any questions by our board members? Go ahead.

MR. FOX: Can you just please clarify how many hours will be shifting from Hawthorne to the facility?

MR. MORADO: Sure thing. In your state board staff report, we show 267 of the 4,900 that they did in 2022.

CHAIRWOMAN SAVAGE: And what other specialties are in your ASTC now, podiatry now potentially pain.

MR. MORADO: Sure. We have a list of those.

MR. SILBERMAN: We have neurology, orthopedic, otolaryngology, general surgery, podiatry, urology, and plastics.

CHAIRWOMAN SAVAGE: And are those picking up, those other services?

MR. MICHAL: Certainly podiatry is, we've got several surgeons that are in the credentialing process right now. A couple that have already been approved will be starting. I went on a tour yesterday with a new surgeon, so that will be picking up. We're also looking at picking up our ENT service line with a new partner that joined our practice or we have an existing partner.

MR. SILBERMAN: There was a question earlier, by the way, about fellowship trained pain management. The individual who's driving this project is a Harvard Fellowship trained certified pain management anesthesia provider. So I just wanted to address that since it was raised earlier.

CHAIRWOMAN SAVAGE: And I think you had said that even though this is Advocate Condell Surgery Center, it's open to other outside Advocate physicians and Surgeries.

MR. MICHAL: Oh, absolutely, yes.

CHAIRWOMAN SAVAGE: Other questions?

MS. HENDRICKSON: Maybe just to help me understand, part of moving pain management into the setting is to alleviate some of the burden in the hospital setting. At the same time, there's a lot of specialties in this ASTC already. So are you actually decreasing the

burden in the hospital setting or are you creating a new gap in the ASTC where there's another prioritization need of that space as well?

MR. SILBERMAN: So if I can start with that right now, part of the motivation of this is we have a facility that is currently not being utilized up to the board standards and adding this surgery center will help do that. Performing these procedures in the surgery setting versus the hospital setting is both cost benefit to the patient and the payer. But it's also to the benefit as far as timing and access and the avoidance of having people facing chronic pain, getting delayed for block time. And as I think was mentioned by Mr. Michal, when you're dealing with the Trauma one Surgery center, a level one trauma surgery center, you have the constant risk that you will get kicked for incoming traumas.

So I don't think it's going to, I think it's going to alleviate some of the need and some of the bumping. I don't think it's going to create a need at the hospital. I might not by the look on your face. I didn't answer that. Well,

MS. HENDRICKSON: I think the question is, it seems to it your listing of all the already existing specialties at the ASTC, this is now an added one to this

list.

MR. MICHAL: Correct. The, the two primary physicians that they actually came to us and were, had significant roadblocks in being able to schedule cases either at Advocate Condell Medical Center, or Hawthorne Surgery Center. And I think through, you know, just the community, they understood that there were some capabilities that we had some space, some OR time. And so that's how the discussion started.

CHAIRWOMAN SAVAGE: Other questions.

MR. KAATZ: So is it safe for me to assume that you have not been able to meet, what was the numbers for utilization? You have not been able to meet what was in the original certificate of need that was approved here years ago?

MR. MORADO: They actually did member Kaatz, if you take a look, I think our comments earlier, they were at 86 percent two years ago, then they added on the third room. Once you add the third room on, you basically have to have another 1500.

MR. KAATZ: Got it. Thank you.

CHAIRWOMAN SAVAGE: Other questions?

(No verbal response)

CHAIRWOMAN SAVAGE: Okay. George, if you could

call the roll.

MR. ROATE: Thank you, Madam Chair. Motion made by Ms. Hardy-Waller. Seconded by Ms. Hendrickson. Mr. Budde.

MR. BUDDE: Based on the staff report and the conversation today, I vote yes.

MR. ROATE: Thank you, Mr. Burnett.

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Based on the staff report and the information today, Yes.

MR. ROATE: Thank you. David Katz?

MR. KATZ: Yes.

MR. ROATE: Thank you. Gary Kaatz?

MR. KAATZ: Yes, based on the staff report.

MR. ROATE: Thank you. Ms. LeGrand.

MS. LEGRAND: Yes. Based on staff report.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: Yes.

MR. ROATE: Thank you. Ms. Hardy-Waller?

MS. HARDY-WALLER: Yes. Based on staff report.

MR. ROATE: Thank you. Chairwoman Savage?

CHAIRWOMAN SAVAGE: Yes. Based on testimony and staff report.

MR. ROATE: Thank you. That's 10 votes in the affirmative.

CHAIRWOMAN SAVAGE: Okay. That permit is approved. Thank you. Okay. Now up is H-06 Well Care Home NFP in Highland, Illinois. Do I have a motion to approve project 23-042 for the establishment of a long-term care nursing home.

MS. HENDRICKSON: So moved.

Second.

CHAIRWOMAN SAVAGE: And then if you persons can, please state your name, spell your name for the court reporter, and then he'll swear you in

MR. USMAN: Ahsan Usman A-H-S-A-N. Last name is Usman, U-S-M-A-N.

MS. HULVEY: Susan Hulvey, S-U-S-A-N H-U-L-V-E-Y, director of Operations for WellCare Homes.

MS. FLOWERS: Tisha Flowers, T-I-S-H-A F-L-O-W-E-R-S, marketing Director for Well Care of Highland.

THE REPORTER: Mr. Usman, Ms. Hulvey and Ms. Flowers, please raise your right hand.

(Whereupon:

AHSAN USMAN

SUSAN HULVEY

TISHA FLOWERS

After being duly sworn, was examined and testified as follows:)

CHAIRWOMAN SAVAGE: Okay. Mike or George, if you could please read the state board staff report.

MR. CONSTANTINO: Thank you, Madam Chair. The applicant proposes to establish a 74-bed long-term care facility in Highland, Illinois. At approximately 74,000 gross square feet of space at a cost of approximately $3.5 million. The applicant failed to meet planning area need. There's a calculated excess of 143 long-term care beds in this planning area, failed to provide referral letters, and there are 35 long-term care facilities in a 17 mile radius. You get 75.5 percent occupancy. We did receive support letters. There was no opposition letters received and there was no public hearing. Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you, Mike. If you'd like to proceed?

MR. USMAN: Yeah. first of all, I would like to thank you respected chair and all the respected board members for allowing us to come up in front of the board and present our project. And again, my name is Ahsan

Usman. I'm one of the kidney specialists and I've been in practice for 20 years. And the project that we are going to present is in Highland, is an existing building. And it is very large building that consists of assisted living facility, which is 36 beds. In addition to that assisted living, there is a portion of skilled nursing facility under the same roof in the same building. And that contains about 74 beds.

We have a I'm the CEO of the Well Care home. And I bought this building back in June last year. It used to be a skilled nursing facility and built at as a skilled nursing facility about 20 years ago. And this is built like state of the art, very beautiful nursing facility. And unfortunately, under previous ownership, this nursing home facility was shut down in approximately two years ago.

And I bought it in June last year. And I have brought that building back up to codes that are required by the city and I got the occupancy permit already. And we already got the license for the assisted living side from the IDPH, which we already have. And we are allowed to admit patients in the assisted living side. So this building is up and running and operational. And now we are here to request for the certificate of need for this

existing nursing facility.

We have a very strong and huge support from the city and the community. And as you have all heard this morning from Christopher Conrad, the city manager who came up as a very first person who presented the city of Highland. He's a city manager and city mayor, and all the city administration is very welcoming and very motivated to get this project approved. And we have huge community support in the area. We have a lot of letters of support from the community as well.

And the, we are asking only like 60 skilled beds and 14 memory care beds. So total we are asking 74 beds. And the goal of my practice is being given my extensive history of training and education, I understand the healthcare very well. And I've been doing this for two decades. And my goal is to have the facility, which is providing the comprehensive care by providing the dialysis facility on site.

There are other nursing home facilities, but there is not even a single nursing home facility within 30 to 40 miles radius that provide dialysis. And that's what I do for a living. That's what I'm trained for. The goal when I bought that building was to have those skilled beds where I can provide dialysis service. And it's not that I'm just

saying that I'm going to provide the dialysis service. I actually already have built a dialysis unit in the building. And the IDPH preliminary inspector has already inspected and signed off on the dialysis unit that it is meeting all the codes. And I have bought some dialysis machines as well as we speak.

So I am coming with this service that is not existent in the Madison County, and there are two or three other counties that are joining to that area. And none of those facilities provide dialysis on site. I have been nephrologist and been in practice since 2011. And I can see the dialysis patients are the most sickest patients that we deal with. And when they are in the nursing home and they are like very sick, elderly, and then they have to be dragged out of the nursing home facility to go to dialysis units every other day, three times a week.

And it is being done under extreme weather conditions. Like they have to leave literally at 4:00 AM or 5:00 AM in a day that is snowing outside and very extreme weathers. And still they have no choice other than just they have to go to dialysis units. So my intention when I bought that building was to build something that will make the life of the dialysis patients who require nursing facility very easier on, on them.

And that's, and then not only that, we, I have another sister facility 15 miles away from this nursing home facility that is a Breeze nursing home. And we have, I and my team sitting here, we have worked hard in day and night to make that facility like five star rated, nursing home, five star. And we had annual IDPH survey in December two months ago. And we end up having that survey with zero deficiency. So this is not, this project that we are requesting to get this certificate of need is not our experimental facility. We have done this before and we have proven ourself and we are going to prove it again. That we going to serve the community with the good quality of care and providing them the dialysis service on site. We are very big in physical therapy, wound care, rehabilitation, all that I do with passion. And that's why we are in this community service. And at the end, I don't want to keep going. I just in at the end, I would request the board to approve the certificate of need that we can serve better and provide more service line in the community that does not exist as we speak. And it is for the community and we are going to make a difference in their lives. Thank you.

MS. HULVEY: Good afternoon. As I said earlier, my name is Susan. I am the director of operations for Well

Care homes. I wanted to touch base on what Chris had said earlier in the comments. We border three counties within a 15 mile radius, which was Vonn, Madison, and Clinton. You add another five miles onto that and we also are touching St. Clara County. So to be able to service all four counties within a 25 mile radius is something that's needed.

But something that is different about this home than other homes. Our semi-private rooms, I don't know, I'm sure most of you have been in a long-term care facility. A lot of them have two beds with the, you know, the drape that goes across. These rooms are set up, they're a little bit larger and there's a three quarter wall. The beds are end to end and there's probably about 10 foot 25th maybe in between the beds with a three quarter wall that goes up.

And so when you walk into the room, it's more of a private setting, even though you're, it sits semi-private room 'cause there's someone else in there. You're not being separated by a curtain. You're being separated by a wall that goes three quarter and then there's a curtain for anybody in case somebody's walking by that could be pulled. So it really is different. I've worked in several other nursing homes and this is the only one that I've

seen, especially in our area that provides that type of setting.

The bathrooms, there's only, it's not a Jack; most nursing homes, if you're lucky, are Jack and Jill bathrooms. You're going to share them with up to four people. Each one of our rooms, whether it's private or semi-private, has their own bathroom. So the most you're going to be sharing with this one person, and that does mean a difference to these people.

You know, it's bad enough if you have to wait for three people to use the restroom and sometimes you can't. And there's only one other facility in town that is a nursing home also. And the restrooms are one on a hall, so that makes a big difference. We also have a memory care unit there, and it is a, four by four square format with a railing that the dementia and memory care residents can continue. They, they're always wanting you to keep busy and they may not know exactly where they're going, but they, they can just keep going in a square and it really occupies their time.

It's a safety issue. It is a secured unit and off the secured unit is also an outside secured unit for them to go out. There's a garden out there, there's some benches where they can sit with their families and make a

difference. We also have a, a covered entry for transportation and loved ones want to come and get their family member for the day and take them out for different things. So this truly is a different setting than a lot of settings that I've seen and been around. And I know in the, the four counties that I'm talking about, I, I truly have not seen another one in this.

Also, doctor Usman had also mentioned that, you know, we do have another facility in the, in the area. But between the two, we can accomplish just about everything, you know, from, from insurance, to private, to Medicaid to Medicaid pending. And I did want to touch base on when that facility closed. Originally last, it was 2020 in April. I was actually there with another company when it closed. And a different capacity. We had 84 residents between the assisted living and the skilled facility. That was very hard on the family, very hard on the residents. It was, it was a very sad day. It was a great economic impact for the community. Not just the town, but the surrounding communities. And we've had residents, family members for residents that were there that have contacted us that want to come back. I think it would be a, a great service to the area to be able to provide this type of setting in a rural community so that their loved ones

don't always have to drive to a bigger city to go and see their loved ones that are actually in a long-term care facility. Here I'll pass it to Tisha.

MS. FLOWERS: Members of the board. My name is Tisha Flowers. I'm the marketing director for both WellCare Home of Highland and Breeze Nursing. As Susan was stating earlier, we were both there when the prior facility closed. It was a very, very bad time. You know, we had a need back then and we still have that same need now. The other facility in Highland, Illinois is full right now, so there isn't anywhere else they have to go outside of their own community if residents are looking for a place to stay.

So right now, as of today's date, I have 17 residents that are on the waiting list. Families that have contacted us, wanting to place their loved ones. Some of them were there before. Some of them are brand new and our building sells itself. It is absolutely stunning. It was gorgeous before and it's even more so now. We do offer hospice care as well. So we, we have the full realm of everything that is offered and it's all under one roof at Highland.

So we have some residents whose loved one lives on the assistant side, and some residents live on the long-term care side, and they can come and go and visit each other.

Over in Breeze at the sister facility, we were able to double that census since we took over. So there is a huge need in our area right now for nursing homes.

CHAIRWOMAN SAVAGE: Okay, so based on the information you provided about your Breeze facility that was not on your original application, that did not give our state board staff sufficient time to look at that facility. We're going to do a few things. So may I have a motion to end this debate on this particular permit applicant?

DR. TANKSLEY: So moved.

CHAIRWOMAN SAVAGE: And a second.

MR. BURNETT: Second,

CHAIRWOMAN SAVAGE: George, if you could call the role.

MR. ROATE: Thank you, Madam Chair. Mr. Budde:

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Yes.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: Yes.

MR. ROATE: Thank you. Ms. Legrand.

MS. LEGRAND: Yes.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: Yes.

MR. ROATE: Thank you. Ms. Hardy-Waller.

MS. HARDY-WALLER: Yes.

MR. ROATE: Thank you. Chairwoman Savage?

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: Thank you. That's 10 votes in the affirmative.

CHAIRWOMAN SAVAGE: Okay, so that motion is approved. And now may I have a motion to amend our original motion on this applicant to postpone this applicant until the next meeting?

DR. TANKSLEY: So moved.

MS. HENDRICKSON: Second.

CHAIRWOMAN SAVAGE: George.

MR. ROATE: Thank you, Madam Chair. Mr. Budde:

MR. BUDDE: Yes.

CHAIRWOMAN SAVAGE: One moment. Okay. George, if you could call the roll on that motion that we just had.

MR. ROATE: Thank you, Madam Chair. Motion to amend:

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. David Katz?

MR. KATZ: Yes.

MR. ROATE: Thank you. Gary Kaatz?

MR. KAATZ: Yes.

MR. ROATE: Thank you. Ms. LeGrand.

MS. LEGRAND: Yes.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: Yes.

MR. ROATE: Thank you. Ms. Hardy-Waller.

MS. HARDY-WALLEN: Yes.

MR. ROATE: Thank you. Chairman Savage.

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: Thank you. That's 10 votes -- 10

votes to amend.

CHAIRWOMAN SAVAGE: Thank you. One moment. And may I have another motion to pass the amended motion -- pass the amended motion to postpone until the May 9th, 2024 meeting. May I have a motion for that?

MR. BURNETT: So moved.

MS. LEGRAND: Second.

CHAIRWOMAN SAVAGE: Okay, George, if you could call the roll.

MR. ROATE: Thank you, Madam Chair. Motion made by Mr. Burnett, seconded by Ms. LeGrand.

MR. ROATE: Mr. Budde.

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson?

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you Mr. Katz, David Katz?

MR. KATZ: Yes. With a short editorial comment. That'd be great going forward to figure out how to be efficient with this stuff. And I'm not, I'm not sure actually when the fault lies with us or with whatever, but

it, it, you know, we've been at this for a half hour and we're going to have to do it again. So

MR. ROATE: Thank you. Gary Kaatz?

MR. KAATZ: Yes.

MR. ROATE: Thank you. Ms. LeGrand?

MS. LEGRAND: Yes.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: Yes.

MR. ROATE: Thank you. Ms. Hardy-Waller.

MS. HARDY-WALLER: Yes.

MR. ROATE: Thank you. Chairwoman Savage?

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: Thank you. That's 10 votes to defer --

CHAIRWOMAN SAVAGE: To postpone. Yes. Yes, sir.

MR. USMAN: I just have one comment that Breeze facility that I purchased, that was after I submitted the application.

MS. DOMINGUEZ: There, there is a, a process by which you could amend that in essence when it's a substantive change. So I think moving forward, you know, just for everyone, if a substantive change happens after your application has been submitted, please feel free to give us a call so we can avoid that. I mean, no one wants

to spend the whole day here and then only to have your application deferred. So I think, you know, that's fair if it changed afterwards, everyone on the board had different information and so now we're hearing very substantive new information, right? And so we need some time to review it. I would suggest that when you leave here give Mike and George a call so they, you can go ahead and get the new information and submit it so that we can get that processed and reviewed by the time that we get back to the May 9th meeting.

CHAIRWOMAN SAVAGE: Okay. So another announcement. We are going to move our rules item on the agenda to the May 9th, 2024 meeting; just so everyone knows. Okay. So now we are going to move on to H-07 North Suburban Pain and Spine Center in Des Plaines, Illinois. Do we have a motion to approve project 23-043 for the expansion of two surgical specialties to the existing surgery center.

MR. BURNETT: So moved

MS. LEGRAND: Second.

CHAIRWOMAN SAVAGE: Okay. Once you all are seated, if you could new people, introduce yourselves. Spell your name for the court reporter and he shall swear you in.

MR. SALDANHA: Darrell Saldanha.

CHAIRWOMAN SAVAGE: Spell your name.

MR. SALDANHA: D-A-R-R-E-L. Last name Saldanha, S-A-L-D-A-N-H-A.

MR. HOOK: Jonathan Hook, J-O-N-A-T-H-A-N. Hook, H-O-O-K.

MR. GIMBEL: Stuart Gimbel. S-T-U-A-R-T G-I-M-B-E-L.

(Whereupon:

DARRELL SALDANHA

JONATHAN HOOK

STUART GIMBEL

After being duly sworn, were examined and testified as follows:)

CHAIRWOMAN SAVAGE: Thank you. Mike or George, if you could produce the state board staff report.

MR. CONSTANTINO: Thank you Madam Chair. The applicant proposes to add general surgery in podiatry surgical services to its existing ASTC in Des Plaines, Illinois. There's no cost to the project. Expected completion date is March 1st, 2024. That may need to be updated if the project is approved; I believe the applicants were going to update it here at the meeting if the project is approved.

The applicants failed to meet projected utilization, service to residents of the GSA, service demand, treatment room need assessment, service accessibility, and unnecessary duplication of service. There was no public hearing request. Thank you Madam Chair.

CHAIRWOMAN SAVAGE: Thank you, Mike, if you'd like to proceed.

MR. MORANO: Yes, good afternoon. Members of the board, we're pleased to be before you today with an application that is, again, rooted in better utilization of an existing facility and seeks to address patient care issues and more than anything else, operational issues that had existed at the facility. North Suburban Pain and Spine is a multi-specialty ASTC, that was designed to offer a full compliment of musculoskeletal outpatient surgical procedures. The application that's before you today is to add general surgery and podiatry services to address these operational issues, which Darrell is going to explain.

Before I get into more detail I want to make sure I introduce everyone with us today, we have Dr. Darryl Saldanha, the medical director of the ASTC, Dr. Jonathan Hook podiatrist, who's supporting this application, Stuart Gimbel, the CEO of the ASTC, who's not going to be

speaking, but is available for questions. And my partner Mark Silberman. Again, we'd like to thank the staff for the Positive Staff report. We're pleased that there was zero opposition and no public hearing requested for this project. Darrell's going to explain for you the history of the facility and why we filed this application. Dr. Hook's going to talk a little bit about the access issues he's facing as a surgeon in the community. And finally, Mark's going to address the criteria that we're not in conformance. And with that, I'm going to pass it on to Darrell.

MR. SALDANHA: Good afternoon. Thank you members of the board for hearing our application for the addition of two specialties of general surgery and podiatry. As we were granted the application back in December of 2018, we have grown to start fulfill our mission of treating musculoskeletal care issues within our center. As the center has grown through the Covid times and come up to speed thereafter, we have encountered the need for additional specialties to service our client population or patient population.

Specifically with general surgery, our spine surgeons are looking to do more anterior or front approach spine surgeries, and they will require a general surgeon to

access that location of the body. And additionally for podiatry, as we have grown to continue to practice with our muscular skeletal care, we have had a need to address issues of the foot and ankle. So to provide more comprehensive care for our patients, our center has been able to access provide greater access to care for surrounding surgeons and have an open staff policy and allow more cases to be done to increase utilization due to our comprehensive anesthesia program and availability of block time for the surgeons.

And I believe that these two specialties will allow us by provide greater care to our patients. And with that, I'll ask Dr. Dr. Hook who can provide some insight into his access issues with himself.

MR. HOOK: Good afternoon. My name is Jonathan Hook. I am a podiatrist and a board certified foot and ankle surgeon. I practice in Mount Prospect and Libertyville. I'm employed by the Foot and Ankle Institute. I also am currently functioning as the fellowship program director. There's quite a few non-operative physicians in my group. So I'm treated as the tertiary surgeon and I do a high volume foot and ankle surgery for our practice. Due to the high volume of surgery, I have difficulty finding adequate block time and

either hospitals or surgery centers either due to anesthesia or staffing issues.

This center is going to provide me with the ability to have additional block time to provide treatment for my patients and have the ability to schedule cases on a regular basis. Thank you.

MR. SILBERMAN: So members of the board, the driving force behind this project is to comply with the board's rules and follow through regarding the commitments they made regarding the utilization of this project. As you've heard, the ramp up during the pandemic was more gradual than expected. So the applicant's doing what it can to make sure that the facility ends up fully utilized. More importantly, they're trying to do this the right way. One of the things that we jumped over out of sort of time, but one of the challenges they've had is there's been various surgical spinal procedures that they've been wanting to do that have a general surgical component to it.

And therefore, based on the fact that they didn't have the general surgical capacity, they have not been willing to do the surgeries at the facility, in part because they don't get the advance approval or the authorization to perform the general component. And so being responsible

and limiting themselves to the categories of service they have, they've passed on those opportunities. By adding the general category of service, they will be able to perform the spinal procedures that have that expanded component where the general surgical component is part of that.

The other aspect of that is also with the podiatric. There are circumstances where anytime, as Dr. Hook explained to me, anytime you pass the patella, you start getting into a question of, is the procedure that's being done, is it orthopedic? Is it pain management, is it podiatric? And the cleanest way to do it's to make sure you simply have the category of service to be able to ensure. Because once you have the lower leg, rather than risk any degree of gamesmanship or very realistically risk claims denials, because we don't have the right category of service, if we have the capacity, we have the interest and we can solve the access issues by providing this care, we want to do it. Adding the specialty makes the most sense.

The negative findings that you have before the board are rooted in the fact that the facility's not fully utilized. And we agree that's actually why we're here before you today. But you know, as you've heard, utilization trends continue to rise. The applicant's

committed to doing what it needs for the full utilization. These negative findings generally relate to a facility being underutilized. And the issue is that the volume of proposed referrals, you heard this earlier today on another application, even with these referrals, it doesn't necessarily get us to full utilization.

But this is an existing facility and that rationale makes a lot of sense when you have a facility that's expanding to add an OR, or to add to its capacity. This is just to add two specialties to make sure we can do the procedures we envision doing and to help add access to care for doctors like Dr. Hook who are looking to find a place where they can perform these podiatric procedures. This project's not looking to expand the volume of the ORs just to expand the services and ensuring better utilization of this facility, which as we've discussed, is a core tenant to this program.

So with that, we've jumped over some stuff out of respect for time. If there's anything we've missed in questions we can answer, please don't hesitate to ask, but we're happy to address any questions You have.

CHAIRWOMAN SAVAGE: Questions by our board members.

MS. HENDRICKSON: What, in your sum -- in the staff

report summary, it mentions that you have not hit your Medicaid or your charity care patient volumes that you had put in your original projection. What are you doing to meet that now?

MR. HOOK: Can I just maybe set it up a little bit and I'll let Stuart, the CEO talk about this further. So one of the things I wanted to point out, and it's described in the application as a result of all the number of delays from Covid, the facility was actually just admitted into the Medicare program as of January, 2023. Which is, you probably are aware means that you can't even get into the Medicaid program unless you have your Medicare enrollment. So that's one thing that has been accomplished along the way. And now I understand, and I think Stuart, he will talk a little bit more about some of the ongoing conversations they're having regarding enrolling in with the Medicaid managed care providers, Stuart.

MR. GIMBEL: Yeah, and just to give you a better idea of the time line we only were able to get our Medicare number in January of 2023. So that was a prerequisite to being able to provide any Medicaid care at that point. We've also been actively trying to get on commercial insurance plan since that time. We would, we

would never turn away a Medicaid patient. We take whatever patients are brought to our door and we're hoping to do more of that in the future.

DR. TANKSLEY: Just a follow up, when did you apply for the application?

MR. MORANO: Which --

DR. TANKSLEY: for the Medicare, you said you received your Medicare -- Medicaid number in 2023. When did you apply for it?

MR. GIMBEL: So we got our certificate of need in December, 2018. We built our building and surgery center through Covid and got certificate of occupancy for the building from the Cook County because we're in unincorporated in Cook County in December of 2020. Then we had some issues getting the equipment we needed. We only got licensed by IDPH in the end of May of 2021. At that point, we had to do a certain number of procedures in order to go through the joint commission certification process. So we started doing procedures at that time. We ended up flying to joint commission, I want to say in about June of 2023. And we aced at that and got our approval in November, got our Medicare number January 9th, 2023.

MR. MORANO: And I think to answer your question

member Tanksley, in page 91 of the application, it does show that the date that Stewart's referencing in terms of the Medicare certification, right now, the current, the facility is currently contracted with United Healthcare Aetna, Cigna, which had Medicaid products. There had been discussions, although no enrollment at this time with the Blue Cross Blue Shield product, nor with the county care product. But it, I can, I guess they would still qualify forward even though they're in an unincorporated county.

DR. TANKSLEY: I'm not sure that I understand. So here you have 10 percent Medicaid was going to be part of your payer mix. Is that, but you're saying that you, you are in network work with Medicaid or you're not?

MR. SILBERMAN: So they have the managed care organizations and some of the some of them have, they're a product. So the ones we're in right now are United Healthcare, Aetna and Cigna.

DR. TANKSLEY: Medicaid.

MR. SILBERMAN: Right. I believe it. Cigna has the Medicaid product.

DR. TANKSLEY: Cigna. Oh, so it's their Medicaid -- It's the Medicaid managed care --

MR. SILBERMAN: Yeah.

DR. TANKSLEY: -- product. Okay. The managed Care

product.

MR. SILBERMAN: Correct. And I think the answer is --

DR. TANKSLEY: Has one as well -- too.

MR. SILBERMAN: I believe they do. I don't know for sure, but I know definitely Cigna and I believe Aetna does. And Blue Cross is of one of the biggest that has a Medicaid product as well as county care. And that's the one I was not sure if it still qualifies, but I would imagine it does. 'Cause It's

DR. TANKSLEY: So you're in Blue Cross, you're in with Aetna.

MR. MORANO: We're not in a Blue Cross, just to be clear. There have been conversations but they have not submitted an application nor enrolled with them yet, neither on the commercial side.

MR. SILBERMAN: And so as to why then we haven't hit the targets at this point is because the window of time in which they've been eligible to be performing Medicare Medicaid is limited to since the beginning of 2023. And just so the patient mix hasn't played out.

DR. TANKSLEY: Thank you.

MR. FOX: Yeah. could you tell me in regards to the general surgery on the three physicians on table

three, I see Dr. Hook is a podiatrist on there, Dr. Sumner and Dr. Gelman. What are their specialties?

MR. HOOK: I can answer that one. One of them is the general surgeon. I think there's two general surgeons, is that right? Yes. He's a general surgeon.

MR. FOX: I asked, so Dr. Sumner is not here.

MR. MORANO: I'm pulling it up right now. Okay. we have Dr. Sumner who is a general surgeon. Correct. And then we have Dr. Hook who's here before us. Yeah. And Dr. Gelman is a podiatrist.

MR. BUDDE: Okay. When you do a procedure, if you're using the general surgeon for access to do the front procedure, is there a double billing for the ortho or does it all just keep billed under the ortho body? Who actually does the, the disc repair or the fusion or what?

MR. SALDANHA: I'm not a billing expert, but I believe there is a assistant component that they have to provide to get into the access portion. So there is a billable component, but a several, several, not from the facility side, but from the certain side there should be a separate billing. And that's rightfully so. 'cause They're performing generally open procedure from the abdomen. So they bill separately, but the facility is still just the same procedure.

MR. KATZ: Okay. Any consideration for delaying this and coming back once you've demonstrated you're going to take care of Medicaid patients?

MR. SILBERMAN: We haven't. And I guess the only thing I would say is this, is that this facility has had a significant challenge in getting up and running and getting going. And it's just really starting to, and we can recommit to the commitments that have been previously made. As with regards to the target utilization, they've already taken the steps of getting enrolled into Medicaid and getting enrolled into various products and they're continuing those discussions.

But at the end of the day, and I think this is a point, when you identify a target goal of what your percentage of Medicaid patients are going to be, it's ultimately going to be reflective of the patients that come through the door. And right now what they're trying to do is to make sure they have enough patients coming through the door across the board. Now there, I mean, correct me if I'm wrong, but all of the different specialties that you provide are accepting Medicaid?

It isn't limited. I, I accept Medicaid. Yes. So if you want to, so

MR. SALDANHA: I do accept Medicaid, I accept

meridians. So that would be a portion of my practice. Personally I'm a, a pain management physician, double board certified anesthesia and pain management. Currently, I cannot take my case as a center because we are not fully enrolled, but we plan to do that fully as soon as the, the products come through and the contractual negotiations are complete. So that would be utilization from that alone as well.

MR. KATZ: I assume that the biggest impact of the new cases are going to be the podiatry cases?

MR. SILBERMAN: Is the podiatric? Absolutely. There are, there are, to be clear, there's some procedures that have been like ankle procedures where there's going to question of whether it should be properly classified. But Dr. Hook is also going to bring a podiatric practice that will have its own Medicaid component.

And then with regards to the general category of surgery, just to be clear, they're not looking to become a general surgeon. This is to facilitate some of the spinal procedures that they want to be able to do and to make sure they're approaching it -- this right way with the appropriate regulatory approvals.

MR. HOOK: I think it's important also, member buddy, to recognize probably a little bit of may up on our

part. And a nod to member Katz, your efficiency arguments you've been making today. The last couple of these ASTCs that we brought forth that have been pain and ortho focused, we typically will apply for three categories of service pain, ortho and podiatry, kind of like as a combo because of the very reasons we're describing today. So should we have brought podiatry under the original one? Probably. I don't think that we could have foresaw the general surgery issues that the facility is facing now. And I think as Mark kind of described, we don't intend to become fully service in doing general surgeries. It's really more as a compliment to everything else that we're trying to do in terms of musculoskeletal care.

MR. KATZ: But once you gain that addition, then whatever the intentions are at the table today can change. 'cause Then you could do general surgery procedures. I guess I'd ask the staff that is there, is that limited to a particular application or once it's general surgery? It's general surgery and it, and it's open at that point in time, it's open.

MR. MORANO: I think we are open to the extent that it would be helpful to a condition placed on that category service limiting it to the support of orthopedic and paid procedures.

MR. SILBERMAN: And what I was going to say is there's, there's no interest to be doing the gallbladders and things. I mean, that's just not the desire or the design of the facility. And then back to your point with regards to the advancement of Medicaid, I think allowing the addition of podiatric will help do that and will help demonstrate that commitment. Even though it's a new component, we're not bringing in new physicians who don't have a commitment and don't already have Medicaid patient population. We're looking to then use that as the opportunity to continue the utilization.

CHAIRWOMAN SAVAGE: Other questions?

DR. TANKSLEY: Yeah, I, I got a follow up to my question. I read page 91 pretty extensively and I just want to make sure that I'm, I'm understanding, so your, your initial application was approved in 2018 for your center; Correct? Okay. And when did you apply for Medicaid? Like when did you apply to be a part of the Medicaid system?

MR. SILBERMAN: So if, and I, if I get the sequencing wrong, I invite anyone in the room to correct me if I'm wrong. But once they, we had the delay with regards to the pandemic to the completion and the getting of the facility up and running. Once the facility was

licensed by public health, they then needed to demonstrate a requisite number of surgical procedures before they could apply for Medicare through the joint commission certification process. Joint certification will yield the Medicare certification. Once they completed that, which if I understood correctly, was in June of 2022 --

DR. TANKSLEY: 2020.

MR. SILBERMAN: 2021, that's when they completed the requisite number of procedures is when they then applied for the Medicare certification, which you said was --

MR. GIMBEL: We got our Medicare license in January of 2023. And then we've been applying with the primary carriers Blue Cross, United, Cigna, Humana, Aetna. And we've been going through that process of getting on as participating members in all of their packages during the course of 2023.

DR. TANKSLEY: So did you do any procedures at all, like prior to your Medicare approval?

MR. SILBERMAN: Yes. Yes. You, you have to do a certain number of procedures in order to go through the joint commission process.

DR. TANKSLEY: I guess I'm just confused on the delay in applying, like, I guess what was the delay?

MR. SILBERMAN: You can't apply until you've completed the requisite. So that's how long it took them to get the requisite procedures Done.

DR. TANKSLEY: It took four years to get things done?

MR. GIMBEL: Well, no, We, we only got our IDPH license in June of 2021. We started and applied for joint commission in 2022. We passed joint commission in November 2022, and we're deemed admitted into the Medicare program in January of 2023.

DR. TANKSLEY: So it looks like it took two years.

MR. SILBERMAN: It took one Year.

DR. TANKSLEY: You were approved here in 2018, right. And then from 2018 to 2020, like what happened from 2018 to 2020?

MR. GIMBEL: We built the building. Yes. Or do you want to talk about.

DR. TANKSLEY: it took three years to build your building?

MR. SILBERMAN: So the, the issues were, there was issues with regards to supply chains during the pandemic. There was issues with regards to construction.

DR. TANKSLEY: These are pre-pandemic dates 2018 2019. These are pre-pandemic.

MR. SALDANHA: If I could just say there, there was since we're unincorporated displays, there's quite a lag of time between getting the permits and then we hit the pandemic and then supply chain issues and everything else. And just a matter of physical workers at the building, there were just not that many. And then a lot of procedures were not being done thereafter due to covid and patient hesitancy. And that whole period, it was stretched out from that time to when we basically got the Medicare license and 90 page license. So it was a lot of lag because of this circumstances of what was going on in the world generally. So that's kind of what our issues have been for that.

MR. BUDDE: I think that the question that Dr. Tanksley has asked, and I'm not sure that I've heard the answer, is have you applied for a contract with public aid and do you have a public aid contract?

MR. GIMBEL: I don't believe we have a contract directly with public aid just through the it was Aetna services provided by the Aetna.

MR. BUDDE: And so, so you're caring for public aid patients, but it's through the Medicaid managed care program?

MR. SALDANHA: Yes, actually the vast majority of

the Medicaid patients that we have encountered over the last couple years in just our different practices are enrolled in a managed care product through these big carriers. So the priority is to get to them, but as a matter of circumstance when we have a manager primary and a Medicaid secondary do accept those and those come through the door all the time. And we have no hesitancy. A lot of our patients are older and with chronic pain and their primary products Medicare, but we were focusing on getting these managed care products taken care of so we can take more of the patients immediately. And we're trying to do everything at one time because there's a lot of hurdles in terms of time line and communication that we have encountered that we are overcoming. But there's a strong need for our center to take Medicaid because we don't want to isolate those patients in any way. And there, there are a lot, it's a huge portion of our practices on the individual providers and surgeons. So it just, it's a, it's just a good idea for to do that quickly. It's just a matter of time. So we're, we're working on it very hard.

CHAIRWOMAN SAVAGE: Thank you. Other questions, Rex.

MR. BUDDE: Yeah, I have one more. In doing the

spinal procedures front access, which I had done three weeks ago my tie is rubbing on the scar. What are the plans, or, you know, if the general surgeon does the access and then the orthopod's doing the spine work, there's a lot of really sensitive stuff between the front and the back. And what's, if something gets nicked, have you, have you thought through what happens if we have a, a bad outcome or if we can, you know, orthopod nick something or, or I mean, what, how are you going to handle that?

` MR. MORANO: These surgeons are very skilled at what they do. So, but there is backup plans for these sorts of instances. We have. Initially there is a, it would be an agreement within a blood bank who could provide you know, blood cells to infuse if there's an issue with nick artery, we have a comprehensive list of what's called hemostatic agents to sort of fix any issue with the artery or vein. And we have a transfer agreement with the hospital that we can utilize. We can always and we have skilled anesthesiologist, that's another important thing. And we have a rapid infusion devices of IV bags to hold the patient over. Everybody in the facility is trained on ACLS and the facility provides a very high standard of care in terms of the practitioners and the

nursing staff and the answering staff and those things. So there's the level of care is just very hospital grade and we're very proud of it and we're excited to put these procedures together because we want to just provide more comprehensive care.

CHAIRWOMAN SAVAGE: Other questions?

(No verbal response)

CHAIRWOMAN SAVAGE: Okay, George, if you could call the roll.

MR. ROATE: Thank you, Madam Chair. A motion made by Mr. Burnett, seconded by Ms. LeGrand.

MR. ROATE: Mr. Budde.

MR. BUDDE: I'm going to vote no and I'd like to see the applicant come back after they've completed their commitment to IDPH and all the applications and demonstrated a track record. So for that, waiting for that, I'm going to vote no for right now.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: I vote no as well.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: I'm going to vote yes because I think the addition of these specialties to an existing facility at no cost will help the facility get to the desired utilization levels.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: I'm going to vote no similar to my earlier peers until I see the numbers reflect what was in the original application in terms of utilization.

MR. ROATE: Thank you. David Katz.

MR. KATZ: I'm going to vote yes and echo David Fox's comments.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: I'm going to vote no, I'm Concerned about the things that were Identified in the staff Report.

MR. ROATE: Thank you. Ms. Legrand.

MS. LEGRAND: I'm also going to vote no at this time for what my board members have said.

MR. MORANO: Excuse me, George. If I can ask for consideration a board deferral at this time, we can come back, get some of that additional information that's been requested by the members and then we can reappear.

MR. SILBERMAN: And if I could, the, the rationale I would offer for consideration is the following. There's clearly there's information that's wanted with regards to the progress regarding commitment to Medicaid and that I think we can address with regards to the ongoing

applications. But the other issue is this, I appreciate the desire to see the commitment towards the utilization that was previously predicted, but the negative findings relate to the fact that we haven't met those utilizations and that therefore, and the addition of the categories of services to help us meet those utilizations. So I think we need to do a better job of evaluating and presenting that to the staff so that they can evaluate it and then to the board. So in an ideal world, we'd love the opportunity to do that. If Roberts allows, we would have no objection to a single vote to recall the vote and approve a deferral. We would not mind a combined vote for the record. We would waive any objection to that. If that helps save time.

CHAIRWOMAN SAVAGE: Okay. May I have a motion to end the debate on this applicant and defer until the next meeting, I guess, or future meeting?

MS. HARDY-WALLER: I'll make that motion.

CHAIRWOMAN SAVAGE: Did we have a second?

MR. FOX: Second.

CHAIRWOMAN SAVAGE: Oh, sorry. George, if you could please call the roll.

MR. ROATE: Thank you Madam Chair. Motion made by Ms. Hardy-Waller, seconded by Mr. Fox.

MR. ROATE: Mr. Budde.

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Absolutely not. I mean, this is like taking a test, getting through eight of the 10 questions, deciding you'd rather take the makeup test the next day. I mean, it's ridiculous. So, no, and I know I'm in a minority here, but absolutely not.

MR. ROATE: Gary Kaatz.

MR. KAATZ: Yes.

MR. ROATE: Ms. Legrand.

MS. LEGRAND: Yes.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: No.

MR. ROATE: Thank you. Ms. Hardy Waller?

MS. HARDY-WALLER: Yes.

MR. ROATE: Thank you. Chairwoman Savage?

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: Thank you. That's eight votes in

the affirmative. Two votes in the negative.

CHAIRWOMAN SAVAGE: So that motion is, or the permit is deferred. Thank you. That's it.

MR. KATZ: Can I, can I make a comment for the record, please? Which is that I would like to understand better how this process works because I just, this like I have a second or third time We've Done this kind of, I don't like where it's going, so let's pretend it didn't happen routine. And that's, I've just never seen a process works the way that may be the way it's supposed to work here. If it is, I'd like to understand that better. And if it's not, I, I'm not sure whether we can undo what we just did with these guys, but it's why I, I maybe that's it. I don't know. I don't know what the right form is to discuss that, it's in the middle of a vote.

MS. DOMINGUEZ: There is a process. But we would've still gone through the process of residing the vote, going through the motion and applying because they're entitled to that by the rules. It's just when they come to here. And I think that's just another, you know, lesson learned.

MR. KATZ: So why would anybody allow themselves to get voted down? Why, why wouldn't anybody who doesn't get approved just pursue the vote? Well, I mean, that's what I would do.

MS. DOMINGUEZ: The board does have the right to also vote to defer matters. So we could, if continued and you have the option to either issue an intent to deny which gives them the opportunity to come back, or the board could have continued with the vote and just done a motion or a vote to defer until, you know, two meetings now or a meeting for now. So there are other options the board could have, we could have continued to do that as well. So I think it's just a matter of reminding the board that you do have options besides yes and no.

MR. KAATZ: Blanca do we have an obligation? We I, oh, I'm sorry. I'm sorry. Oh, do we have an obligation that when we approve the CON we're approving somebody coming before us saying, I'm accountable, this is our plan. And we, we are committing to these numbers or this progress or whatever. Do we have an obligation as a board that if they're not doing that to basically halt the project

MS. DOMINGUEZ: Well, there are options. You could always issue a permit based on contingencies and having them or, or contingent, you know, or conditions on the permit. But I, I think that's a, a more of a CEU type of basis for the board.

MR. KAATZ: What is CEU?

MS. DOMINGUEZ: Oh or continuing education type of thing? Just to advise you, remind you and, and stuff the options that you as board members have so that you're better prepared to know this is the action that I want to take with this particular application.

MR. KAATZ: I Mean, I'm, I'm almost offended when somebody comes in and said several years ago we promised to do all this, if you please approve this, right? And then we approve them and then they come back basically say, no, we can't, we can't do that. We have to add these and our board of staffers have to write it all up again against all the same standards and they come back all negative.

MS. DOMINGUEZ: The board does have discretion to revoke permits, but again, we have to go through and, you know, kind of go through the process educate everyone on what that looks like and what parameters you can set on something like that. Before we go to that, but again, I think that's for a different day. So that we can try to get everyone.

MR. BUDDE: Gary, I'm sympathetic with your comment and I would add that because of the pandemic, I think people's plans have been thrown up in the air in terms of growth of volume and even completion of the

facility. So even as we want to hold people to the promises they make in the presentation, in this particular case, maybe the pandemic impeded their ability to grow the program.

CHAIRWOMAN SAVAGE: Okay, well we're going to move on. Already been delayed today, so let's just keep going.

CHAIRWOMAN SAVAGE: All right, so H-08 Innovia Surgery Center in Wood dale, Illinois. May I have a motion to approve project 23 - 046 for the expansion of two surgical specialties to the existing surgery center?

MS. LEGRAND: So moved.

CHAIRWOMAN SAVAGE: Second.

MR. FOX: Second.

CHAIRWOMAN SAVAGE: Okay. folks can introduce yourselves, spell your names for the court reporter and then he will swear you in.

MS. SCHMIDT: Thank you. Vera Schmidt, V-E-R-A S-C-H-M-I-D-T

MR. GOYAL: Vinnie Goyal, V-I-N-N-I-E-Y G-O-Y-A-L.

CHAIRWOMAN SAVAGE: And you can use the other one too, sir.

MR. ERICKSON: My name is Robert J. Erickson, E-R-I-C-K-S-O-N.

MS. COOPER: Ann Cooper, A-N-N-E C-O-O-P-E-R.

THE REPORTER: Ms. Cooper, Mr. Erickson, Mr. Goyal, and Ms. Schmidt, please raise your right hand.

(Whereupon:

VERA SCHMIDT

VINNIE GOYAL

ROBERT ERICKSON

ANNE COOPER

After being duly sworn, were examined and testified as follows:)

THE REPORTER: You may proceed.

CHAIRWOMAN SAVAGE: Thank you. Mike or George, if you could share the staff, state board staff report

MR. CONSTANTINO: The applicant proposed, proposed to that spine in orthopedic surgery to an existing specialty, ASTC located in Wood dale, Illinois. Project cost is approximately 1.7 million, and the expected completion date is June 30th, 2024. The applicant's failed to meet projected utilization, treatment room need assessment, service accessibility, unnecessary duplication, and financial viability. There was no public hearing requested. Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you. If you'd like to proceed.

MS. COOPER: Before we start our presentation Dr. Erickson has a deposition that's starting shortly, so we would like for him to provide his comments at the start and then we'll continue with our presentation.

CHAIRWOMAN SAVAGE: Very well, best wishes.

MR. ERICKSON: Thank you. It's a pleasure to be here. And I'm pleased to support the proposal for spine surgery at Innovia. Just worried about my background. I, I'm trained as a neurosurgeon. I've been in Chicago through the period of my training during the first half of my career, which is academic, and the second half of my career, which is in private practice. I do have extensive experience in outpatient spinal surgery. It's something we began while I was on faculty at the University of Chicago in terms of performing anterior super discectomy infusion safely. We performed a series of operations in the late 1990s so two thousands, and we became comfortable sending people home the same day. Since 2012, well over 10 years, a large part of my practice has been involved in outpatient spine surgery.

My patients go home the same day. They very rarely would need a 23-hour observation period, and many procedures are well performed and perfectly safely done in outpatient setting. I don't think it's controversial

anymore. With that said there are a lot of surgery centers in the area. I've been to a good number of them in my career, which has been fairly long. I've operated in surgery centers in Lake County in Cook County and downtown and in the suburbs. This is one of the better facilities I've seen or had the opportunity to tour.

It's accessible. It's on Urban Park Road. The ceilings and the interior are high. Space is well lit. It's very clean. The operating room is large, which is important to us because we need nerve monitoring running throughout the case. My cases are all done under the operating microscope. That is the same scope we would clip aneurysms and brain surgery with, and I'm very pleased with the state of the equipment, the size of the facility, and the accessibility of the parking. I've done a lot of work downtown in surgery centers and parking's a major issue for patients and practitioners and getting everybody together; It's not trivial, and they have that worked out well.

This is a place where surgery could be done safely. Number one, it's a place where my patients could be seen after surgery and post-op visits very easily. They're set up to help me with my clinical care after surgery as well. The plan is to involve interventional pain management and

for there to be coordinated workup, evaluation operative care and postoperative care. I'm sure you'll hear that there are already a very active surgery center that does procedures that carry risk and have, have done very well. So, in brief, I, I can't be more pleased. I am totally supportive of their efforts. I am a, a spine surgeon that will take cases and take care of patients within that surgery center in Wood dale. Thank you very, very much.

MS. SCHMIDT: Okay. good afternoon in perspective Chair savage and board members. I'm Vera Schmidt. I'm the Chief of operations for Innovia Surgery Center. Thank you for letting Dr. Erickson speak with me today. I also have Dr. Vinnie Goyal to seat next to me. He's one of the physicians currently doing procedures at Innovia and our CON attorney Anne Cooper. Before I begin my formal remarks, I would like to thank the board for approving our application. During the last October meeting for to perform general dentistry under general anesthesia. Upon approval, we were able to complete the project in four weeks. And we are currently scheduling patients, pediatric patients, and patients with disabilities for dental procedures.

This has been an emotional and heartwarming journey for our staff treating these patients who are experiencing

such healthcare disparities. It's quite eye opening to see the detrimental effects on these patients knowing they had to overcome barriers and accessing timely care. And most of these patients are actually Medicaid patients. Over the past, past five years, more than 30 percent of our patients are Medicaid beneficiaries, and over 15 percent receive charity care. Which is significantly higher than the state average of four percent Medicaid and 0.3 percent charity care. Treating underserved patients is the core of who we are.

We have never sent any patients to collections in the last 25 years. While we understand this is an unusual model for a for-profit surgery center, we believe it's important to give back to our community. We are here today to request the board to approve our pending application to allow physicians to perform orthopedic and spine procedures at our surgery center. Importantly, we are not adding any additional capacity, and there was no opposition to this project. The addition of orthopedic and spine surgery will improve access to patients in the northwest suburbs of Chicago who face various barriers to healthcare, specifically those with financial hardship.

For many low-income patients, Innovia is their only option Of the 22 surgery centers mentioned on the state

report, only two provide a meaningful amount of Medicaid care. However, both of these surgery centers have nonprofit ownership. There are only four surgery centers in the area that provide any charity care, and only one of those having over one percent of charity care patients. Innovia accepts all patients for outpatient surgery. It is our goal admission to build a healthcare system that values and prioritizes the wellbeing of all patients, regardless of their socioeconomic status.

We understand that many patients sorry, patients work essential jobs and cannot take time off during the week to accommodate patients work schedules. We are able to schedule procedures on Saturdays, our extended hours provide more flexibility so patients can minimize their time off of work, making healthcare more accessible to working patients. Before I turn over the presentation to Dr. Goyal, I would like to thank the board for considering our application and request that the board approve the addition of orthopedic and spine procedures at Innovia. Thank you for your time.

MS. COOPER: So we did pre we did prepare a presentation for Dr. Goyal reflecting on his experience at Innovia. And in the interest of time if the board would like to hear it, we, we are happy to present. If not I'd

like to address the negative findings.

Okay. I'm Anna Cooper, one of the attorneys for Innovia. I'm here to address the negative findings in the state board report. First, I'd like to take the time to thank the board staff for the mostly positive report, and to reiterate that Innovia is an existing surgery center, and this project will not add capacity to the area. The first negative finding is for projected utilization for a positive finding on projected utilization. The surgery center must operate at least 1500 hours annually to justify a second or just for reference Innovia does have two operating rooms. Importantly, the projected cases included in the state board report did not take into account Dr. -- projected dentistry volumes. For those of the recently recruited physicians, as noted in his referral letter for the general dentistry application that was approved in October, Dr. Sing anticipates performing 260 procedures at Innovia for a total of 520 surgical hours.

With the recent recruitment of EMT physicians, anticipates 400 EMT procedures with an average case time of two and a half hours, including prep and cleanup for a total of 1,000 surgical hours this year. Finally, Dr. Erickson and Dr. Park anticipate referring 102 orthopedics

and spine cases for a total of 173 surgical hours. Collectively in Innovia anticipates 1,693 surgical hours in 2024, which is sufficient to justify its two operating rooms. The next finding is service accessibility. The service accessibility criteria requires an applicant to document the surgical ties that are necessary to improve access for residents in the geographic service area. For example, existing underutilized surgery centers in the geographic service area have restricted admissions policies. For example, they do not accept Medicare, Medicaid, or offer charity care.

There are nine hospitals in 22 ambulatory surgery centers within Innovia s geographic service area. While it would appear that there are many options for patients Innovia, serves a large low income population who have limited options for healthcare. As noted in the application, utilizing hospitals for surgical procedures that can be safely performed in an ambulatory surgery setting is not an efficient use of resources. Furthermore, Medicare payment rates for most procedures performed in a hospital are nearly twice as high as ambulatory surgery centers, which results in higher cost for both patients and payers. As Vera Schmidt noted in her presentation, Innovia treats a high volume of Medicaid and charity care

patients. Of the 22 ambulatory surgery centers in the area seven treat Medicaid patients with Lurie children's outpatient services in Westchester and Loyola Surgery Center, providing a meaningful amount of Medicaid care, 6 and 3.5 percent respectively.

Among the seven surgery centers that accept Medicaid only DuPage Eye Center and Children's provide charity care. Moreover, DuPage Eye Center is only approved for ophthalmology and children's only treat pediatric patients, which leaves no viable options for low-income patients in the area. This project will not result in an unnecessary duplication of services. As Vera noted in her presentation, this project will not add OR capacity at an Innovia. Further, as previously discussed, hospitals are not an appropriate use of scarce healthcare resources and are not viable options for low-income patients, due to the high out of out-of-pocket costs. Of the 22 surgery centers within the Innovia Surgery Center surface area, only eight are approved to provide both orthopedics and neurological surgery. Of these eight surgery centers, only one, one only serves pediatric patients. Five do not serve Medicaid patients and the remaining two do not provide charity care.

Given the significant low-income population and Innovia

serves, there are no options for these patients in the area. Accordingly, the project will not result in duplication of services. Finally, the purpose of the financial viability review criteria is to determine whether a healthcare facility has the financial resources to adequately provide services to the community. Innovia Surgery Center, previously known as Advantage Healthcare has operated in Wood dale for over 25 years. It has always paid its bills when due and has never filed for bankruptcy. The addition of orthopedics and spine procedures will improve its financial position and ensure it can continue to operate as a going concern into the future. It should also be noted that this is an all-cash project. The only financial cost is the real estate list. There are no other expenses. I thank you for your time and attention and we're happy to answer any questions you have.

CHAIRWOMAN SAVAGE: Okay. Any questions by our board members? Mr. Katz?

MR. KATZ: where's the cash coming from?

MS. COOPER: There is no, it's, it's in terms of the project?

MR. KATZ: Yeah.

MS. COOPER: It's just the lease for the real

estate. Okay. There is no, yeah, there's no equipment being purchased. It's strictly the lease.

MR. KATZ: No equipment at all?

MS. COOPER: No, they have it all.

MR. KATZ: Thank you.

MS. HENDRICKSON: You mentioned that the DE program has started already being operationalized at the site. Do you know roughly how many monthly, just how many patients have been seen?

MS. SCHMIDT: Monthly. For last year we saw 125 patients. But we were also just starting some new specialties. So that volume will be higher, much higher this year. So right now, you know, I'm calculating monthly I would say probably about right now, 50 patients per month.

MS. COOPER: She's asking for dental patients.

MS. SCHMIDT: Oh, for the dental patients? I'm sorry. So we just when we first started we were during the holiday season, so we did a couple, I think it was like October, November, and then we just started again in January. So we've done I think 30 dental patients so far.

CHAIRWOMAN SAVAGE: Rex. Or not Rex, sorry, David.

MR. KATZ: The I appreciate you going straight to

the questions. It was super efficient. I appreciate that. The only question I had with what you said was just this notion that moving patients out of the hospital into the surgery center is lower cost and it gets its effect, something we were talking about earlier today. Yes. Except the hospital is that big fixed, fixed cost burden. So, and I don't know if we've, from a staff standpoint kind of come to the view that this would create an undue burden not nearby hospitals. Is it, do, do we have a staff view on that? Or, or No,

MR. CONSTANTINO: That's my view. Yes.

MR. KATZ: It is your view. Yeah. And, and I guess maybe the question, why is that something we should not be worried about?

MS. COOPER: Well, so Innovia, unlike most surgery centers, they, they serve a high percentage of Medicaid patients. As, as I believe the board staff report says over the last five years, about 30 percent of their patients are Medicaid. So it's not like Innovia is cherry picking the high, you know, the commercial insurance or Medicare. I mean, they've got a, a good mix of everything, but they take a disproportionate number of Medicaid and patients who are uninsured or underinsured and they have a, a very generous financial assistance policy to serve

those patients as well.

MR. CONSTANTINO: Are you going to do any interventional radiology procedures ever?

MS. SCHMIDT: We do plan on doing those later this year.

MR. CONSTANTINO: We approved that two years Ago.

MS. SCHMIDT: Our interventional radiologist has had he actually, his practice has moved and he's had some changes in his office, but he ensures us that within the next few months he'll be seeing some patients at our facility.

MR. CONSTANTINO: That isn't what you told the board two years ago that these going to be doing these procedures and we approved you based upon what you told the board. I, I, this is just constant with these ASTCs.

MS. SCHMIDT: I guess we can't necessarily control where the doctor takes his patient or when he brings his patient to us. He, it was, he gave us the numbers that he would he anticipated on bringing, I know his office moved, he's had some staff changes, and so he was in the position to bring patients to us at that time.

MR. CONSTANTINO: We weren't notified of it.

CHAIRWOMAN SAVAGE: You might have mentioned

this, but in terms of your different specialties with only two ORs, how are you scheduling that's, you know, all the different procedures that you have here?

MS. SCHMIDT: Well, since we're not fully utilized right now, we are able to block time for those procedures, so it's not a problem.

MS. HARDY-WALLER: On that note question, because that was my question. You, you are smaller ASTC just two ORs, and you have eight specialties. You want to add two more. Can you talk to us a little bit more about how you make the time to add more specialties, particularly maybe are underutilized?

MS. SCHMIDT: So for the new specialties with orthopedic and spine, we were approached by orthopedic and spine physicians that saw a facility would love to bring their patients to us. Some of the other, we're not as busy with some of the other specialties, and so we have the room and the capacity to accommodate them. And so that's why we're here asking for, to expand into those specialties to fully, fully utilize our facility.

DR. TANKSLEY: I just find it interesting that, I mean, I can understand physicians would want to bring the their patients there, but what guarantee do you have a year from now that the utilization that you're asking for

is going to happen? I think that's one of the things we continue to see with the ASTCs is this, you know, persistent under utilization of the specialties, but yet we continue to get requests for more specialties.

MS. COOPER: Unfortunately, the referral letter isn't a binding contract. And so to the point that, that Vera made earlier is that we can't really control where physicians choose to refer their patients to. All we can do is offer them block time. I know that Dr. Park and Dr. Erickson are independent practitioners, so they're not affiliated with a hospital or another medical group. So it's hard for them to get block time for their cases. And so they're looking for, you know, any, and unfortunately Dr. Erickson's not here to speak to this, but any opportunity to, you know, get blocked a significant amount of block time so they can treat their patients.

MR. CONSTANTINO: And the board makes the decisions based upon that referral letter and the note, they're notarized, signed by the doctor. Now you're telling us, it's not a contract. That's what the board here, you come under oath and tell us this is what they're going to do. And it doesn't turn out to be the case.

CHAIRWOMAN SAVAGE: Well, the question is, are you looking for doctors to replace that doctor or to add

to his or her case?

MS. SCHMIDT: Yes. We are constantly recruiting physicians.

CHAIRWOMAN SAVAGE: 'Cause I, at this point, I would think that more doctors would want to come given that they're having difficulty finding this block time at all specialties. So do you have a robust marketing plan to the physicians or surgeons as the case would be?

MS. SCHMIDT: We do. We are reaching out, we reach out through vendors, specialists, and work with the doctors at different locations. We have several different marketing methods. We have a person that visits doctor's offices, and letters are sent out, emails are sent out. So we are actively pursuing.

MS. COOPER: I would also like to note that in 2021 or 2022, they had several other physicians who had committed to perform cases at Innovia that had retired. So that was kind of an, and they started a recruitment program to replace those physicians. There was an opportunity, another group had stepped in to try to buy the surgery center and that, so they ceased their recruiting efforts at that point in time. And when that transaction fell through they had to restart that process.

DR. TANKSLEY: I have a, a just a couple

questions. I, I'd like you, if you can kind of help me understand what kind of you know, process improvement or, or, or quality plan, you know, quality assurance type of plan you look at to say, this is a specialty we want to keep or we're going to get rid of. Is that ever part of the plan? And, and I ask also the second part to that would also be just the dentistry numbers that you gave, is that from, you know, the October time that you were approved or is that just the since October, so since October. So since October, which is, let's say it took you a month to get it going five months or so. You've done like six dentistry cases per month on average since October?

MS. SCHMIDT: Well, it was a little bit less during the holidays and now it's a little bit more robust. So it's, I would say more now it's probably like six a month, yes.

DR. TANKSLEY: Okay. And so the first question being like, how, what do you utilize to say this is viable, let's continue doing it, versus this is not, we're going to reevaluate and, and eliminate services as opposed to continuing to end?

MS. SCHMIDT: And I think we'll probably get to that point at some point. Right now our EMT surgeries are

robust. We have a steady stream of the dentistry patients, which are building up, and we feel with the orthopedic and the spine doctors coming on board they're very eager to get in. They're seeing patients and they're just waiting for us to say, okay. So I think at that point we would probably reevaluate with the other specialties and see, you know, we could continue. I, I would say continue recruiting. But if we don't find other, other interested parties, then, you know, maybe we could reconsider at that time.

MR. KATZ: Can I just ask one more question?

CHAIRWOMAN SAVAGE: Sure.

MR. KATZ: I'm sorry. You mentioned back to the 30 percent, not cherry picking, but the profitable procedures OR patients. Would you anticipate that spine and ortho would've the same mix of Medicaid as I guess the others with 30 percent in Medicaid? Or are you trying to supplement a pretty nice payer mix with cherry picking?

MS. SCHMIDT: I wouldn't say cherry picking. You know, our, our numbers from 2020 were different from 2022 and 2021. So we, we openly take Medicaid patients, Medicare patients, charity care. At one point we weren't able to give very much charity care, but last year we did give 3 percent and we look forward to continuing that.

MR. KATZ: Thank you.

MR. GOYAL: Mr. Katz. If I could just make a comment here. I'm someone of the EMT docs working at an OBIA for about a year now, part of my decision, and I have my own independent patient referral pattern, and that's, the insurance is totally independent of what Innovia is bringing in. So it's my referrals to Innovia So mine specifically with my patients, we're close to 20 percent Medicaid. So ultimately it must be up to that surgeon's specific payer mix on what they bring to the surgery center. So of my over a hundred patients now that have operated on, we're closer to that 20 percent. So ultimately it is up to Dr. Erickson or any other X, Y, Z specialty on their practice, what they bring in as you know. So all the higher payers, absolutely consistent with the --

MR. BUDDE: Dr. Erickson's on looking on table four is talking about referring 20 cases to the center. 20 neurosurgical cases spread over years doing one once in a while. Once, how, how's the staff, surgical staff and the recovery staff going to remain competent to deal with, you know, the neurosurgical cases? It can, it can be pretty tricky.

MS. SCHMIDT: Well, we hope that it increases. We

hope other doctors come on board, but to keep them competent our staff right now have come from other surgical centers that do spine and orthopedic surgery. So and some of them are part-time that work at the other facilities, and so they stay competent there. And, and, and our Nurse -- nursing Supervisor is also, her background is in orthopedic and spine.

MR. GOYAL: There, there is a small overlap between EMT and spine and I have assisted neurosurgeons to get the anterior approach for the neck as they approach the spine. At the ASTC I am doing my anterior neck cases as I normally would. So in terms of preoperative postoperative nursing and construction cure for the patient, I'm confident in their staff to care for my patients. There might be an overlap to cover for that as well.

CHAIRWOMAN SAVAGE: Other questions?

(No verbal response)

CHAIRWOMAN SAVAGE: Okay George, if you could call the roll.

MR. ROATE: Thank you, Madam Chair. Motion made by Ms. Legrand, seconded by Mr. Gary Kaatz.

MR. ROATE: Mr. Budde.

MR. BUDDE: You know, if it weren't for, if

you didn't have the Medicaid and the charity care support, I'd be a resounding no quite frankly. But I'm going to vote yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: I'm going to vote no note based upon the Staff report and testimony.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: On the one hand, I appreciate the fact that the surgery center is open for business to Public Aid and to some charity care. 'cause that is pretty rare. I am concerned about the projected volume, however, of spine cases that Dr. Erickson talked about. And I worry that, not so much about him because he'll be doing cases in various places, but about the staff that supports him. So I am, it's a close call for me, but I'm going to vote no.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: I vote no based on the concerns about utilization.

MR. ROATE: Thank you. David Katz.

MR. KATZ: I'm going to vote no. I'm probably as sympathetic as anyone to, for-Profit Healthcare. I'm trying to understand why some on our team are very concerned about the negative impact this would have on the

local acute care hospitals. And my concern is that we're taking an underused and underutilized facility and trying to supplement the under utilization with super profitable procedures and it's going to come out of someone's mind. And that feels counter to what we're trying to do here.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: I'm going to vote no and I echo what Mr. Katz just said. And my big concern is really the staff report and the questions around utilization.

MR. ROATE: Thank you. Ms. LeGrand.

MS. LEGRAND: I'll also vote no based on Mr. Katz.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: Okay. I, I will I, I want to make the, the statement that I, I really think it would be advantageous to the center to look at all of the things that you're offering and really, really you know, determine is it necessary, is it not? You know, really kind of do some planning around what services you truly should offer and should not. I echo my colleagues that I'm concerned we're just adding something without much intention. But I am sensitive to the fact that you may be one of the few ASTC you know, surgical centers that actually opens your doors to a wide range of individuals

that wouldn't generally have access to those centers. And so I'm going to abstain from this vote.

MR. ROATE: Thank you. Ms. Hardy-Waller.

MS. HARDY-WALLER: I think I have the same conflict. So I really do echo Dr. Tanksley's comments. I, I will have to unfortunately vote no. I think where my bigger concern and issues lie is in my question that I asked earlier about the myriad number of specialties that you provide and whether or not many of those specialties are a result of trying to increase the utilization for the facility. And so I would agree, I think there's an opportunity here to begin to think through what really makes sense for the ASTC, where your priorities are and being a lot more intentional.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: I too vote no, based on what my colleagues have said here.

MR. ROATE: Thank you. That's eight votes in the negative one vote in the affirmative and one vote of obtainment.

CHAIRWOMAN SAVAGE: This permit is an intent to deny, so the board staff will be in touch.

MS. COOPER: Thank you.

MS. FRIEDMAN: We are rushing up here because the

applicant does have a plane to catch at midway at 6:30 so that he can make sure to see his cases tomorrow.

CHAIRWOMAN SAVAGE: Okay. So the next case is H-09 O'Fallon Surgery Center, O'Fallon, Illinois. Ms. Legrand is going to recuse herself. May I have a motion to approve project 23 -047 for the expansion of a surgery -- surgical specialty to the existing surgery center?

DR. TANKSLEY: So moved.

MR. HENDRICKSON: Second.

CHAIRWOMAN SAVAGE: Thank you. If you could introduce yourself, spell your name and he'll swear you in.

MR. AHMED: Shakeel Ahmed, S-H-A-K-E-E-L. Last name is Ahmed, A-H-M-E-D.

MS. FRIEDMAN: And Kara Friedman.

THE REPORTER: Please raise your right hand.

(Whereupon:

SHAKEEL AHMED

KARA FRIEDMAN

After being duly sworn, were examined and testified as follows:)

CHAIRWOMAN SAVAGE: Mike or George, could you share the state board staff report?

MR. CONSTANTINO: Thank you, Madam Chair. The

Applicants proposed to add neurology surgical services to an existing ambulatory surgical treatment center located in O'Fallon, Illinois. Total project cost is $10,000. Inspected completion date is December 31st, 2024. The applicants did not meet utilization, treatment room need assessment, service accessibility, and unnecessary duplication of service. There is no public hearing requested. Thank you Madam chair.

CHAIRWOMAN SAVAGE: Thank you, Mike. If you would like to proceed.

MS. FRIEDMAN: If I could just mention the issue about referral letters and on broad basis for the group. We are approached by, or we approach in various settings physicians to do cases at hospitals and surgery centers. And they have to sign a certification that they intend to refer cases to the surgery center, we submit that as part of our application. As I'm sure some of you know, we cannot pay those physicians for such a commitment and therefore it's not a contract. It is a good faith suggestion that they want to do cases at the surgery center. So I think you're seeing that in certain situations a physician may come and then they may kind of go in another direction. And so this is part of the reason that physicians are continued to be recruited by surgery

center when they have block time that can be utilized. And I'll go ahead and let Dr. Ahmed Present.

MR. AHMED: Good afternoon. My name is Dr. Shakeel Ahmed. I'm a board certified gastroenterologist and the owner of O'Fallon surgical center in a Illinois. I also operate at Midwest Surgery Center. And I thank you for your time and thank you for your assistance. I will keep it brief that the project has received no opposition and many letters of support. I've been providing healthcare services, including surgical services in the Illinois Metro East area for the last 22 years. I'm here today to request permission for O'Fallon Surgical Center to credential a spine specialist so we can provide pain management injections and minimally invasive spine surgeries. As you know, we are already approved to provide pain management procedures. Because of the board certification in neurosciences, we need to approve to credential him. We have not been able to schedule pain management at our surgery center. Since our last pain management physician, Dr. Mark Belzer, moved his practice away from O'Fallon to about 50 miles from our center to the western suburbs of St. Louis.

We have retained the extremity equipment and the staff qualified to support physician performing interventional

pain procedures so that can provide image guided procedures at the center, which will allow us to take advantage of the equipment we have and care at the center. ASCs like ours provide the same high surgical care as hospitals, are more accessible and more importantly for this board a fraction of the cost. This combination of quality, convenience, and affordability has led to significant growth in values mentioned by in Medicare's approval of many more certain types in the setting in the past few years.

For example, in 2021, CMS approved reimbursement for certain total replacement procedures, which is already to save Medicare 75 million. Also, I know this board has focused in recent months the movement of cardiac cath cases to the ASC side. This is another change that has been removed by Medicare policy. Most recently, Medicaid added 11 codes to the ASTC list of 26 more in a previous batch of codes over the summer. There's more and more cases that are expected to shift from hospital to ASCs. The US ASTC market is protected to grow 59 percent from 2021 to 2028 this likely explains why you have so many centered matters before you today.

Increasingly health system is routinely up to do elective cases in hospital or underlying more on the care

setting. For example, Northwestern Memorial Hospital, the largest adult hospital in the state, just acquired its first ASTC in January, recognizing the importance of this costly alternative to surgical care. Until then, they only provided the service on site at the hospital at a higher cost.

As you know, the surgeon that plans to perform the certain procedures at our center care consist of Illinois patients in the St. Louis locations. For all those complicated cases, he will keep them in St. Louis and minimally invasive pain management procedures that have to be repeated over time due the limited duration of time. these cases will be provided locally and the lowest cost setting feasible relative to travel for care, surgical care that would be considered primary or secondary not includes cataract, colonoscopies, pain management, D-N-C E-N-T, podiatry, and now joint and minimally invasive spine. We're working on building these services at our center as a county with 250,000 residents the county should have these types of surgical cases available within the county. Patients have to travel further for more complex tertiary care like cancer and complex neurosciences. But for the simpler cases, it shouldn't have to go to St. Louis.

They should be able to stay in Illinois and get their care locally. In closing after the doctor will provide this minimally invasive care. Locally, all of the projected deferrals that were included Dr. -- physician letter resident who travel to for this care, back pain injections and discs allow people to stay active in spite of conditions like arthritis and stenosis. We're proud of what we do for our community and take care of our patients. We have remained financially viable despite some physician departures. I'm asking and requesting the rule to approve a request so we can expand out patient care we provide to safety county residents. One final word. When I first came to this board 10 years back to request my first CON I promised the board that we will provide care to Medicaid and indigent population, our patient population of 30 percent Medicaid 10 years back, 10 years later, our patient population is still 30 percent Medicaid, if not more. And that's something we are proud of and that's a promise we can that's my personal patience. Happy to answer questions.

CHAIRWOMAN SAVAGE: Okay, so one question would be, you have these other specialties. So you have ophthalmology, pain, podiatry, and now you want to add neuro plus you have GI. So with two rooms, how are you

dealing with all of scheduling of all five of those including new cases of GI?

MR. AHMED: Yes, ma'am. So we don't do GI cases at the same time as sterile procedures or surgeries. We usually follow sterile procedures. So GI would come later in the afternoons. Podiatry, spine and pain management can be done concurrently with the Dr. Morris.

CHAIRWOMAN SAVAGE: Unpleasant for the patient though. Okay. Other questions by board members?

DR. TANKSLEY: Just a question of clarification. I, I heard you note that for the past 10 years you've been presiding, excuse me, providing 30 percent Medicaid care to Medicaid patients and that you currently still aren't doing that yet. In the table eight it notes that currently, and then maybe you can help me because maybe the data is different. It's just 2 percent.

MR. AHMED: So those, those are my personal patients in GI, the current patients at that center are mostly ophthalmology. Ophthalmology is, is almost never Medicaid. They're all Medicare patients because 99 percent of them get cataracts released. So in, in some form we are providing services to the right patients at that center. Currently, they just aren't Medicaid as a rule. And most of my GI cases are done at Palos Heights location.

DR. TANKSLEY: Okay. And of the specialties, GI and pain management has very low utilization, if any, is that correct?

MR. AHMED: Yes, ma'am. At the center currently Yes.

So that Medicaid population is Based on your ophthalmology patients?

MR. AHMED: Based on GI.

DR. TANKSLEY: Based on GI

MR. AHMED: but at a different location.

DR. TANKSLEY: But not this location.

MR. AHMED: no, ma'am. Got it. Thank you.

MR. FOX: How many neurology patients do you forecast in the future being able to take care of in the surgery center, what types of procedures?

MR. AHMED: Yes, sir. So this is St Clara county. we don't have any viable neurosurgery groups there. The last ones left a few years back 'cause of the malpractice situation at the, they all need to care. They all want to be done at a facility -- there's a mindset about going cross the bridge to St. Louis. So whatever we can handle, but at least a few hundred patients guaranteed every year once we get these specialties up and running.

MR. FOX: So do you have neurosurgeons who are

wanting to get on staff at the surgery center?

MR. AHMED: Yes sir, we do.

MR. FOX: And have they provided any projections on how many patients they would bring?

MR. AHMED: I don't have what the numbers would be at least, at least a few hundred for pain management injections. Dr. Mark left those patients scattered. So at the least we can invite those patients back to our facility right off the bat.

MR. FOX: Okay. So you're talking about mostly pain management patients. You're not talking about neurosurgical patients. I'm just trying to understand.

MR. AHMED: Yes, sir. So the neurosurgeon performs like pain procedures those injections. Okay.

MR. FOX: So not an anesthesiologist, but a but a neurosurgeon is performing them.

MR. AHMED: Yes, sir. Okay. Pain implant neuromodulator replacements for, for spine issues.

CHAIRWOMAN SAVAGE: Rex?

MR. BUDDE: Yeah. What is the motivation of the hospital moving cases out of the hospital into the center? How busy is the hospital right now?

MR. AHMED: These patients are going to St. Louis, sir.

MR. BUDDE: Pardon?

MR. AHMED: These patients are all going to St. Louis. So these surgeons are, are going to bring the patients back to Illinois and to our facility. We won't be taking anything from the local hospitals. Plus they are extremely busy. The wait list is in the months, if not longer, for, for getting care. So that's a very viable alternative we provide.

MR. KATZ: I apologize. I'm just, I guess I'm just not following this it, if they're not taking it from the hospital, from the St. Mary hospital?

MR. AHMED: No, sir. No sir. These patients are currently are going to surgery centers and hospitals in St. Louis

MR. BUDDE: From Champaign

MR. AHMED: oh no, from O'Fallon, Shiloh, the whole =southern.

MR. BUDDE: So they're all down by the St. Louis area, right?

MR. AHMED: Yes, sir. Yes sir.

MR. BUDDE: And this surgical center is where?

MR. AHMED: Right there in O'Fallon, Illinois. St. Louis. So East St. Louis is right across the river from St. Louis City. Most of our care for these patients

was provided in our area until a few years back when we lost our pain management doctor. And then all the patients scattered and currently including patients with DR all going across the west into St. Louis for their care.

MR. KATZ: I guess a question for ourself or for maybe for John or George Mike if there weren't a state line in between, we'd be saying, boy, are we, or is the plan to take those couple hundred patients from the hospital right next door, but there's a state line in between. Do we, does that impact our thinking? Should that impact our thinking?

MR. CONSTANTINO: No, not the ones in Missouri. No.

MR. KATZ: Meaning those hospitals they were going to in Missouri were just on this side of the border MR. CONSTANTINO: No, in Illinois,

MR. KATZ: That's a different Medicaid agency. Same. Medicare was thinking out loud. So there's nowhere to get those procedures done In Illinois in your area,

MR. AHMED: the, the physicians left. So every year there's, there's an immigration of at least a few high risk specialties from St. Clara County to St. Louis. And that the patients follow them.

MR. KATZ: And the reason, the reason I'm asking

the question is the reason that the area is such that there's such a high prevalence of Medicaid procedures, that it's just hard for some docs to make a living.

MR. AHMED: It's the malpractice crisis, but it's malpractice county, county is, is infamous for.

CHAIRWOMAN SAVAGE: Other questions?

MR. BUDDE: Clarification on malpractice. Physicians have left the area because of malpractice but you're saying these physicians will bring patients back to the area.

MR. AHMED: Yes. Sir.

MR. BUDDE: How confident are you these physicians will actually bring patients back.

MR. AHMED: Yes, they're desperate. They, they talk to us about this all the time. They, they need a place to operate and, and, and we provide that. We, we started ophthalmology about four or three years back. We are already doing about 2,500 cases year in our facility.

CHAIRWOMAN SAVAGE: Do the surgeons in St. Louis find they're having trouble with block time there too?

MR. AHMED: Yes, ma'am. Very much so.

DR. TANKSLEY: I just wanted, I I'm also not following a few places. I'm sorry. So the, the request is for your O'Fallon center, correct?

MR. AHMED: Yes, ma'am. And the, the, the current specialties at your O'Fallon center are pain, GI, and ophthalmology.

MR. AHMED: And Podiatry.

DR. TANKSLEY: And podiatry. I'm sorry. I don't see that listed in that table.

MS. FRIEDMAN: That was just approved I believe in October.

DR. TANKSLEY: Oh, and I missed that meeting. Okay. Thank you. That being said, would you speak to, because I, I guess what I'm not following is like the need for additional services at this center when you're not actively utilizing like your GI procedures or your pain management procedures at this facility currently. So can you help me understand like why bringing neuro neurosurgical procedures there? And, and I'm very familiar with the area, so I agree with you in the sense of a lot of so I went to school at Southern Illinois School of Medicine. So the Belleville East St. Louis area is very desolate. It's also very, very impoverished and very high state age utilizers. Very much so. And so I'm concerned that if you are one center that's not in O'Fallon is the one that mostly sees the Medicaid patients. What will be the impetus of these, the new physicians to take on the

Medicaid patients at the O'Fallon Center?

MR. AHMED: That's right. So Medicaid patients at the Fairview Heights location are, and we basically provide almost all our care at one center this way. We don't mix the specialties as the chairman said, but we, instead of a nonsurgical non-sterile cases, the pain management doctors have a very high percentage of Medicaid patients. We depend on the doctor that brings the cases to us and whatever they bring is welcomed with us. We just don't close the doors ourselves to Medicaid. As I mentioned with ophthalmology, there's virtually no Medicaid, Medicaid with cataract patients. So the doors open to whoever comes and should bring a healthy dose of Medicaid patients.

DR. TANKSLEY: But they haven't. Have you, have you seen that so far? 'cause It looks like they haven't according to your table seven

MR. AHMED: Because we just do ophthalmology there.

DR. TANKSLEY: Okay.

MR. AHMED: So ophthalmology doesn't have Medicaid.

DR. TANKSLEY: So you do not, okay, so let me, let me clarify again. So the services that you provide at the

O'Fallon locations

MR. AHMED: Yes, ma'am.

DR. TANKSLEY: Are ophthalmology only?

MR. AHMED: Oh, predominantly, yes. And we just started podiatry and we're, we do pain management, but we haven't been able to do that for a while because we lost our doctor.

DR. TANKSLEY: Okay. And GI as well?

MR. AHMED: We haven't done that recently. We lost our doctor.

CHAIRWOMAN SAVAGE: But previously you did the GI in the afternoon, it seems?

MR. AHMED: Yes ma'am. Yes, ma'am. When the other doctor was there?

MR. AHMED: Yes, ma'am. But not recently. We, we are enrolled in all the Medicaid management managed care organization plans.

CHAIRWOMAN SAVAGE: Other questions? Okay, George, if you could call the roll.

MR. ROATE: Thank you, Madam Chair. Motion made by Dr. Tanksley, please. Seconded by Ms. Hendrickson.

MR. ROATE: Mr. Budde.

MR. BUDDE: I'm going to abstain on my vote. I think I may have a conflict in, in the region with

my son is going to be a neurosurgeon in, in that market. So I'm just going to stay out of this vote.

MR. ROATE: Okay. Thank you. Mr. Burnett.

MR. BURNETT: I'm trying to, based upon today's testimony, there are some reservations I have about utilization and some assumptions that you have shared, and I'm unsure. I'm unsure. I understand. You anticipate those referrals from St. Louis. I'm going to say yes with strong reservations.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: I can say in 2019 you did have pain patients in the facility and then obviously you lost your physician. I'm apprehensive about counting on referral promises from neurosurgeons who say they'll, they'll bring their patients to your facility. But given that you're, you're talking about doing low intensity services, not anterior access neurosurgical spine cases, I, I don't feel uncomfortable in terms of the staff's ability to take care of those patients. So maybe it is a wing of prayer. I'm going to say yes. I hope you're successful.

MR. ROATE: Thank you, Ms. Hendrickson.

MS. HENDRICKSON: Based on the staff report and the feedback provided today, I too want to say yes, I do though believe that it is part of this discussion just

keeps going back to, are we throwing a lot of service points into a ambulatory service and then hope one of them sticks that, but at the same time, the risk is minimal. It is a really hard one for me to kind of wrap around, but I don't think that's necessarily based on what you've provided, but my own recognition of potentially some barriers that as a group we have to kind of work through. So what I'm saying, yes.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Yeah, I'm, I'm a yes as well. I, I think I'm fine with this. I do think there's some taking of patients from the hospital. I, although now that Mike's out of the room, I, I it does strike me as different if we're taking patients out of other states, hospitals for the Illinois State Board, not the Missouri State Board. And I think there's an element of taking some money out of the plaintiff's bar, which I'm also less sensitive to. So I, I, I, vote yes.

MR. ROATE: Thank You. Thank you, Gary Kaatz.

MR. KAATZ: Well, this is a tough one. I'm very bothered by the promise for St. Louis patients coming back. And I'm very concerned about the criterion that was not met by our in-house staff. So I'm going to have to

vote no.

MR. ROATE: Thank you. Ms. Legrand. No, she's recused herself Dr. Tanksley.

DR. TANKSLEY: I'm going to vote no as well. I based off the staff report I am and the testimony today, I'm really not clear on what the strategy is to even bring neurosurgeons in. You know, I, I, I understand that there is a provider who's promised to bring some services. I'm, I'm very confused by looking at the numbers for one center, but we're talking about a different center. I and so I have too many reservations to vote in favor.

MR. ROATE: Thank you, Ms. Hardy-Waller.

MS. HARDY-WALLEN: I, I, I'm reluctantly I have to say no, and, and it, I think it's primarily because of my lack of understanding around the service line, the specialty that you're looking at. I, I understand that you've lost a lot of physicians as a result of the malpractice. They're going across state lines. I, I get all of that. I, I think what concerns me most is this is ASTC that started with four specialties. We're down to really one specialty, and one we're trying to revive in the pain management with the neurological neurology specialty. And again, the unguaranteed really commitment from a physician that you're going to accredit

to, to provide the referrals. So I think that once you can get a handle on and some true understanding of what those referrals look like and some strength in the specialties of the ASC Would be helpful.

MR. ROATE: Thank you. Chairwoman Savage?

CHAIRWOMAN SAVAGE: I'm going to have to vote no as well. I think the state board staff report was pretty clear in the presentation A little fuzzy for most of us. You know, just in the fact that one, ophthalmology. Now, I understand that you have no guarantees with visit surgeons, you know, staying or coming to your facility in general, but, you know, you have five specialties. So adding another one, it would seem you need a, maybe a better marketing plan. I'm not sure. Maybe I'm, maybe, I don't know the O'Fallon area very well, which I can attest to that. But hopefully you can find some more surgeons to come your way to fill up your surgery center.

MR. ROATE: Thank you, Madam Chair. That's four votes in the affirmative. Four votes in the negative two votes or recusal one based on conflict.

CHAIRWOMAN SAVAGE: Okay. So that permit is an intent to deny and the board staff will be in touch.

MS. FRIEDMAN: Okay. And I believe That the ASTC Rules are kind of coming up for review. So it would be

great if we're going to have some public comment at these meetings. 'cause I personally, as a consultant have some viewpoints about looking at this. So hopefully I can participate in that.

CHAIRWOMAN SAVAGE: Thank you. All right, so next up is going to be H-10 Olympian Surgical Suites in Champaign, Illinois. May I have a motion to approve project 23-050 for the expansion of a surgery surgical specialty to the existing surgery center.

MR. BURNETT: Motion

CHAIRWOMAN SAVAGE: Second. Anybody?

DR. TANKSLEY: Second

CHAIRWOMAN SAVAGE: All right, thank you. All right, new folks, if you, I think all of you maybe are new. So if you could state your name for the court reporter and spell your name and then he'll swear you in.

MR. OGAN: Dr. Brian Ogan, B-R-I-A-N. Last name O-G-A-N.

MS. ROOT: Julie Root, J-U-L-I-E R-O-O-T

MR. BARNHART: JT Barnhart, B-A-R-N-H-A-R-T.

MR. WEBER: Ralph Weber, R-A-L-P-H W-E-B-E-R

THE REPORTER: Mr. Ogan, Ms. Root. Mr. Barnhart and Mr. Weber, please raise your right hand.

(Whereupon:

BRIAN OGAN

JULIE ROOT

JT BARNHART

RALPH WEBER

After being duly sworn, were examined and testified as follows:)

CHAIRWOMAN SAVAGE: Thank you. Mike or George, if you could just share the state board staff report.

MR. CONSTANTINO: Thank you, Madam Chair. The applicants proposed the addition of pain management services at Olympia Surgical Suites in Champaign, Illinois. There's no cost to this project and expected completion date is June 1st, 2024. The applicant's failed to meet service area residence, service accessibility, and unnecessary duplication of service. There's no public hearing requested. Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you. You can proceed.

MR. BARNHART: Good afternoon. Thank you for your time. Again, I'M JT Barnhart. I'm the president with OSF Healthcare at Heart of Mary Medical Center in Champaign Urbana. I have been in the role for one year now. Heart of Mary Medical Center as a full acute care service hospital serving the Champaign community. When I started a year ago, about a year ago today part of my role as the new

president of, of the hospital was to identify services that are have a strong patient demand and not enough access and capacity within our community. And, and as we've evaluated those, there were three service lines that came up as, as kind of meeting those, those needs of, of the patients of, of our area. And so we looked at the opportunities that we could be impactful, where we could recruit new specialists to the market and be able to offer better access, faster access, good quality care to patients who are struggling to find it.

And so those three service lines that we evaluated were general surgery, gastroenterology, and interventional pain medicine. We have kind of a two-pronged process that, that I'll discuss with you briefly today. So the first is recruiting of those specialists we hired last year, a new general surgeon who's now an employed provider with OSF, Dr. Greg Ward. You have a letter from him supporting the project. We have also hired a gastroenterologist, Dr. Elaine Serla(ph). You also have a letter from her supporting this project. And then we have the, the third piece of that interventional pain, pain management. We have a provider that's here with us today in support of the project. Dr. Brian Ogan. He's an interventional pain physician who is interested in establishing a practice in

Champaign Urbana and relocating. He has spent the last 10 years providing service in the Effingham area.

So in, in conjunction with recruiting providers to, to help expand access for the patients in the, in the areas that we serve. We needed LSF as a health system in ambulatory surgical approach to, to what we're doing in the community to be able to expand access. And so last summer, OSF acquired the majority stake in Olympian surgical suites. We, as a 75 percent owner, have set up under a new joint venture, a new board I am the president of, of that board. And, and so very much focused on how can we use that center to revamp it, revitalize it. It had historically had been bariatric surgical ASTC.

And so with, with our plan being to take patients from the GI to general surgery and hopefully pain as we present to you today, to be able to offer those services at, at the ASTC to our already in the license, GI and general surgery. So our addition would be pain, the strategy of, of adding specialists. And as I mentioned, revamping the existing surgery center will ensure stronger access to quality efficient outpatient surgery in the most appropriate setting. Our request today of adding interventional pain medicine to the existing services offered at Olympian will improve current patient wait

times. In, in some cases patients are waiting three or four months in Champaign Urbana to see an interventional pain specialist. And also deliver care in a lower cost and easier to access location. Thank you for your review as we ask for your approval of this project. I will now turn it over to Ralph Weber, who will discuss the negative findings. Thank you.

MR. WEBER: Thank you JT. And I'll, I'll be brief. The first of the three negative findings is service to residents to the GSA. And the issue here is that fewer than 50 percent of the patients are from a 17-mile radius around the project location. There are two significant and practical reasons why that's the case. First, the bariatric patient volume historically has come from mostly outside the area. Only 13 percent are from the 17-mile area. The patients come from over 100 different zip codes. This is as diffused a service as I have ever seen and does not fit with the 17-mile radius, Dr. Ogan's current patients live mostly in the Effingham area and south, quite a bit south of the Champaign or Bay area. Some patients will no doubt follow him, but we conservatively stated that it would be about 15 percent of his patients and it probably will be more, but we're being conservative. Answered in our pre-application conference,

for technical assistance with the state staff, we discussed the GSA and the lack of fit with an area defined by the 17-mile radius.

And staff suggested that we try using the county and we use Champaign and Vermilion County. We added Vermilion in order to capture physician referrals for pain management from OSF sacred Heart Medical Center in Danville. 71 percent of the surgery center will be from these two counties. So that's more than the 50 percent threshold. We, we define the planning area as these two counties consistent with the state's instructions in the purpose of the project section where they say per the applicant's own definition, the applicant can define their planning area. So there's a planning area, there's a, the GSA, we don't meet the GSA requirement, but those are the two reasons that are, we think, pretty practical for this. Number two is service accessibility.

The project is a joint venture with an area hospital, heart of Mary Medical Center which is one of the criteria for serve accessibility. It was decades ago, three maybe, that the purpose of acknowledging joint ventures with hospitals was added to flavor or to favor relationships with providers supportive of one another, collaborative efforts in a service area to avoid outsiders coming in to

cherry pick. So collaboration is accomplished here within the OSF system of the two institutions, and it is why OSF acquired the surgery center last year.

Another intent of this joint venture criterion was to offload some of the volume when a hospital surgery department is full. That is not the case here, at heart of Mary Medical Center. But as you weigh this issue, please know that any impact on utilization of the hospital's ORs is self-contained within the OSF system and is not a negative effect on other hospitals or surgery centers. It is also the case that if more of Dr. Ogan's patients follow him more than 50 percent, those cases will consume more capacity and cases from Heart of Mary Medical Center, maybe less. The focus of this project is the surgery center, not the hospital. It is that John is commissioned by the OSF board to balance both. More important, the project does not add to the supply of ORs in the region. The number of ORs remains the same while utilization is improved at the surgery center.

The third negative finding is unnecessary duplication. This is the negative finding that almost all projects proposing to add a clinical service receive. We are the eighth of eight surgery center projects you've heard today with a negative on this one criteria. Like this project,

most of those have purposes other than addressing capacity, like extending service. The impact on the other two providers in the GSA is small. It's 141 patients a year. That's less than three a week. There was no opposition to the project. No public hearing or letters of opposition. We can open for questions.

CHAIRWOMAN SAVAGE: Okay. anyone have questions?

MR. BUDDE: Now I can ask him a question. what's the utilization at the hospital currently in, into the ORs and transferring? What's the impact of transferring this business out of the hospital into the ASTC On the utilization?

MR. BARNHART: Yeah. It's the most, it's the most appropriate care setting for these lower level ambulatory surgical procedures around GI in general. Obviously, the hospital will do we do open heart, we do spine, we do vascular, we do complex orthopedic revisions. Surgeon general surgery cases will not move to the surgery center. And there are certain acuities around GI certain cases for GI that will not be appropriate for the surgery center. So really it's a system wide approach between our, our hospital and the ASTC Olympian to make sure that we're scheduling patients in the right setting, the right care setting, a lower cost setting and not bringing them to the

hospital when they meet the a better need at Olympian.

MR. BUDDE: But you didn't answer my question. What is the utilization percentage of the rooms in the hospital?

MR. BARNHART: We're running around 45 percent. And some of that is due to the size of the OR, but now compared to an older facility that I think we run a lot more efficiently these days. We don't, we don't utilize all of the rooms because we can turn rooms faster and we can block a little bit differently. So it's, it's lower based on the license.

MR. CONSTANTINO: Okay. How many rooms do you have operating?

MR. BARNHART: We, we operate five. Usually

MR. CONSTANTINO: You have 15 on your, on your survey data for 2022. Are you're going to, are you going to take those 10 out of service and, and eliminate those 10 surgery centers?

MR. BARNHART: I think there's one thing we, we've learned over COVID is that healthcare is constantly evolving. Our, our strategy is to continue to recruit and build up more robust acute care surgical procedures within the hospital. So it is, it's not part of our plan to reduce the OR count at the hospital. No.

CHAIRWOMAN SAVAGE: Do you have robotics in your surgery suites?

MR. BARNHART: In, in the ambulatory center?

CHAIRWOMAN SAVAGE: No. In the hospital?

MR. BARNHART: No, we do not.

CHAIRWOMAN SAVAGE: Other questions? David?

MR. KATZ: The surgeons who will be working in the surgery center, the two new general surgeons, for example, are they employed by the health system?

MR. BARNHART: One's GI and one's general surgery? Yes. Yes, sir. They're employed by OSF? Yes.

MR. BUDDE: Okay. And I'm asking that question in part because any commitments that they've made for doing cases there are going to be enhanced by the fact that they're employed in OSF?

MR. BARNHART: Yes, sir. That's correct. And Dr. Weber can speak to his commitment as well to you pain there?

MR. WEBER: Yes. I, I, I can't speak to why the ORs in the hospital are running at the efficiency in the OR I have been working in Effingham for the last 15 years. I built a practice there. I sold the assets to St. Mary's Health system. I'm fulfilling a contract with them. It expires later this year, at which point I want to relocate

to Champaign for family reasons. I fortuitously met JT shortly after he acquired the surgery center. And when I look at this project, it's an opportunity for me to come back into an area that I worked in for a couple years before moving further south in Illinois. That's vastly underserved. JT ran a study in the area that shows there's approximately six additional interventional pain management physicians needed for the area.

I need the surgery center ORs in order to provide somewhere for my patients to go for me to take them to the hospital. It's an unnecessary burden or cost on these procedures. The most patients have difficulty meeting the needs just in an ASTC or an office setting that own a hospital setting. So for my purposes, those ORs at the ASTC or are vital I don't have objective criteria to demonstrate what the number is for the underserved patients. But two weeks ago in the Champaign Gazette was an article indicating that Aunt Martha's is coming to the area, which is a federally federal healthcare program. I know Mr. Burnett has some experience with federal health programs, and I'm sure before they commit to coming to an area, they do the necessary studies to demonstrate the need in the area for them. So there's definitely an unmet need in the area.

The number of cases I do is public record. I've been doing cases in ASTC since 2012. I average between 2000, 2,600 cases a year. For the purposes of this meeting. Ralph was trying to be very conservative 'cause he didn't want to over promise to this committee what we could do. But I see no reason why I can't do those same numbers where I'm going. And I would say it's very, very conservative to say that only 15 percent of people will go where I am. Simply because in central and southern Illinois, getting on the highway and driving an hour is nothing. If I told somebody around the suburbs of Chicago, they had to sit in their car for an hour and 40 minutes to go somewhere, they'd look at me like I was speaking Portuguese. But for Southern Illinois, that's nothing. And if you have faith or confidence in someone who's taking care of you, you're going to get in your car and you're going to go just as I would. If I had my trust in someone and I felt comfortable with them, I would go where they go. Where this ASTC is located is very accessible, is immediately off interstate 57, less than a mile from the exit. There's easy parking, easy in, easy out. You know, if you've ever taken a family member to a hospital, you know what a hassle is to park. I did my training at Northwestern. If you've parked in that parking facility

there and gotten out of that garage, a hundred door dens in your car, you're, you're not telling the truth.

So, I mean, this is very, very easy in and out, easy to take your family member somewhere. I mean, I sat here all day for the most part. Mr. Katz said something earlier today that caught my attention and I tried to apply it to our application. He asked, he asked earlier, team, who loses in this deal? And, and I thought about it all day as I sat out here drinking this water, I was hoping for coffee, but Ralph, told me not to touch the coffee. Nobody loses in this deal. Nobody does, because essentially the surgery center has been dying on the vine for the last five years. The hospital's dying on the vine.

I have the opportunity to come in here, bring a service line that's underrepresented, provide access to the community, immediately inject commerce into the surgery center and create revenue for, for the system. So I, I don't see who the system would unfairly deal, quite honestly.

MR. KAATZ: This is just off the top of my head. I get the idea of more convenient setting for surgeries and stuff instead of parking going in the hospital. But what's your reaction, or what would your reaction be to, you have a significant number of ORs that are underutilized of

taking some of those? I would, I don't know if I would go with all the underutilized ORs and getting some of those off the, off the rolls in exchange for, you know, getting this project approved.

MR. BARNHART: We, we feel this is the right step in our community for our health system and for, and, and to, to be impactful. And so we want to be able to utilize the new ASTC Olympian. We want to be able to utilize those ORs. If we had to look at a refresh, I, I would evaluate that on the hospital side from an OR standpoint.

MR. CONSTANTINO: I was told you had a plan. What is the plan?

MR. BARNHART: Well, our plan, as I alluded to earlier, is, is to, to focus on some higher acuity specialties. We have a contract pending with a third open heart surgeon. We're, we're seeing some massive market share growth around our cardiac program with EP being a STEMI receiving facility, open heart surgery. In the same regard, we are working with INI, Illinois Neuro Institute out of Peoria, who's partnered with OSF to establish spine program with neuro and orthopedic spine. And so several areas that we are focused on to try to expand some of those more acute surgical procedures that would better utilize hospital operating rooms.

MR. CONSTANTINO: You added a surgery room from 2021 to 2022. Why did you do that? That's in survey data you reported to us. Why would you do that when you have only using five?

MR. BARNHART: I can't, I can't speak to that. I'm sorry. I started in March in '23.

CHAIRWOMAN SAVAGE: Other questions of our members. Mr. Kaatz over here.

MR. KAATZ: I'm trying to make sure I get the picture correct. Mr. Bar Barnhart.

MR. BARNHART: That's correct.

MR. KATZ: So did OSF acquire the hospital within the last year or

MR. BARNHART: 2018.

MR. KAATZ: 2018.

MR. BARNHART: Yes, sir.

MR. KAATZ: And the surgery center really didn't have much to do with the hospital. It was an independent bariatric center?

MR. BARNHART: Single provider, independent bariatric center. That's correct. Yes.

Mr. KAATZ: Decent facility.

MR. BARNHART: It's a great facility, Very nice.

MR. KAATZ: So OSF acquires the hospital. How big

is the hospital please?

MR. BARNHART: 220 beds.

MR. KAATZ: So OSF acquires it and they're going to make a bet on your leadership to figure out how to refresh or re-engineer the hospital and how to get a footprint going in the outpatient setting.

MR. BARNHART: That is my challenge. I, I've been doing hospital administration for almost 20 years, so that, that is what I'm tasked with yes, sir.

MR. KAATZ: Got it. So you're going to figure out a plan on the ambulatory surgery center. And as a function of that, you're also going to take a look at what your options are with regard to acute, most of the inpatient based surgeries.

MR. BARNHART: Yes, sir. That's the plan to, to, to run them sort of together continuous from an outpatient inpatient standpoint.

MR. KAATZ: Who owns the other 25 percent of the surgery Center?

MR. BARNHART: Right now, The original owner, Dr. Sid Rach(ph) is the other 25 percent. He's the other bariatric surgeon.

MR. KAATZ: He's still going to be doing bariatric Surgery?

MR. BARNHART: He will do bariatric cases there.

DR. TANKSLEY: I just wanted to ask Dr. Ogan a couple questions. What is your specialty?

MR. OGAN: Ogan, ma'am? Ogan, OGAN.

DR. TANKSLEY: Oh, I'm sorry.

MR. OGAN: Oh, that's all right. That's all right. I am my background is, pain management. My background is anesthesiology and am a board certified Interventional Pain Management. I completed my residency at Northwestern, and then I did a fellowship there as well.

DR. TANKSLEY: Thank you. I, I just want to Clarify. So you're, the addition would be pain management with you on board. And, and if I'm understanding this correctly, the other physicians that would be a part of this center are already employed by your center, is that correct?

MR. OGAN: Yes mam, That's correct.

DR. TANKSLEY: Okay. And the reason I'm asking is because as you have sat through all day with your water, you recognize that a number of individuals that came forward mentioned that physicians come and go, they make promises and then they don't follow through. And I just really wanted to hear more about the assurances.

MR. OGAN: Sure.

DR. TANKSLEY: That you have, that there's actually going to be a follow through and completion of the this.

MR. OGAN: So, so let me say this, this will be my last job. Okay. I came out of school. I spent about two and a half years at Carl, which is JT's competitor. And then I started practice in Effingham. And, you know, at that time, I was single, I didn't have kids, I have a wife, I have two kids. And driving every day from Champaign to Effingham isn't working. So changes need to be structured, and one of those is coming closer to home. One of the issues is with when our youngest was born during Covid, she came premature. She spent two, two months in neuro ICU nicu. And it kind of changes your priorities a little bit in how you're doing things. I don't want to leave the patient base that I have. I believe in what I'm doing. I like my patients. I don't want to go, I'm from Deerfield. I can very easily pick up and take a job somewhere else. I haven't done that in the last 20 years. And like I said, I'm very comfortable. I think JT has come in. He's inherited really a mess, and he's done a good job sorting through it. I think I could work with JT and, and with Julie very successfully for the rest of my career.

MR. BARNHART: I'll just add the, the other providers are employed by the OSF system, so there isn't a, a hope and a wish that maybe they'll, they, they already worked for us. So yeah, that's first. If I could just go back, Mr. Constantino, I did, threw me off when you asked why we added an or I, I, I, now I, I know what it was. We, we added a hybrid OR in our cath lab to do TAVR procedures and that would've aligned with the timing that you mentioned. So sorry for that.

CHAIRWOMAN SAVAGE: Other questions right here.

MS. HENDRICKSON: Sorry. so you mentioned that part of the plan is to provide increased capacity in the five rooms that you currently utilize at the hospital to go to more acute. Where are acutes going? Are they, are you taking these acutes from your Peoria market, or are they coming from Carl?

MR. BARNHART: It, it, it's incremental cases. It's, it's patients who didn't use to access OSF Heart of Mary, who may have gone to Carl, patients who have come to Chicago, St. Louis, Indianapolis, Peoria. I mean, I think that we are looking at what specialties we can recruit that we can you know, have, have offices, have access that key people from having to travel, give people a another option in our community. Then it's one thing we hear

anecdotally is that we, we wish you had this service at OSF, so we could utilize, it's very hard to access in, in other health systems.

MR. WEBER: Let me add just a little bit. I don't know if you want numbers, but when we put the permit application together, there were like five buckets of categories of patients. One is Dr. Ogan's patients, the 15 percent, again, probably a small number, and that equates to about 180 procedures, that that's pretty small. He's not going to come all the way up here just for 180 cases. And other referrals for pain management by physicians within OSF, either at Heart of Mary Medical Center in Urbana or at Sacred Heart in Danville. And that was about 408 cases per year. And by the way, those are only in licensed healthcare facilities. And that we would counts of doctor's office procedures, and then we discounted them. We made it real clear in a table. We were not counting those toward the volume.

And then referrals from Safe Works, which is an industrial medicine clinic in the area, Champaign. And Dr. Ogan has a special relationship with the medical director there. And then the five surgeons, two GI and three general surgeons from Heart Mary, that would transfer about 850 hours of surgery in a year. And then the

continuation of bariatric. And that all totaled to 1,675 hours, which is more than the utilization of the one surgical room. So it justifies the two, and we were pretty conservative in these numbers.

CHAIRWOMAN SAVAGE: Other questions?

(No verbal response)

CHAIRWOMAN SAVAGE: Hearing none, George, if you could call the roll.

MR. ROATE: Thank you, Madam Chair. Motion made by Mr. Burnett, seconded by Dr. Tanksley. Mr. Budde.

MR. BUDDE: I'm going to vote no. I'd like to see a reduction in unused inventory in the community as a condition of improvement to start a new service.

MR. ROATE: Thank you, Mr. Burnett.

MR. BURNETT: First I just want to express my appreciation to you, Dr. Ogan, for your testimony today. And I didn't write down the name of the president CO, but reference you as JT. Forgive me. I appreciate you referencing your, as our community versus I've heard testimony from individuals using they and them, and it should be we. So it's a connection with the community. I'm going to vote yes with Reservations.

MR. ROATE: Thank you, Mr. Fox.

MR. FOX: I'm going to go vote yes for a few

reasons. One is I'm very impressed with Dr. Ogan's presentation here today. And I'm pretty confident that he's going to be a pretty busy physician in the surgery center. So, unlike some of the earlier presenters today where there were some promises conveyed, I, I have high belief in this one. I'm also encouraged generally that the surgery center has got a new owner and new life coming in, in the form of some additional physicians. So that will make this surgery center, which let's face it, when any of us need surgery in the future, assuming the quality is high, we'd rather be in a surgery center than in a hospital. And I used to run a hospital and had part ownership in a surgery center. You know, the issue of 15 ORs and five or six of them are being staffed right now. That that's a, that issue of warehoused licenses is an issue that really is all over the state. And I, I don't want to penalize your project today because you've got some excess capacity. Our, certainly our, our license inventory would be better cleaner if, if people, if we would license the beds and ORs that are currently being used. I realize you're new in your facility, you're trying to attract some new specialties, which will require maybe some more operating rooms. So even with that concern as a background, which I, I think Rex raised appropriately I,

I'm going to support this and wish you the best of luck.

MR. ROATE: Thank you. Monica Henderson -- Hendrickson.

MS. HENDRICKSON: I will vote yes. I do have concerns about under utilization under ORs. I do think there is domino effects of moving services. But since you had no letters of opposition, I, I think that's that gave me a little bit of a reassurance.

MR. ROATE: Thank you. David Katz.

MR. KATZ: I'm also a yes, and, and I echo your comments. I, I appreciate the presentations, they were really helpful. I, I think the reason for me that this one is different than all the other cases where people are trying to boost up profitability through adding pain is that this is much more of a closed loop system. And with Dr. Ogan maybe being the one exception, but this is a real life great doctor who has a need to be in a different geography. And it, that's, that's a whole different kettle of fish. So good luck with it.

MR. ROATE: Thank you. Gary Kaatz?

MR. KAATZ: I vote yes, and I have no reservations. I think I think that what I've seen today is high energy team effort, just the beginning. I look forward to you guys coming back here with a couple new

initiatives and years to follow. I think I, Mr. Mr. David Katz has brought up and David Fox also, that some of the losers sometimes are the hospitals. I don't feel that way here. And I think maybe a little competition with Carl May provide a big benefit to the community in terms of that quality of care to David just mentioned. So, I like it. I like it. I think you guys are going to succeed. I think you're a good team. I like the presentation. Thank you. No, no reservations. Best of luck to you. Thanks.

MR. ROATE: Thank you, Ms. Legrand.

MS. LEGRAND: I also vote yes, based off What I've heard today. Good luck.

MR. ROATE: Thank you, Dr. Tanksley.

MR. ROATE: So we didn't talk very, very much in detail about like your charity care and those things. I know OSF has a pretty decent charity care policy. I will say at some of the charts you've provided, I have some concerns and reservations about I agree with my colleagues that I think you guys are fairly genuine in, in what you're saying and that you're probably going to try to do good by definitely by the folks in the area, which is what's most important. I appreciate that you have identified that there is an FQHC, that's what it's called, an FQHC, federally Qualified Health Center. It's, that is

coming to your neighborhood and I think it's a great opportunity for you to learn more about them. I worked in Danville at some point. It's a very impoverished area and also a high amount of Medicaid. And so I think it would be advantageous to get to know the community to be able to provide pain care for them as well too. And transportation. 'cause It's tough for a lot of those folks to actually get to Champaign and they're often very marginalized, but they're able to access in that community. That being said, I am going to vote in favor of this. I look forward to hearing about really how you guys are expanding access to the to those populations.

MR. OGAN: Okay. Can I make a comment? Would that be all right? I appreciate the yes vote doctor, but I, I want to just tell you personally right now, my payer mix is probably 70 percent government payers including Medicare, Medicaid tri-care. So we see everybody.

DR. TANKSLEY: I went to Southern Illinois, I'm familiar with Effingham. Thank you though. Appreciate your work.

MR. ROATE: Thank you. May I ask, did Ms. Hardy-Waller recuse herself? She had to step out. so we'll mark her absent Okay. Chairwoman Savage

CHAIRWOMAN SAVAGE: I too vote yes, based on

the testimony today and the state board staff report. And I think Dr. Ogan, you did a great job and I think more facilities should bring their doctors to be able to speak to that. And JT unfortunately, I don't remember your last name either, but I think as the CEO, you certainly have the energy. It certainly doesn't look like 20 years. So you're doing good. Your hair hasn't fallen out, so life is good. So I wish you much success and hope that you know, you guys really turn it around over there.

MR. ROATE: Thank you, Madam Chair. That's eight votes in the affirmative. One vote in the negative and one absent.

CHAIRWOMAN SAVAGE: And so that permit is approved. Thank you.

MR. OGAN: Thank you. Thank you everyone for your time today.

CHAIRWOMAN SAVAGE: Safe travels home. Okay, so now we're going to hear H-11 and H-12, which are dialysis care center, Oak Lawn in Oak Lawn, Illinois. So, may I have a motion to approve project 24-003 for the discontinuation of the dialysis center.

MR. KATZ: So moved

DR. TANKSLEY: Second.

CHAIRWOMAN SAVAGE: Okay, so we have some new

folks here. Would you like to introduce yourself? Spell your names for the court reporter, and then he will swear you in.

MS. SMITH: Melissa Smith, director of operations, M-E-L-I-S-S-A S-M-I-T-H.

MS. SHUMATE: Stephanie Shumate, director of operations for the M center program. S-T-E-P-H-A-N-I-E S-H-U-M-A-T-E.

MR. SALAKO: Babajide Salako, CEO care center, S-A-L-A-K-O. First name Bae. B-A-B-A-J-I-D-E.

THE REPORTER: One more time, First and last name?

MR. SALAKO: S-A-L-A-K-O.

THE REPORTER: Thank you very much.

(Whereupon:

MELISSA SMITH

STEPHANIE SHUMATE

BABAJIDE SALAKO

After being duly sworn, were examined and testified as follows:)

CHAIRWOMAN SAVAGE: So we're going to postpone H-11 and instead, may I have a motion to approve project 24-004 for the establishment or replacement of a dialysis center.

MR. FOX: So moved

DR. TANKSLEY: Second.

CHAIRWOMAN SAVAGE: Okay. All right. Now Mike or George, could you give our state board staff report.

MR. CONSTANTINO: You talking about the discontinuation?

CHAIRWOMAN SAVAGE: No, the establishment,

MR. CONSTANTINO: The applicants are proposing the establishment of a 12 station ESRD facility in Oak Lawn, Illinois. The applicants are also requesting to add two stations for a total of 14 stations. The cost of the project is $5.4 million, and the expected completion date is December 31st, 2024. There's currently an excess of 77 stations in this planning area, and there are 19 facilities within five mile miles with 336 stations with a utilization of 52 percent. There was no public hearing requested and there was no opposition letters received. proceed. Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you, Mike. If you'd like to proceed.

MR. SILBERMAN: Thank you. And thank you for your continued patience through a long day. It's never enviable to be the last task on a long agenda with your permission and indulgence and not in any way, shape or form to be presumptuous. What we're going to do is just introduce the

project, let Juan address the negatives, and then open it up for questions. We'd rather spend the time answering the questions you have than telling you what we think you want to know. So we've sworn everyone in, so whatever questions you have, we'll be able to address. Let me identify first who we have with us today. I have Dr. Salako, who is the CEO of DCC, Stephanie Shumate and Missy Smith, who are directors of operations, and obviously my partner Juan Morado. You have before you two applications.

One is to discontinue an existing facility at 9115 South Cicero Avenue in Oaklawn. The other is to reestablish or to establish a facility at 4425 Southwest Highway. It's about a half a mile away, as you can see from table one, page two of the staff report. This facility has been operating at over 90 percent utilization. There is a desire and a need to add two more stations at that facility, but as part of being responsible and planning and responsible with the spending of healthcare dollars, the applicant concluded it would make more sense from a business perspective and a healthcare delivery perspective to do so in a new modernized facility that has the capacity for this, the ability to grow further and the stability for a longer term lease.

The existing process does not allow for the relocation of a facility, therefore you have the two applications before you. But this project will not add to the volume of ASTC stations. And I say that even though the proposal is to go from 12 to 14 stations, the applicant has already begun the process at its original site of adding two stations, utilizing your 10 percent 20 bed rule. But it would be wasteful both in time and resources of the applicant, but also of public health to go through that process. So rather than take the next step, which is design and construction standards and all of the IDPH process, we decided rather to come here and ask to advance the process to ask if this board would approve the relocation of this facility in the form of a discontinuation and establishment that you have before you. And with that, I'm just going to turn it over to Juan.

MR. MORADO: Thanks, mark. So as I've heard, this is a simple relocation application. We think it's important to address the findings of non-conformance, of which there are three, two of those deal with excess capacity in the geographic service area. And the other one deals with availability of funds. I'm going to start with availability of funds, which to be clear in this case, is

not an indication of there being an issue with the ability to fund the project, but it's simply because the applicants do not have audited financials, which are what your rules are currently drafted to require.

'Cause of the size of the organization and the significant costs associated with obtaining what is technically referred to as a financial audit. The organization does not complete one, nor is one required by law. These are more common for hospital systems and other not-for-profit organizations. However, to ensure that they're meeting the spirit of your rule, they have in the past and have regularly and have for this application submitted a third party review, financial statement for board staff to review.

These statements indicate the funds are in fact available for this project and if necessary. The CEO is here to attest to that fact. As you heard, the current site is at maximum capacity. It is literally bursting at the seams table one in the nearest SR your reflects the operation is currently over 90 percent utilization. And even when the new facility comes online, that same table indicates that we're going to be at 79 percent utilization, which is just one percent short of the state's target. The truth is, there's a need for even more

stations at this facility. We do anticipate coming back before this board for further expansion at this site. Should this be approved the applicants still want to start with getting this relocation completed. And we also want to note that importantly, this is not adding to the overall number of stations in the planning area because right after this we're going to hear the discontinuation, which is going to take those 14 that are currently in, in get the inventory out.

This site's going to offer the ability to practice to expand the practice which unfortunately, because kidney disease continues to be an issue in this area and for this practice groups patients their patient base is growing. In short, that new locations will offer the accommodation of, in addition to temporary home dialysis patients who receive treatments from time to time in the facility because it's whether for training or there might be something wrong with their equipment at home. It's also going to allow the applicants to pour resources into the new space, which they have secured a long term lease for, and in turn will result in a consistent location for their patients to receive care, which and Mark noted is down the block and around the corner about five blocks away. So we thank you for your consideration. Happy to answer any

questions you may have.

CHAIRWOMAN SAVAGE: Do you any questions? Mr. Kaatz?

MR. KAATZ: Help me understand. 19 dialysis centers within five mile range. Is that, is that the situation?

MR. MORADO: I believe that's what your table reflects in table 4.

MR. KAATZ: And a current and a current occupancy of 52 percent.

MR. SILBERMAN: That is in the area, but not at this 55 --

MR. KAATZ: I believe, but to average in the, of all the area.

MR. SILBERMAN: Okay. And part of the issue, and I'm going to speak to this in a positive, not as a negative. Yeah. One of the things that DC offers is an option that is not the two largest providers is DCC dialysis care. I apologize. My apologies. No. Is there are times where both physicians and patients want an option that is not one of the two large more institutional providers and they offer that opportunity. And so I think the fact that their utilization is at such a high and sustained level is reflective of the fact that both the

physicians and the patients want to be receiving their care there. And I'm only going to say that as a positive based on the applicant's abilities, not as a negative to anyone else.

MR. KAATZ: So if they're that busy, then the other centers are really, really Not busy.

MR. SILBERMAN: We can't speak for them, but I think that your numbers would bear that out. Yeah. Other questions? Rex?

MR. BUDDE: How many hours a day do you operate the current facility?

MS. SHUTMATE: Currently we're in operation for currently with the Oakmont facility. We're in operation for 14 hours a day. So that would be 5:00 AM in the morning to 8:30 at night on Monday, Wednesday, Fridays. And then it would be on our TTS shift. It would be from 5:00 AM in the morning until 3:30 in the afternoon. Okay. Thank you.

MR. KAATZ: Anything on Saturday?

MS. SHUMATE: That's the tts. Tuesday, Thursday, Saturday.

MR. SILBERMAN: I figured it out if she went away.

MS. SHUMATE: Oh, okay. Sorry about that. MWF is Monday, Wednesday and Friday. Right? And then TTS is Tuesday

Thursday and Saturday.

DR. TANKSLEY: I, I have a quick question. What and, and or how does your facility work with individuals who may potentially be candidates for transplant to get to those options?

MS. SHUMATE: Okay, so our social worker in our in our center program, they help to steer the individual into getting onto the transplant list to go through the to go through the process of getting on the transplant list, and then they follow up with the patients as well. We also have lobby days for our patients where we have the transplant hospitals come in and provide education for those patients as well and try to encourage them to get on the process in the program as well.

DR. TANKSLEY: Would you say is the percentage of patients that go from dialysis to transplant?

MR. SALAKO: Actually, that has, can I answer that? That has improved tremendously in the last few years and which is a good thing. So I, I think now we are probably hovering at about close to 10 percent, which is the highest it's ever been, you know, between seven to 10 percent, which is the highest it's ever been in the United States, especially in this area where we have options. Loyola, we have a transplant with Loyola and with

Northwestern. So we do have folks from Loyola coming on a very regular basis. And Northwestern, most of our patients are transparently in those two particular facilities centers or programs.

MS. HENDRICKSON: This is just a quick question. How long have you been operating? When did you begin operating at your original site?

MS. SHUMATE: January the eighth, 2018.

MR. KAATZ: If I may let the record show that member Burnett has left the meeting. Thank you.

CHAIRWOMAN SAVAGE: Other questions?

MR. KAATZ: 10 percent of your current patients.

MR. SALAKO: If, if, so what happens is the patients come in, we, we transfer at least -- everyone, you know, for whatever. Then they go to the transplant centers, the social workers meets with them, the, all sorts of things happen to them. Right. You know, they get, they get prepped for transplant, right? We don't make the determination whether they are transplant eligible or not. We make the services available to them Right now as transplants become available, right? As kidneys become available, these patients get transplanted. What we are beginning to see across the company, not in the particular location, is the incidents of our, or the, the our

transplant rates have increased tremendously. Right? more kidneys are becoming available to dialysis patients either because of you know, more awareness or, or the ability, and I'm know, and I'm not going to speak to the to the, that particular or the, the availability or more kind of very kidneys in the community. So yeah, transplant rates have really gone up, which is a very good thing for the dialysis community, which is very good.

CHAIRWOMAN SAVAGE: Other questions? Very mad. George, if you could please call the roll.

MR. ROATE: Thank you, Madam Chair. Motion made by David Katz, seconded by Mr. Fox. MR. Budde.

BR. BUDDE: Yeah. Based on the conversation today and the presentation, I vote yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Yes.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: Yes.

MR. ROATE: Thank you. Ms. LeGrand.

MS. LEGRAND: Yes.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: Yes.

MR. ROATE: Thank you. I'm going to mark Ms. Hardy Waller absent. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes. Based on state board staff report and testimony today.

MR. ROATE: Thank you. That's eight votes in the affirmative and two votes absent.

CHAIRWOMAN SAVAGE: So that permit is approved. And so now we will resume our motion to, I can't think, discontinue the previous dialysis center down the street. So do we have anything else that you would like to say?

MR. SILBERMAN: Just that the discontinuation will be upon completion of the new location.
Will, we will do it. So there's no disruption of care.

CHAIRWOMAN SAVAGE: And did Mike or George have anything else to add about the discontinuation portion?

MR. CONSTANTINO: Nope.

DR. TANKSLEY: I ask one quick question. Of course. This is really quick. I just want to know what's your ratio of like social workers to patients?

MS. SHUMATE: For our social workers? it's one social worker to 105 patients.

DR. TANKSLEY: Okay. Thank you.

CHAIRWOMAN SAVAGE: Any other questions?

(No verbal response)

CHAIRWOMAN SAVAGE: All right. Hearing none, George, if you could call that roll. Thank you. Madam Chair. MR. Budde:

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Fox?

MR. FOX: Yes. Thank you. Ms. Hendrickson?

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Yes. Thank you. Gary Kaatz.

MR. KAATZ: Yes.

MR. ROATE: Thank you. Ms. Legrand.

MS. LEGRAND: Yes.

MR. ROATE: Thank you. Dr. Tanksley.

DR. TANKSLEY: Yes.

MR. ROATE: Thank you. Chairwoman Savage?

CHAIRWOMAN SAVAGE: Yes, based on the state board staff report.

MR. ROATE: Thank you. That's eight votes in the affirmative votes. Two votes absent.

CHAIRWOMAN SAVAGE: So that permit is approved for discontinuation. Thank you. Thank you. Bearing with us today. Appreciate it. Thank you. So we, we decided to

forego rules until next meeting. So let's see. Okay, so financial reports. John.

MR. KINERY: Thank you Madam Chair. Your, your financial report looks pretty good. Ask you to look at page six. Start at page seven. You'll see that it appears that the quarters are slowing from previous years. Moving to page eight this, this gives you an overview of each year for the last five years. We did really well last year. We were able to keep expenses down and revenues up. Some of that's going to be changing as we move forward be just because we hired more staff. And, and hopefully it'll, it'll help the board run as smoothly as and, and then just moving to page one. And I, I'm going over this quickly, so if there are any questions, please let me know.

MR. KATZ: I'll let you know after the meeting.

MR. KINERY: There you go. So, so I just want to point out the appropriation balance for, for this last quarter and then cash balance in our, in our fund. And I am seriously worried about that sitting there because there's a good possibility that could be swiped even though we have issues and that, that we'd like to spend it on and, and furthering the board's mission. So yeah, we need to, we need to have a field trip. So, so that's the

financial report. If there are any questions, let me know. I'd be more than happy to go over any of this with you. It's, it's very similar to what we've seen in the past as well.

CHAIRWOMAN SAVAGE: Anyone have any questions? All right. Don, do you have only a second Mike and Kenton have some information on our 2023 inventory of healthcare facilities and services and need determinations.

MR. CONSTANTINO: Yes. It needs to be approved for both hospitals, ASTC ESRD and our other services needs to be approved. Even though it's on the website, it does need to be approved by the board.

MS. HENDRICKSON: I'll make a motion to approve the project.

CHAIRWOMAN SAVAGE: Any questions? No. Okay. George, would you call the roll yet again?

MR. ROATE: THANK YOU. Motion made by Ms. Hendrickson, seconded by Dr. Tanksley. Mr. Budde.

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. Mr. Katz.

MR. KATZ: Yes.

MR. ROATE: Thank you. Gary Kaatz?

MR. KAATZ: Yes.

MR. ROATE: Ms. Legrand?

MS. LEGRAND: Yep. Dr. Tanksley?

DR. TANKSLEY: Yes.

MR. ROATE: Chairwoman Savage?

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: That's eight votes in the affirmative.

CHAIRWOMAN SAVAGE: Okay. You have our approval to continue that. Okay. So now Don has a legislative report.

MR. JONES: There isn't much to update the board on, except we do have one bill. It is house bill 2134. And that is the bill that would allow, actually would mandate the board to establish a trauma center between the communities of Calumet City and Dalton. That bill

CHAIRWOMAN SAVAGE: That I would run, right?

MR. JONES: Yes. That the board would either run itself or would hire a management company to run for you. That bill was in the House Finance Committee as of January 31st of this year. I did check this morning. And that Bill has moved to the revenue sales and amusement and other tax

subcommittee as of March 8th. It's my understanding and if a bill moves to a subcommittee, it probably isn't going anywhere, correct. But now that I've said that, I probably jinxed it.

CHAIRWOMAN SAVAGE: I'm not running the trauma center.

MR. JONES: There are other bills in, in your legislative report, but they really haven't had any movement recently. But I did want to bring to the board's attention in that bill Because it did move on March 8.

CHAIRWOMAN SAVAGE: When it comes to nursing bills, when they get to subcommittee, they wait till the next year.

MR. KINERY: Madam Chairman, if I can add just a little bit to that. There are a couple burn center rules that, that aren't moving because one already has. There's a whole slew of Open Meeting Act rules. We are trying to push one or two of those just to help alleviate some of the issues. Yeah. With, with having the meeting. And then there's also a new, we haven't seen from the last first part of the session last year, are long-term care bills. They're trying to address an issue and I just want to put out for this board that they're all, they're each trying to address a certain issue that collectively could all be

done just by bringing long-term care back to the board. So I try to make that point to the powers to be, but we shall see. Thank you.

CHAIRWOMAN SAVAGE: Such fun. Okay, so now we are going to move to executive sessions. So in accordance with 5 ILCS 120/2C1 personnel matters, tying board staff paid to union staff raises administrator compensation, and in accordance with 5 ILCS 120 - 2C11 impending and pending administrative and judicial actions. So, may I have a motion to go to executive session?

MR. BURNETT: So moved.

MR. FOX: Second.

CHAIRWOMAN SAVAGE: George.

MR. ROATE: Thank you, Madam Chair. Mr. Budde.

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Yes.

MR. ROATE: Thank you. Gary Kaatz.

MR. KAATZ: Yes.

MR. ROATE: Ms. Legrand.

MS. LEGRAND: Yep. Dr. Tanksley.

DR. TANKSLEY: Yes.

MR. ROATE: Ms. Hardy-Waller.

MS. HARDY-WALLER: Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: That's nine votes in the affirmative.

CHAIRWOMAN SAVAGE: So we are now moving to executive session. If we could clear the room except for the board.

CHAIRWOMAN SAVAGE: May I have a motion to return to open session.

MR. FOX: Motion.

MS. HENDRICKSON: Second.

CHAIRWOMAN SAVAGE: George, if you can call that roll again.

MR. ROATE: Thank you. Madam Chair. MR. Budde.

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. David Katz.

MR. KATZ: Yes.

MR. ROATE: Thank you. Gary Kaatz?

MR. KAATZ: Yes.

MR. ROATE: Ms. Legrand?

MS. LEGRAND: Yep. Dr. Tanksley?

DR. TANKSLEY: Yes.

MR. ROATE: Ms. Hardy-Waller.

MS. HARDY-WALLER: Yes.

MR. ROATE: Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: That's nine votes in the affirmative.

CHAIRWOMAN SAVAGE: Yes. All right, so we're back in open session. So now as you were your question, Monica, could you share that again?

MS. HENDRICKSON: Yes. I, I would just ask for staff if they could provide just, I, I think this was part of the orientation packet about the different actions that we are able to do. Just so I fully understand, especially the contingency aspect. I know we talked a lot about some of the ambulatory services and one of the notes I shared was what happens if a contingency was one you had to drop one of your specialties? You know, is that even allowable? And so kind of understanding those nuances would be helpful.

CHAIRWOMAN SAVAGE: Thank you. And did you have anything to share?

MS. DOMINGUEZ: No, I, yeah, I, John and I like from day one, which it's only been a week. But we have been talking about potentially looking at May as a kind of training giving you guys a refresher on open meetings on FOIA because anything that you're doing for the state is foiable, right? And so we want to be careful, especially if you are using your personal devices for stuff like that. So I want to make sure everyone's up to date with that. And then of course you been serving for a long time, but I don't know when the last time you really looked at the details. And so just kind of reminding everyone of their options when it comes to different actions, considerations that you have.

Mike and George, the criteria, and talking you through that and what they're looking at and stuff like that. Just to kind of give you that background and context so that when you're taking action on an item, you feel comfortable that you're, you're voting on the right thing and you're saying the right thing. 'cause That's where the objective, the outcome is that you want. Right? So and we are looking that as soon as we get that together, we're aiming at May.

MR. KATZ: Yes. That would be great. I haven't really thought about the FOIA stuff. I mean, do you, is I'm being serious, is there an option to have a state

issued device for communication with the board?

MS. DOMINGUEZ: I don't know, I'm not going to speak to that.

CHAIRWOMAN SAVAGE: Well, if you put your email on the phone or something for then it's FOIA

MR. KATZ: You know what I'm saying? But I it it's an email and it's a device 'cause it's also text. Right? So is does the state issue devices?

MS. DOMINGUEZ: They do for employees, I don't know what they do for boards. I would have to,

MR. KATZ: It'd be great if you have an answer by May.

MS. DOMINGUEZ: Yeah, well I'll Research on that.

CHAIRWOMAN SAVAGE: John will check on that. Okay. So we're going to have a few more motions. So may I have a motion to refer the five legal ca -- the five cases to legal? Do I have a motion.

MR. BUDDE: Motion.

DR. TANKSLEY: Second

CHAIRWOMAN SAVAGE: George.

MR. ROATE: Thank you, Madam Chair. MR. BUDDE:

MR. BUDDE: Yes.

MR. ROATE: Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Ms. Hendrickson.

MS. HENDRICKSON: Yes.

MR. ROATE: David Katz.

MR. KATZ: Yes.

MR. ROATE: Gary Kaatz.

MR. KAATZ: Yes.

MR. ROATE: Ms. Legrand.

MS. LEGRAND: Yes.

MR. ROATE: Dr. Kingsley.

DR. KINGSLEY: Yes.

MR. ROATE: Ms. Hardy Waller.

MS. HARDY-WALLER: Yes.

MR. ROATE: Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: Thank you. That's nine votes in the affirmative

CHAIRWOMAN SAVAGE: Thank you. That motion is passed. And then now may I have a motion to approve salary pay for John Kinery, Kenton Tilford, and Sherry Ryan.

MS. LEGRAND: So moved.

DR. TANKSLEY: Second.

CHAIRWOMAN SAVAGE: George.

MR. ROATE: Thank you. Madam Chair. MR. BUDDE:

MR. BUDDE: Yes.

MR. ROATE: Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Ms. Hendrickson.

MS. HENDRICKSON: Yes.

MR. ROATE: David Katz.

MR. KATZ: Yes.

MR. ROATE: Gary Kaatz.

MR. KAATZ: Yes.

MR. ROATE: Ms. Legrand.

MS. LEGRAND: Yes.

MR. ROATE: Dr. Tanksley.

DR. TANKSLEY: Yes.

MR. ROATE: Ms. Hardy-Waller.

MS. HARDY-WALLER: Yes.

MR. ROATE: Chairwoman Savage?

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: That's nine votes in the affirmative.

CHAIRWOMAN SAVAGE: My, that's wonderful. And now for the all important, may I have a motion to adjourn? All in favor say Aye.

THE BOARD: Aye.

CHAIRWOMAN SAVAGE: And our next meeting for our folks in here we're being adjourned is May 9th, the Thursday here at the Bolingbrook Golf Course. May 9th

meeting adjourned.

(Which were all the proceedings had in the above entitled cause on this date)

STATE OF ILLINOIS.)
) SS:
COUNTY OF COOK)

I, Michael Marciniak, CER, Notary Public, electronic reporter doing business in the State of Illinois; reported the proceedings that were held on the date, time and place set out on the title page hereof; and that the foregoing is a true and correct transcript of report of proceedings so taken aforesaid.

I further certify that I am not related to any of the parties, and I have no financial interest in the outcome of this matter.

Michael R. Marciniak
_____

MICHAEL R. MARCINIAK.
Certified Electronic Reporter, CER 2316
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