ILLINOIS HEALTH FACILITIES

AND SERVICES REVIEW BOARD

STATE BOARD MEETING

REPORT OF PROCEEDINGS had at the meeting in the above-entitled cause before MS. DEBRA SAVAGE, Board Chairwoman, at Bolingbrook Golf Club, 201 Rodeo Drive, Bolingbrook, Illinois, on October 29th, 2024, commencing at 9:00 a.m.

PRESENT:

MS. DEBRA SAVAGE, CHAIRWOMAN
MR. REX BUDDE, BOARD MEMBER
DR. AUDREY TANKSLEY, BOARD MEMBER
MR. GARY KAATZ, BOARD MEMBER
MR. DAVID KATZ, BOARD MEMBER
MS. ANTOINETTE HARDY-WALLER, BOARD MEMBER
MR. DAVID FOX, BOARD MEMBER
MR. GEORGE ROATE, IDPH STAFF
MR. DONALD JONES, IDPH STAFF
MR. JOHN P. KNIERY, ADMINISTRATOR
MS. BLANCA DOMINGUEZ, IDPH ATTORNEY

CHAIRWOMAN SAVAGE: Good morning, everyone. We are going to go ahead and get started. But first I would like to wish Mr. Rex Buddy a very Happy Birthday today. Fun way to spend his birthday.

All right. Now, pursuant to the Open Meetings Act, this meeting is being recorded officially via the court reporter, but we are also recording through the Webex format.

George, would you please call the roll?

MR. ROATE: Thank you, Madam Chair.

Mr. Rex Buddy?

BOARD MEMBER BUDDE: Present.

MR. ROATE: Thank you.

Mr. David Fox?

BOARD MEMBER FOX: Present.

MR. ROATE: Thank you.

Mr. David Katz?

BOARD MEMBER KATZ: Present.

MR. ROATE: Thank you.

Mr. Gary Kaatz?

BOARD MEMBER KAATZ: Present.

MR. ROATE: Thank you.

Dr. Audrey Tanksley?

BOARD MEMBER TANKSLEY: Present.

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

BOARD MEMBER HARDY-WALLER: Present.

MR. ROATE: And Chairwoman Savage?

CHAIRWOMAN SAVAGE: Present.

MR. ROATE: Thank you. Thank you.

CHAIRWOMAN SAVAGE: All right. Now, as you have noticed, the docket number has been reorganized throughout the agenda to proceed through it more efficiently.

May I have a motion to approve the October 29, 2024 meeting agenda?

BOARD MEMBER: So moved.

BOARD MEMBER: Second.

CHAIRWOMAN SAVAGE: Thank you. All those in favor, say aye.

BOARD MEMBERS: Aye.

CHAIRWOMAN SAVAGE: Any nays? Okay. The ayes have it.

Now, may I have a motion to approve the September 19, 2024 meeting transcript?

BOARD MEMBER: So moved.

BOARD MEMBER: Second.

CHAIRWOMAN SAVAGE: All those in favor, say aye.

BOARD MEMBERS: Aye.

CHAIRWOMAN SAVAGE: Any nays? So the ayes have it.

Now, before we move on to the next agenda item, a few reminders from our Board Staff.

ATTORNEY DOMINGUEZ: Good morning, everyone. I'm just wanting to welcome everyone. I know the Board is very excited to proceed here today and hear everyone's presentation. But before we start, I just wanted -- a couple procedural matters just to try to help move it along.

We do anticipate a lot of speakers, and a few of the projects are probably going to have a lot of information. So please, if you want to ask for a deferral, please do so any time before the Board starts to vote. Once the Board starts voting on your item, you will not be allowed to ask for a deferral.

If you do get an intent to deny, you do not get the six required yes votes, it is not the end of your story. Just you'll get a letter from the Board Staff that will explain your options, one of which will be to defer the project to provide additional information.

The other thing, just for the sake of making motions a little smoother so we don't have to abide by

the rules directly. If there's no opposition to the motion, so like someone makes a motion to amend and there's no opposition from the other members of the Board, we'll go ahead and unanimous consent the motion and then proceed on the amended motion.

Any comments, please make sure that you keep those comments -- if you're not presenting an application, you keep those comments to the public participation portion. Thank you.

CHAIRWOMAN SAVAGE: Thank you. That was our attorney, Blanca Dominguez.

Okay. So now we are going to move on to public participation. Mr. Jones?

MR. JONES: Thank you, Madam Chair. The first person is Nicolette Alberti.

ATTORNEY DOMINGUEZ: I'm sorry. Can we go ahead and call a couple of people at a time?

MR. JONES: This was the only one for that project.

ATTORNEY DOMINGUEZ: Oh, okay. On the public participation, just a couple of comments. Because we do have many speakers, we are going to unfortunately time you off at two minutes. I tried to find the best buzzer to not scare everyone as they are speaking, which I couldn't find a loud one. So I apologize ahead of time

if you're shocked.

When the buzzer goes off, please wrap up your comments immediately. If there's time at the end, we may re-open it. But for now, everyone who comes up will be speaking for two minutes. You'll come up, get sworn in. And right before you start speaking, please state and spell your name for the court reporter. Thank you.

MR. JONES: The first person is Nicolette Alberti for project 24-027.

CHAIRWOMAN SAVAGE: Project 24-027.

MS. ALBERTI: Hello. So my name is Nicolette Alberti. And my name is spelled N-i-c-o-l-e-t-t-e. And my last name is A-l-b-e-r-t-i.

Do I need to be sworn in before I start speaking?

CHAIRWOMAN SAVAGE: No. You can just go ahead.

MS. ALBERT: So my name is Nicolette Alberti. I'm a resident physician specializing in emergency and internal medicine at the University of Illinois in Chicago. We are a safety net hospital that provides services that no one else in our state provides.

I chose to practice medicine in Chicago because I am deeply committed to serving diverse communities and addressing severe healthcare inequities

that exist both in our city and across our nation.

Unfortunately during my time as a resident physician, I have witnessed firsthand the devastating consequences of delayed care to many of my Medicaid patients and noninsured patients who face overwhelming barriers in accessing basic healthcare, much less specialists.

We desperately need expanded outpatient specialty and cancer care services in our west and south side communities in Chicago. These areas long have struggled with increased healthcare needs due to the compound effects of economic disinvestment, segregation, and systemic neglect over decades.

The health conditions we manage are severe and life threatening. Too often when patients arrive at our local healthcare institutions, they find that necessary specialists, equipment, and resources are simply unavailable to them because of their insurance status.

This leads to lengthy transfers of care to other facilities or outright disenfranchisement from the medical system, further compounding the delays in care. Delays that can mean a difference between life and death. It is the norm for far too many patients in the south and west sides of Chicago.

Meanwhile, Northwestern Health is advancing plans for a new Huntley medical office building where there are already dozens of specialists. Why aren't we seeing similar investments in Chicago's most vulnerable communities where the need is far greater? I just ask -- ensuring equitable investment in healthcare for the south and west sides of Chicago is not simply about fairness. It is a matter of health equity and justice. Thank you.

ATTORNEY DOMINGUEZ: Speakers, if you have your comments in written form, can you please tender them to our Board Staff? Thank you.

MR. JONES: Our next four presenters are Brian Roberts, Ikea Johnson, Germaine Dixon.

Okay. Our next presenters are Brian Roberts, Ikea Johnson, Jermaine Dixon, and Jacqueline Algee.

MR. ROBERTS: Good morning, everyone.

CHAIRWOMAN SAVAGE: If you can spell your name for the court reporter, and then you can begin, sir.

MR. ROBERTS: Absolutely. My name is Brian Roberts.

CHAIRWOMAN SAVAGE: Speak into your microphone a little more.

MR. ROBERTS: Brian Roberts. B-r-i-a-n,

R-o-b-e-r-t-s. I'm speaking on behalf of SEIU. My name is Brian Roberts. I'm a patient transporter at Northwestern Hospital.

For a long time I have known that there is inequality within healthcare. I have been working at Northwestern as a transporter for the past three years and see this inequality every single day. We are understaffed at the hospital, making it hard for patients to receive the immediate care they need.

I encounter patients who have been waiting at the hospital for 10 or even 12 hours just to be seen and receive treatment. Often times they are grateful to see me because they feel like they finally have someone to discuss their experiences with.

In other cases, they are just plain angry. They don't understand how they can travel so far to receive the care they need and still feel invisible. Patients have told me. They drive hours just to get to Northwestern because the hospitals near them don't provide them with the necessary care.

Being and living from where we are, I can relate to these patients. It is clear that our community does not have the same healthcare resources that communities in the suburbs do. We are not

prioritized or treated the way we should be.

For example, I often see the same patients regularly. You get to know them and the struggles they face. When I hear a patient I have connected with has passed away because they were not diagnosed or treated in time, it saddens you.

Working at the hospital, I know many of these illnesses and deaths could be avoided. But because patients don't already have access to specialty care services, their aren't. Individuals are faced to advocate for themselves constantly. And by the time they get to where they should be, it can be too late.

CHAIRWOMAN SAVAGE: Thank you for your comments.

Okay, Ma'am. If you'd like to take the microphone, and if you can spell your name for the court reporter and begin.

MS. ALGEE: Good morning. My name is Jaquie Algee. And that is spelled J-a-q-u-i-e, A-l-g-e-e. I am vice president -- a vice president of SEIU Healthcare Illinois, Indiana, Kansas, and Missouri. And I've come here to make comment with regard to application 24-027, Northwestern Medicine Huntley Medical Office Building.

SEIU Healthcare Illinois is a union comprised of over 90,000 strong healthcare and social service

workers, including more than 1500 service and support workers at Northwestern Memorial Hospital. We are here today to testify in opposition of application 24-027, Northwestern Medicine Huntley Medical Office Building in regard to the urgent need for additional outpatient and especially cancer care services in the south and west side communities where our members live. And I might add those members are workers of Northwestern.

We assert, and the relevant data affirms that there is much greater need for capital investment and expanded access to these services in the south and west side communities located in Northwestern Memorial Hospital's primary service area than in northwest suburban communities adjacent to and that utilize Northwestern Medicine Huntley Hospital.

Community areas in the Northwestern Medical Hospital service area located on the south and west sides have some of the worst cancer mortality rates in Chicago reflecting decades of segregation, economic exploitation, and disinvestment and neglect by healthcare providers. Thank you.

CHAIRWOMAN SAVAGE: Thank you.

MS. DIXON: My name is Germaine Dixon, spelled G-e-r-m-a-i-n-e, and I'm a worker at Northwestern

Hospital.

My name is Germaine Dixon, and I'm a patient care tech at Northwestern Medical. I am from the south side of Chicago, and I have seen firsthand how the lack of specialty care of facilities in my area impacts families, including my own.

Less than a month, my godmother was diagnosed with lung carcinoma. When she first became ill, we spent countless hours taking her to emergency rooms, but no one seems to know how to help her. With my familiarity with hospital settings and patient care, I knew that advocating for her health was absolutely necessary.

After encountering many hurdles, she was finally diagnosed, and the facility offered to arrange transportation to the hospital where she would receive care. Unfortunately, when it came time for her to be transported, they informed us that they could not legally assist with her oxygen tank, which left us without the support we needed to get her to her treatment.

With few options, my godmother had to relocate to Bolingbrook, Illinois in hopes of receiving better care. While the care she has been receiving is an

improvement, she has now reached a stage in her illness where hospice care is needed. I can't help to wonder if greater access to cancer and specialty care facilities could have led to a different outcome.

As a patient care tech, I have always believed that quality healthcare should be basic human right. Unfortunately throughout this journey, quality care has not been our entire experience. I show compassion to my patients, and I do my best to assure that they receive the best care possible. Especially after witnessing some of the challenges patients and people in my community go through. Thank you.

CHAIRWOMAN SAVAGE: Thank you so much. We are going to move on now to more participants.

ATTORNEY DOMINGUEZ: Please turn in your comments, your written comments.

MS. DIXON: We did.

ATTORNEY DOMINGUEZ: Thank you.

MR. JONES: Our next person is Reverend Dr. Marilyn Pagan-Banks, and she's making comments on project 24-009, Peterson Surgery Center.

MS. PAGAN-BANKS: Good morning. My name is Reverend Dr. Marilyn Pagan-Banks. M-a-r-i-l-y-n, P-a-g-a-n-B-a-n-k-s. I am the Executive Director of

Just Harvest located at 7653 North Paulina, which is in Rogers Park near the Howard train stop.

Founded over 40 years ago, the commitment of the organization is to feed the hungry while creating healing spaces, building communities, and developing entrepreneur opportunities in and for the community.

We believe these are the initial steps toward collective wellness. I'm appearing here today in support of the relocation of the surgery center in Rogers Park to Peterson Avenue. The two project numbers for this planned relocation are 23-009 and 24-010.

Just Harvest has several different programs working to address hunger specifically by providing a sit-down hot meal seven days of the week, operating a food pantry, as well as a grocery delivery service, and managing four organic growing spaces.

Given the suffering we see every day, we are always educating and searching to find ways to help the community thrive, not just survive. We are neighbors of the surgery center and understand its challenges in operating at its current Paulina location, while we also recognize from our perspective the timeliness in taking over the facility to expand our wellness work and operate a substance use disorder clinic.

I have been in this community for over 25 years, and I've witnessed the social-economic challenges and increase in the number people suffering from mental illness, homelessness, and addiction.

The opioid crisis is fueled by easy and cheap access to synthetic opioids like Fentanyl, and we know it is highly addictive, and I'm sure you know that sometimes folks overdose. We have had that happen with community members that we know and love.

And our community does not have the resources to effectively combat substance use disorder, especially given the increasing numbers. The community does have limited access to harm reduction with Naloxone and training EMS providers. But we know that Narcan is not a remedy to substance use. The disease needs to be treated.

CHAIRWOMAN SAVAGE: Thank you.

MR. JONES: All of the individuals who will be providing public comment now are presenting information regarding project 24-018, NorthPointe Neighborhood Hospital.

The first five individuals are State Representative John Cabello, Senator Andrew Chesney, Dr. Desai, and Dr. Ken Klein.

CHAIRWOMAN SAVAGE: Ma'am, why don't you go ahead and get started on the end.

DR. DESAI: Hello. My name is Chitra Desai spelled C-h-i-t-r-a, last name Desai, D-e-s-a-i.

I'm Dr. Desai. I'm a board certified pediatrician serving the Beloit Clinic at Beloit, Wisconsin. I have taken time away from my practice this morning to voice my support of Beloit Health System's plan to add emergency and inpatient hospital services in nearby Roscoe, Illinois.

As a pediatrician, I see firsthand the challenges our families face with seeking healthcare. A significant portion of my patients rely on Medicaid which often means limited options for care. Without a hospital in Roscoe, residents must find transportation to Rockford. This impacts not just the quality of care but also the health outcomes of our children.

Imagine patients rushing their sick child to the ER only to find it filled to capacity, or struggling to find transportation. This reality -- this is a reality for far too many families. A new hospital would alleviate this burden, provide a timely comprehensive care right in the community.

Moreover, a hospital would allow Beloit Health

System to expand our services. We could offer specialized pediatric care, mental health support that addresses the unique needs of our patients, including our Medicaid population. This is not just about treating illness. It is about fostering a healthier future for our children.

Investing in the new hospital means investing in our community's well-being. It is about ensuring that every child, regardless of their health insurance status, has the access to the quality care that they deserve. I urge you all to support the establishment of a new hospital.

Together we can create a healthier environment for our children and move toward the future where no family has to face the barriers of care that so many unfortunately do today. Thank you.

MS. SCACE: My name is Kim Scace, K-i-m, S-c-a-c-e. And I am here to read State Senator Andrew Chesney's comments. As the State Senator representing the 45th District, I wholeheartedly endorse the NorthPointe Neighborhood Hospital project, and ask the Illinois Health Facilities and Services Review Board members to vote in favor of the project.

This initiative is not merely a proposal. It is a vital step towards healthcare's accessibility and quality for our community. My Senate District is home to over 200,000 residents, many of whom reside along the state line. They deserve a healthcare system that matches their needs and aspirations.

As both a public servant and a small business owner, I understand the critical importance of ensuring safety for our community, fostering economic development, promoting consumer choice, and maintaining a competitive market.

It is crucial to recognize the competition in healthcare is not a future prospect. It is our present reality. The NorthPointe Health and Wellness Campus, operational since 2007, has been providing essential care and specialized services to Illinoisans for years. The proposed expansion to include emergency services and inpatient beds is a logical and necessary progression.

The NorthPointe Neighborhood Hospital project represents a crucial opportunity to enhance healthcare access, stimulate economic growth, and meet the express needs of our community. I implore all stakeholders to support this initiative which promises to deliver improved health outcomes and economic benefits to the

45th Senate District and beyond.

Let's embrace progress and ensure that our healthcare system evolves to serve all Illinoisans efficiently.

MR. KLEIN: My name is Ken Klein. K-e-n, K-l-e-i-n.

Good morning. I am Dr. Ken Klein, board certified nonsurgical orthopedist with over 30 years at this health system where I also serve on the Board of Directors.

I fully support the establishment of the NorthPointe Neighborhood Hospital and the benefits it will bring to the Stateline community. At the Beloit Health System, we prioritize treating each patient like family and delivering exceptional care.

Over the years, we have developed a comprehensive orthopedic and sports medicine program that includes evaluation, diagnosis, integrated treatment, therapy, and surgical care.

Our pain management strategy guided by federal studies emphasizes a multi-faceted approach focusing on mood management, physical therapy, yoga, and meditation while minimizing opioid use and opting for minimally invasive surgeries.

The NorthPointe Neighborhood Hospital represents a significant investment in our community, enabling low-acuity inpatient services closer to home. This will reduce travel times for families, facilitating their involvement in patient care which is vital for recovery.

Additionally, the hospital will enhance primary care access to the Stateline area and address challenges related to timely care. It will also support physician recruitment, provide access to advanced technology, and foster collaboration among medical disciplines.

Finally, a full service emergency department will ease the strain on our current emergency services in Beloit, offering local options for Illinois patients, eliminating the need to travel to Wisconsin or elsewhere for emergency care.

For these reasons, I enthusiastically endorse the NorthPointe Neighborhood Hospital. Thank you.

MR. CABELLO: Good morning. My name is John Cabello. I'm a State Representative of the 90th District. I'll try to keep my comments short. They said I had two hours.

So I have a unique perspective. I had a

speech wrote out, but I just want to talk to you from the heart. So I've been a police officer in the region for over 30 years. So I've seen a very unique perspective of what goes on with the three major hospitals we have in town. All three are great. All three provide unbelievable services. The problem is there's not enough of them.

We have so much going on within our region. When you go to the ER, you unfortunately have to go to the ER, you are waiting for hours. Hours upon hours. When I had my mother go to the ER, she was transported by ambulance. Then they moved her into the waiting room. I drove from Springfield to Rockford, and she had just gotten into a room. That is three hours. She passed away shortly after.

So we need to make sure that we are doing things in a different way. I can tell you that I spoke to a police officer that had just gone to the ER in uniform at Rockford hospitals. The ERs were so far backed up, she went to the emergency facility in Roscoe where she waited two hours.

Two hours in uniform. Not that that means she should get ahead of anybody. Two hours at a 10-bed facility. Once in that facility, Dr. Pine was

unbelievably rude. She will be more than willing to speak to anybody that wants to hear about this.

So we have the opportunity of helping our citizens. We have the opportunity of making sure that they are safe and will be transferred if necessary to another facility. But we need to do what is right.

I serve Mercy. That is in my district. And I serve NorthPointe. There's enough for everybody to go around.

CHAIRWOMAN SAVAGE: Thank you. Thank you.

MR. JONES: Our next five presenters are Senator Dave Syverson, Javon Bea, Jordan Powell, Karen Harris, and David Gross.

MR. BEA: Javon Bea. J-a-v-o-n, last name B-e-a.

Good morning, Chairperson Savage, Members of the Board. I'm President and CEO of Mercyhealth. I'm here to express Mercy's great concerns about the Beloit application to request this Board to allow them to take advantage of unsuspecting sick patients in a town of 11,000 people by calling their NorthPointe facility a hospital.

When the state calls an entity a hospital, the public believes it is safe to go there with serious conditions such as heart attacks, strokes, appendicitis,

and other emergent episodes. Beloit Health System in their application only promises to increase primary care besides the typical ED docs. They say they will attempt to partner with neurologists and orthopedists.

Their application has no mention of having a general surgeon or a cardiologist available on the site, which are needed for very common conditions that come into a real hospital.

Once an entity is called a hospital, the public expects a higher level of service that Beloit Memorial will not be able to provide at its Roscoe hospital if it's allowed to be called that.

There are already seven hospitals, four of which are major trauma centers in the 17-mile radius that Beloit says they are going to capture patients from. And there's no justification in their application for capturing patients from a 17-mile radius.

The reality which really is occurring here is that we have a Wisconsin-based health system that wants to cross the Illinois border to go into a very high commercial area serving Roscoe and Rockton and cherry-pick high affluent patients. The average income in Roscoe and Rockton is over $111,000 a year compared to Rockford's average income of $54,000 a year. And

they are more than happy to leave all the charity care and uninsured for us in Rockford while they cherry-pick the high affluent area.

They are also going to tell you that Mercyhealth was allowed to build a small format hospital, meaning under 100 beds in Crystal Lake, Illinois. What they are not going to tell you is it was to serve 110,000 people, not 11,000 people, and that we added a large multi-specialty clinic with 17 specialties on-site to take care of the patients coming into the hospital. Thank you.

CHAIRWOMAN SAVAGE: Thank you.

MR. SYVERSON: Good morning. Senator David Syverson, S-y-v-e-r-s-o-n. Thank you Madam Chairman, Members of the Committee. I served as the ranking member on the Senate Health and Human Services committee and public health committees, and I cochair the bipartisan Medicaid working group. In this position I work closely with Illinois's Health Systems.

And I'm not telling you anything that you've not heard before, but hospitals are struggling. Inflation hits hospital and healthcare differently than other businesses. Labor, supplies, medicine, food, insurance, all going up. But unlike other businesses,

health systems cannot raise their fees.

Compounding the problem, especially in this Winnebago County area, is that health systems are seeing a payer mix shift to more Medicaid, uninsured, noncitizens, and seniors choosing to use advantage plans. Illinois hospitals are struggling, and that is why I have concerns with this proposal.

The first concern is this Board is being asked to allow an out-of-state hospital to build in a part of Winnebago County that has an ideal payer mix. Heavy private insurance and little Medicaid or uninsured. That will result in the three existing health systems already in the county who are already struggling to have their payer mix get dramatically worse.

Second, as a State, because of the legal precedent you would be setting here today, we will be opening the flood gates of applications from out-of-state health systems coming into Illinois cherry picking the best mix areas to build in.

This was the whole reason we created this Board was to prevent overbuilding and to cherry-pick of mixes. That is why you see legislators and letters of support from across the state from both parties urging this Board not to go down this path.

Thank you very much for your time. I appreciate it.

CHAIRWOMAN SAVAGE: Thank you.

MS. HARRIS: Karen Harris. K-a-r-e-n, H-a-r-r-i-s. Good morning Chairman Savage and Board Members. I'm Karen Harris, the general counsel for the Illinois Health and Hospital Association.

I'm here with my colleagues today to speak on behalf of our 200 members in opposition to NorthPointe Neighborhood Hospital, project 24-018. We believe the small-format hospital project will have a harmful effect on the existing community hospitals providing central healthcare services to a medically underserved community in surrounding areas. And we have serious concerns about the entrance of an out-of-state provider with a hospital that is not meant to be sustainable on its own.

As you're aware, at this time the Health Planning Act and your rules do not take into account the relatively new concept of small-format hospitals. The existing legal and regulatory rulings on small-format hospitals appear mostly to be based largely on level of community support rather than the orderly development of healthcare facilities delivering healthcare services in the state.

IHA and the hospital community are concerned about this inconsistent approach, and have sought the review board's partnership in developing comprehensive regulations around small-format hospitals. Without clear rules, the Board is evaluating two very distinct models of care utilizing one set of standards meant for general acute care hospitals.

The applicant claimed during the August 13 Public Hearing that their proposed project meets IHA's criteria for a small-format hospital, but this is inaccurate. In 2022, IHA submitted recommended minimum criteria for small-format hospitals for this Board's consideration. The applicant does not meet IHA's recommendation, which is that a small-format hospital should be owned and operated by an Illinois-based acute care facility.

Practically speaking, lacking the adoption of rules and regulations for small-format hospitals in Illinois, it is impossible to gauge whether this project will meet any necessary standards. Thank you for your consideration.

MR. GROSS: Madam Chair, Review Board members, my name is Dave Gross, G-r-o-s-s, and I serve as Senior Vice President of Government Relations for IHA.

In addition to the concerns that Karen mentioned around lack of applicable guidelines relating to this type of proposed project, we also believe that this facility would lead to an unnecessary duplication of services in the region.

The applicant indicates the proposed hospital will be serving a 17-mile service area, and that service area as defined by the applicant includes part of Wisconsin, which of course are outside this Board's purview.

Within the Illinois service area there are currently seven hospitals. Two Level 1 trauma centers, one Level 2 trauma center, and eight emergency departments.

The Board's own report shows that there's an excess of 94 med-surg beds in the service region. The three existing health systems are currently providing care in this service area and consistently demonstrated that they are well-equipped to meet the region's healthcare needs.

As a result, we believe the approval of this project will have a negative impact and will further challenge the delivery of healthcare services in the region, while also raising the cost of healthcare since

current outpatient services provided by the applicant will flow to the inpatient acute care setting.

And finally, as mentioned earlier, Illinois faces a critical shortage of healthcare workers, including the Rockford region. And the entrance of an unneeded hospital, that will only aggravate the challenges that the existing health systems face in providing qualified providers to their communities.

It is for these reasons, various reasons that IHA opposes this application.

Madam Chair, thank you.

MR. POWELL: Good morning, Madam Chair, Board members. My name is Jordan Powell. J-o-r-d-a-n, P-o-w-e-l-l. And I'm IHA's Senior Vice President of Health Policy and Finance. And I join my colleagues today in strongly opposing NorthPointe's application.

I think it is important to note that IHA rarely, if ever, testifies against proposals before this Board. But this is an application from an out-of-state entity seeking approval for a model of care that has absolutely no rules or regulations to govern it.

Small-format hospitals are a relatively new concept in Illinois. And as a matter of policy, to approve such a model with no clear rules or regulations

will undermine the entire healthcare ecosystem of this state.

Regarding this specific application, we should all have concerns with an out-of-state entity that is going to serve Illinois patients who are then going to have to travel to Wisconsin to seek higher levels of care. In addition, the owner and the transfer hospital are based in Wisconsin, therefore outside of the purview of this Board and IDPH's licensing requirements.

Essentially the applicant can get up before you today and make promises they know they don't have to keep. And it is clear that the location the applicant has selected it is intended to syphon commercially insured patients while Illinois hospitals will continue to serve the most vulnerable patients within their community. This ultimately jeopardizes services provided by the established hospitals in this region, putting access to patient care at risk.

So again, this is a new concept of care. New care delivery. Absolutely no rules or regulations from an out-of-state entity. Approving this application at this time is premature.

So for those reasons and those cited earlier by my colleagues, we strongly urge you to deny

NorthPointe's application. Thank you.

CHAIRWOMAN SAVAGE: Thank you.

MR. JONES: The next five individuals are Deputy Chief Justin Jobst, Mayor John Peterson, Roscoe Village President Carol Gustafson, Chief Sam Holly, and Courtney Avery.

CHAIRWOMAN SAVAGE: You can go ahead.

MS. GUSTAFSON: Thank you. Good morning. My name is Carol Gustafson, C-a-r-o-l, G-u-s-t-a-f-s-o-n. I'm the Village President, Village of Roscoe. I've been involved in local governments for over 10 years as Village Trustee and now as Village President.

Roscoe is a thriving community in northern Illinois having nearly doubled in population over the last 20 years, now exceeding 11,000 residents. Our community's growth has created an urgent need for enhanced and accessible healthcare services.

The proposed expansion of NorthPointe Neighborhood Hospital is a critical step in addressing this need. This project not only fills vital gaps in emergency care and primary care access as identified in the 2023 community health needs assessment, but also alleviates bed utilization issues in the region.

The village of Roscoe's residential and

commercial areas stretch west to Old River Road, east beyond I-90, north almost to Wisconsin state line, and south to Machesney Park. One of the most significant advantages of this expansion is that it will enable village residents to receive their healthcare locally within Illinois without the need to leave the state for Wisconsin or travel south to the congested and overburdened hospitals in Rockford.

The creation of the NorthPointe Neighborhood Hospital will ensure that residents from all corners of our community and our region can access timely and convenient care right here at home. This is essential for their health and overall well-being.

I heard this morning from the opposition two main concerns. Fear of competition, and the fear that a 10-bed hospital will exacerbate their financial condition. What it will do is alleviate anxiety such as I felt the first weekend in September, Labor Day weekend. My husband was taken critically ill. I had to spend 25 minutes going to a Rockford hospital, chose the wrong one. Blood draws done in hospital. Waiting -- waiting in the hallway, six hours in the emergency room.

Our support of this hospital will bring economic growth to our area, jobs, and it will get

people timely healthcare. Thank you.

CHAIRWOMAN SAVAGE: Thank you.

MR. PETERSON: Good morning. My name is John Peterson. J-o-h-n, P-e-t-e-r-s-o-n, and I'm the mayor of Rockton, Illinois.

I am speaking in support of the NorthPointe Neighborhood Hospital proposal before you, including adding an emergency room because I think it is in the best interest of the residents of Rockton that I represent, as well as the Stateline community region.

For me to have to come and support the health and safety of our residents in Rockton, we have responsive, excellent emergency responders. We know that ambulance transport times in the region can range from 15 to 25 minutes. Every minute counts.

And it is not hard to think about the amount of time making a huge difference. Having an emergency room in the community will shorten those times, insuring prompt intervention, thereby increasing the patient's chance of survival.

Ambulances transporting patients to a facility close to home will ensure the ambulance will come promptly back in service and ready to answer the next call when Rockton residents are in need. Supporting the

small-format neighborhood hospital here in our neighboring region is the right call to make for public safety.

On a personal level, I'm a realtor, husband, father, diabetic, two-time COVID survivor, and an active community member. And I am a longtime Rockton Lyons Club member and active volunteer in Rockton. I've worked in Rockton. It is a place for visitors, business owners, and entrepreneurs. People enjoy being here, and we have a strong community worthy of further development and support.

Right now the NorthPointe Health are great resources for families in town to get access to many types of care. From mothers bringing their babies into the world, to seniors enjoying their golden years in senior living.

I have heard many Rockton residents who appreciate having NorthPointe here to serve them. NorthPointe has proven it can deliver the care that people need and want. And if our area is short of physicians, we should help prevent people having to drive out of the area.

The bottom line is having a neighborhood hospital will help Rockton residents. Thank you very

much for your time. I really appreciate it.

CHAIRWOMAN SAVAGE: Thank you.

MS. AVERY: Good morning. First I would like to thank you for your time. My name is Courtney Avery. C-o-u-r-t-n-e-y, A-v-e-r-y. And for a combined 15 years I've served as a member of this esteemed Board, and then as an agency administrator. I am proud. My work with the Board helped to ensure access to quality healthcare and to address community needs in this state.

I am here before you today to encourage approval of the NorthPointe Neighborhood Hospital. A non-profit provider requests to add inpatient and emergency services on this existing Roscoe campus.

During my tenure with the Board, Mercyhealth, an opponent of the CON, was granted approval to build a small-format hospital in Crystal Lake. Through the CON process, it was made clear that a small-format hospital makes sense despite outdated dated rules pertaining to the 100-bed requirement. This resulted in a negative finding in the State Board's Staff Report.

As you are aware, Illinois courts have also been explicit that the role of this Board is not to maintain the market share providers. Therefore, you have the discretion to approve this project which will

stem out-migration of Illinois patients to Wisconsin. And with a relatively small footprint, it will not threaten the much larger health systems that operate in the Stateline community, but in Rockford.

Those systems which together are opposed to this project have a combined revenue of approximately $5.2 billion. Relative to the bed need, the bed availability figure is not accurate. 22 of the beds are for pediatric care, and they are largely used with practitioners sending children in the need of advanced pediatric care programs in Madison, Wisconsin, Milwaukee, and Peoria where health systems operate specialized children's programs.

There are another 34 beds, which your data are completely unused at the satellite hospital in Belvidere. When you examine the data, a small-format hospital in affiliation with a nearby hospital will have a negligible impact on other areas.

It is one thing to be wary of a not-for-profit health system, but it is important that we have a level playing field to attract services for non-profit hospitals operating close to the state border.

Again, I ask that you -- humbly ask that you focus on this and approve this project. Thank you.

CHAIRWOMAN SAVAGE: Thank you.

MR. HAWLEY: Good morning. My name is Chief Samuel Hawley, S-a-m-u-e-l, H-a-w-l-e-y. Thank you for your time this morning, Ms. Chairwoman and all members of this Board.

My name is Sam Hawley. I'm the Chief of Police for the Roscoe Police Department. I'm here this morning to offer my full support for the NorthPointe Neighborhood Hospital project, as it will greatly benefit our community by enhancing access to healthcare and supporting economic growth.

Most importantly, an established emergency room in Roscoe would address a gap in healthcare service in this area. As a police officer, I'm all too aware that a matter of seconds can make the difference between life and death during an emergency.

Today folks must travel to Rockford to receive life-saving interventions, even during those time-sensitive situations. With this in mind, I have no doubt that the addition of the emergency and inpatient services on the NorthPointe Health and Wellness campus will save lives and have a positive impact on the overall well-being of our citizens.

I'm also confident that this development will

contribute positively to our local economy, creating job opportunities and stimulating economic growth. As the area continues to increase in population, having a local hospital will serve as an immensely valuable resource for our police and fire department personnel, as well as help fortify critical infrastructure.

We are excited to see the positive changes that this development will bring to our community, and we fully endorse this initiative. The Roscoe Police Department will stand behind by Beloit Health System in its efforts to provide quality healthcare services to our residents.

We look forward to our continued partnership with NorthPointe Health and Wellness in serving our community. Thank you very much for your time.

MR. JOBST: Good morning, Board. Thank you for having us here today. My name is Justin Jobst. That is spelled J-o-b-s-t. I am the Deputy Chief of the Rockton Police Department.

I have served for over 20 years after serving this country in the U.S. Navy. Rockton is the neighboring town up-river from Roscoe. I know I'm among many Stateline community residents who enthusiastically support plans for a NorthPointe Neighborhood Hospital.

Over time, I have led the department in DUI arrests and received several certificates of appreciation for DUI and intoxicated motorists. I have also received a Hero award from Mothers Against Drunk Driving. Stopping people who drive under the influence of drugs and alcohol and taking them off the road and sending them to treatment when possible is a step toward reducing the people who require hospitalization for accidents with impaired drivers.

When we arrest a driver who is suspected of driving while impaired, officers often find themselves needing to go to the hospital emergency department for blood tests to run blood-alcohol content, or the presence of drugs.

These duties take us well away from our district because the testing cannot be performed at the police department and because there is not a nearby hospital. We also deal with suspects who have physical or medical issues and must be seen by a licensed physician and medically cleared prior to taking them to jail.

Again, we are usually forced to travel to Rockford. The testing is relatively simple, but cannot be delayed. Depending on the circumstances, these

hospital trips can take more than two hours, which is two hours away from our policing work.

Having an emergency department in Roscoe will reduce the travel time and keep our officers on the streets in their respective cities and village. Again, I want to thank you for your time. And please approve NorthPointe Neighborhood Hospital.

CHAIRWOMAN SAVAGE: Thank you.

MR. JONES: Our next five presenters are August Querciagrossa, Jeni Hellatt, Natalie Manley, Michelle Pankow, and Greg Schwarze.

MR. QUERCIAGROSSA: Good morning Chairperson Savage and Board members. I am August Querciagrossa, A-u-g-u-s-t, Q-u-e-r-c-i-a-g-r-o-s-s-a. I serve as the Regional CEO for OSF Healthcare, and I support, represent OSF St. Anthony Medical Center in Rockford and our surrounding communities. I'm here to address the critical issues surrounding the proposed NorthPointe Neighborhood Hospital by Beloit Health System in Winnebago County.

Our region, as you've heard already and confirmed by the Illinois Department of Public Health, has excess med-surg beds, sufficient emergency services including nine emergency rooms, emergency departments,

and several urgent cares within a 17-mile radius.

Adding another hospital in this area will create an unnecessary duplication of services resulting in increased healthcare costs, and there will be no corresponding improvement in patient care. Moreover, the proposed facility lacks secondary tertiary services essential for comprehensive emergency care, which poses risks to patient safety and causing delays in critical treatment.

From a financial perspective, the Board has already heard that directing insured patients out of state to Wisconsin undermines our Illinois providers, including St. Anthony Medical Center. This is impacting our ability to sustain programs that support Illinois patients and programs.

The loss of insured patients also threatens our mission of charitable services which relies on the financial stability to provide care to the marginalized and underserved populations. This project will reduce our capacity to serve in those in-need areas, as we are already financially stretched to provide high-quality, charitable healthcare.

Additionally, our region faces significant workforce shortages. And introducing another hospital

will strain that ability to recruit and retain our clinical staff, and risking further inefficiencies and gaps in care. Instead of expanding in a saturated market, we would prioritize strengthening our current healthcare infrastructure and ensuring the effective and equitable care to Illinois residents.

I respectfully urge the Board to consider the implication of this project. Thank you.

MS. MANLEY: Good morning. Can you hear me?

CHAIRWOMAN SAVAGE: Yes.

MS. MANLEY: Good morning. My name is State Representative Natalie Manley. Welcome to the 98th District State of Illinois where it is always 82 degrees on October 29th.

I am the Deputy Majority Leader in the Illinois House of Representatives, and also the Chairwoman for the Healthcare Access and Availability Committee.

Given my experience on the Healthcare Access and Availability Committee, I'm here to express my opposition to the Wisconsin-based Beloit Health System proposed NorthPointe Hospital.

Without a diverse payer mix, these facilities are often unable to offset the cost of pivotal care that

they provide to our most vulnerable populations. And I am extremely familiar with the need for safety net hospitals.

Beloit Health system has made no secret of their intention to facilitate transfer of the patients who arrive at Roscoe, Illinois to relocate to Beloit, Wisconsin. This practice will serve only to redirect the commercial payer mix associated with more the affluent community residing in Roscoe out of Illinois and into Wisconsin. However, the effect of this practice will have great consequences.

The redirection of these patients will deprive the existing hospitals in the area of the ability to offset the cost of care delivery to those underserved patients in those communities who need it most.

I fear that if existing facilities see extreme changes to their patient payer mix, we face a real risk these higher acuity safety net providers could be forced to close programs and possibly the facilities so many people rely on.

I worry too that this model will be duplicative like other state facilities, further draining the financial resources needed by healthcare providers to fund a vital safety net of services they

provide. If Roscoe was located in a healthcare desert, I could understand why there would be a need for this. But everything I have learned about this application points that there is no need for another hospital in the area. As such, I urge the Board to oppose this project, and I thank you for your consideration.

MR. SCHWARZE: Good morning. My name is Greg Schwarze. G-r-e-g, S-c-h-w-a-r-z-e. I am here today on behalf of Deb Conroy, the Chair of DuPage County Board and former Chair of the Illinois House Mental Health Committee.

I am a member of the DuPage County Board where I serve as Chair of our Human Services Committee. I served over 28 years as a firefighter-paramedic, and I am a longtime resident of DuPage County.

I am here to express our opposition to Beloit Health System, Inc.'s proposed NorthPointe Neighborhood Hospital. Securing the continued viability of our existing hospital providers and their ability to offer safety net services should be of the utmost importance to the Board.

These institutions provide a vital service to our community's most vulnerable populations by ensuring they have access to needed medical care. For mental

health, behavioral health, and substance abuse services, to full-spectrum primary care that can help identify and address social determinants of health, these institutions serve healthcare needs with services that are often poorly reimbursed, if at all.

As such, I'm deeply concerned about the impact of the proposed hospital on the existing healthcare system in northern Illinois. Beloit Health System proposes to create a hospital campus in a community that does not need an additional hospital.

To allow the creation of a new hospital in Roscoe raises the real risk of destabilizing the payer mix that existing facilities rely upon to offset lower or no reimbursement received for the care they provide to our vulnerable populations.

The proposed hospital will disrupt the payer mix for the hospitals that already exist in Illinois and route these funds to Wisconsin. As such, the existing facilities run the risk of seeing the commercial payer mix that offsets the loss they incur in providing safety net services to drop precipitously.

The outcome of this destabilization is a very real risk. Services or locations will be forced to close, and the patients that rely upon them are left

without the care they need. I urge the review board to oppose the proposed NorthPointe Neighborhood Hospital, as this project will redirect the resources needed by our existing hospitals to support our local communities.

Thank you for your consideration.

MS. PANKOW: Good morning, Madam Chairwoman and Board. My name is Michelle Pankow, M-i-c-h-e-l-l-e, P-a-n-k-o-w, and I'm here today as the Fire Chief of the Rockford Fire Department and also representing the office of the City of Rockford Mayor Tom McNamara in opposition to the proposed NorthPointe Neighborhood Hospital in Roscoe, Illinois.

I have served my community, the Rockford community for the past 32 years. This is a community that is only 11 miles from Roscoe and is incredibly blessed with exceptional healthcare services. It is the only city of its size in Illinois that has three trauma centers, all of which are easily accessible for the Roscoe community. And as such, we have highly-trained specialists offering world class care to our community.

Our hospitals also provide vital safety net services to our community. UW Health is one of the few facilities offering inpatient mental healthcare services, and the only one that does so within the

proposed service area.

As this Board knows, the availability of inpatient mental healthcare services is of the utmost importance, and we need to protect those institutions that provide this needed service.

Additionally, the existing hospitals in Rockford provide much-needed medical care to low income and underinsured patients in our community.

And in 2022, the three hospitals in Rockford alone provided $17.9 million in free or charitable care and provided over $217 million in care to the Illinois Medicaid recipients according to the Board's records.

These figures represent real commitment to our communities most in danger. And I'm grateful to these institutions for working with the mayor's office and the Rockford Fire Department to ensure access to care.

The proposed NorthPointe Hospital threatens to weaken the healthcare services offered in the service area by selecting and choosing patients of higher income from Roscoe and Rockton.

I strongly urge you to oppose the establishment of the proposed small hospital in Roscoe, and instead protect existing facilities that are meeting the true needs of our community.

Thank you for your time.

MS. HELLATT: Good morning. My name is Jeni Hellatt, J-e-n-i, H-e-l-l-a-t-t, and I'm a vice president with Mercyhealth. Thank you very much for giving me an opportunity today to express my opposition for the NorthPointe Hospital.

I'd like to bring your attention to the map in reference to the service area that this so-called neighborhood hospital is expected to serve based on Beloit Health System's application. You can see that it is hard to see because there's a lot of different facilities there as indicated by NorthPointe. But NorthPointe is in the middle.

And this is their 17-mile capture radius. It goes all the way down to the I-90/39 Interchange and all the way up to the north side of Janesville, Wisconsin. And in this area, it has already been mentioned there are seven hospitals, including two Level 1 trauma centers.

So imagine if you took your family to Hurricane Harbor which is within the 17-mile radius on the south side of the radius, and your child started to get severe stomach pains. Not bad enough to call 911, but bad enough that you want to get your child checked

out.

Would you drive past three emergency departments, three hospitals, two of which are trauma centers, to go to the Roscoe Neighborhood Hospital? Beloit Health thinks you are gullible enough to think you would. In this 17-mile radius, there are 22 emergency rooms and urgent cares that already are meeting the existing demand of the population.

In their own application, it is stated that NorthPointe currently serves about 27 patients per day in their urgent care, which is based on their hours of operation is about two patients an hour.

So based on this, they have capacity. And as to the other urgent cares and emergency departments in area, and having just two patients in their urgent care an hour certainly does not justify the need for additional services.

There is no need for this hospital, and we urge the Board to consider the real duplication of services within this application. Thank you.

CHAIRWOMAN SAVAGE: Okay. We are going to take about a five-minute break, and then we'll be back.

(Short break.)

MS. SALAAM: My name is Melissa Salaam,

M-e-l-i-s-s-a, S-a-l-a-a-m. I serve as the Director of Transitional Care in Beloit Health System. My role involves coordinating healthcare services between the hospital and the various facilities including nursing homes, assisted living facilities, and patient homes to ensure seamless continuity of care.

Today I'm here to express my strong support of the establishment of NorthPointe Neighborhood Hospital. The NorthPointe campus, which opened in 2007, offers a wide range of services including NorthPointe Terrace's assisted living facilities that serves numerous residents. However, what the campus currently lacks is a hospital and inpatient emergency room services.

The assisted living facilities are typically residents who are typically frail, often have multiple comorbidities, making them more susceptible to hospitalizations compared to younger patients for similar illnesses.

For example, an elderly patient with a urinary tract infection might require hospitalization to IV antibiotics to monitor for complications such as cellulitis. Sudden onset of confusion, a common complication often necessitates hospital monitoring, especially for patients living alone.

The proposed NorthPointe Hospital will just -- is steps away from the NorthPointe Terrace. This proximity will facilitate the quick transport of residents who require emergency care of hospitalization.

Additionally, it alleviates the burden of families who play a crucial role in patient care, as they are already familiar with the campus and will find it easier to navigate a smaller hospital compared to a large acute care facility.

The establishment of NorthPointe Hospital will significantly improve access to healthcare for residents at NorthPointe Terrace in the broader Stateline community by providing local access to vital medical care including emergency services and lower acuity medical care. The hospital will enhance healthcare outcomes and reduce transit times to emergencies.

I urge the State Board to approve this exceptional project, which will be a tremendous asset to this community. Thank you.

MS. HECOX: Good afternoon. My name is Sharon Hecox. I'm the Executive Director of the Stateline Mass Transit District. Our agency provides affordable, reliable, and safe public transportation service for the residents of the Stateline area of northern Illinois,

and I'm here to express our support to this proposal.

Our transportation services are crucial in ensuring the low income and elderly residents have access to essential medical care at the NorthPointe campus. These services bridge a gap for individuals without reliable transportation, reducing missed appointments, and improving overall health outcomes. By providing these rides, we help mitigate the financial and logistical barriers that often prevent multiple populations from receiving timely medical attention.

Additionally, our transportation services enhance the quality of life for elderly residents by promoting independence and reducing social isolation. These programs are vital for fostering a healthy and more equitable community, and we truly value our partnership with Beloit Health System.

I support the approval of this proposed neighborhood hospital. NorthPointe services focuses on wellness and patient-centered care. By prioritizing preventative care, well-being, and empowering patients to be active participants in their health journey, this provider demonstrates a deep commitment to improving the overall health of the community.

I know many transit-dependent individuals who

use NorthPointe services and do not have access to alternate transportation outside the area. When people need care that is not available locally, it is very taxing for the patients and their families, especially when a hospital stay is required.

Keeping area residents close to home for healthcare will enable patients to remain near their loved ones, making it easier for family members to visit them while in the hospital.

SMT strongly supports the transition of NorthPointe to a hospital facility to meet the needs of the local community. NorthPointe is a strong community supporter. Their presence continues to benefit both local businesses and our riders.

Thank you for your time, and bravo to NorthPointe for seeking real solutions to real world problems.

MS. HOPPES: Good morning. My name is Sonya Hoppes. S-o-n-y-a, last name H-o-p-p-e-s. I will start with saying I have a three and a five year old. So I'm not that nervous. It is just that I have dirty kids.

I want to thank the Board for being here today as well as this room filled with people. I'm the City Administrator for the City of South Beloit. It is that

little town right on that invisible state line.

I want to take a minute to highlight that I'm familiar Rockton and Roscoe are also here in strong support. We don't always all three get along. But we all feel very strongly about this project, and I think that is worth calling out.

We support the creation of the NorthPointe Neighborhood Hospital with emergency room and added surgical needs. We need the specialty care. I deeply care about our city and our region. I want what is best for the people who live in South Beloit, including my parents, my grandparents, my children.

South Beloit has suffered economical hardship with over 12 percent of the population living below the federal poverty limit. 65 percent of our students qualify for free or reduced lunches. It is important to recognize the way that South Beloit is unique.

As a city, we work really hard to ensure that our services are coordinated, local families have access to the resources that they need, while we try to grow and attract even more investment and opportunity. We support this project for helping us reach these goals.

During construction it will provide 50 jobs. After the hospital opens, 30 permanent jobs. Local

opportunities like this are exactly what we wait for.

An important aspect of this project is that the planned hospital will provide 24-hour care to the most vulnerable members of our community. These people lack access and transportation and have difficulty finding someone who can drive them 30 minutes to a Rockford hospital.

Just because we reside near roads and highways does not mean that everyone has the same access and opportunity to travel. Having to travel outside of our area isn't always easy, especially when you don't have access to care. It is difficult when you have a family member who is getting care, or you can't visit or pick them up.

I urge the support of the NorthPointe Hospital. Thank you.

MR. CRUISE: Hello. My name is Keith Cruise. K-e-i-t-h, C-r-u-i-s-e. Yes. My name is Keith Cruise. I'm a resident of the Stateline area, and I'm also a member of the Beloit Health System Foundation Board.

I support this proposal to expand the NorthPointe Health programs as submitted to the Illinois planning agency. Beloit Health System has had a significant and positive impact on healthcare in our

community. As a Foundation Board Member, I reaffirm our commitment to transforming healthcare delivery.

A health system's mission must ensure that everyone has a medical home for comprehensive and personalized care. We pledge significant resources to achieve this, focusing on enhancing facilities and using technology to streamline care coordination. This will improve quality care and reduce service duplication, and this is particularly important in our facility in Illinois which is located in healthcare professional shortage areas.

We are constantly expanding and developing our healthcare team, including primary care physicians, nurses, and care coordinators, while investing in staff training to ensure the highest quality care.

At every opportunity presented, we will strengthen our collaborations with local organizations to address social determinants of health and eliminate care barriers, promoting health equity.

Primary care availability is crucial for good health, helping patients with serious concerns as well as routine checkups. Lack of access burdens our emergency services with routine and preventable conditions.

To that end, we are creating the Gold Primary Care Center named after Dr. Kenneth Gold with a $6.2 million investment to add 10 new primary care providers and to modernize our clinic space. We do this so we can continue to provide improving care and alleviating emergency service burdens. We are investing in primary care.

Thank you for allowing me to present today and to express my unwavering support to Beloit Health System's expansion initiative at the NorthPointe campus. Thank you.

MS. NEIRA: Hello. My name is Virginia Neira, V-i-r-g-i-n-i-a, N-e-i-r-a. I am 83 years old, and I have lived at the NorthPointe Terrace assisted living facility for a little over four years.

NorthPointe Terrace is part of the Beloit Healthcare System, and is located at the NorthPointe Wellness Campus next door to the proposed Neighborhood Hospital site.

I am here to voice my strong support for the NorthPointe Neighborhood Hospital. For me, it is a no-brainer. As I am aging, I worry about having more falls, cardiac episodes, or anything that will require me to be hospitalized. Currently there is an immediate

care next door, but they are not equipped to handle all emergencies, and frequently we need to send our residents to the hospital from immediate care.

I would be so grateful to avoid an additional 20-minute uncomfortable, bumpy ride in an ambulance to get to the nearest hospital. A neighborhood hospital staffed with quality doctors and equipment would mean so much to me. A two-minute trip to the emergency would mean quicker treatment and possibly a better outcome for many of us.

Time is everything. Recently we lost a dear friend. We wonder if a closer hospital could have made a difference. We'll never know. In addition to swift access, the 10-bed hospital would provide a more convenient location for our families to visit and to give us support.

We also know that our Roscoe neighborhood would benefit from the added services and inpatient care. Our NorthPointe Health and Wellness Center already has quality doctors, an array of specialists, physical therapy equipment, pools, and so on. It seems to me to be a logical extension of service at our location, and it would be a wonderful next step for our campus.

The seniors deserve better care. I do, and all of Roscoe does. Thank you for your time.

CHAIRWOMAN SAVAGE: Thank you. And again, if you have prepared comments, if you could give them to our Board Staff.

MR. JONES: Our next individuals are Meaghan Moriarty, Nequita McIntosh, Christopher Shireman, Todd Anderson, and Ladd Udy.

MS. MORIARTY: Good morning. Meaghan Moriarty, M-e-a-g-h-a-n, M-o-r-i-a-r-t-y.

I've been a licensed attorney practicing in healthcare law for 16 years, advising healthcare systems in complying with CMS rules and guidelines including CMS's provider-based rules.

Based on my years of experience, I'm highly sceptical that the proposed NorthPointe Hospital would qualify as a remote location of the Beloit Memorial Hospital campus as proposed in Beloit's application.

Compliance with the provider-based rules is paramount if the hospital wishes to ensure that the partnering location can be considered a part of the hospital. An outcome with significant financial benefit, such as the ability to receive higher reimbursement for outpatient procedures and transporting

patients between hospital locations without charging patients an additional ambulance fee or additional inpatient charges.

Given that this hospital is going to require regular patient transfers to various hospitals including Wisconsin hospitals, this could yield significant increased cost to patients if the location does not qualify.

Whether the location will meet the PB requirements is something that should be clarified before the Board approves a project like this so that the true costs are well understood.

The bases for my concerns are as follows: First, the provider-based rules require that the remote location operate under the same name as the main campus. As it is clear from the Beloit application, the proposed location will not meet this requirement.

Secondly, the rules require remote locations be located in the same state as the main hospital campus unless allowed by the laws in the two adjacent states. I am aware of no law within Illinois that would allow an Illinois hospital to be licensed as a subordinate and integrated to a hospital located in another state.

Finally and third, the proposed location would

be subject to review of its provider-based compliance by CMS's Chicago regional office. This regional office is well-known for its strict compliance approach to provider-based requirements, and there is no guarantee that the Roscoe location will pass muster.

Based on these concerns, I urge the Board to oppose the proposed NorthPointe Neighborhood Hospital. Thank you.

MR. McINTOSH: Good morning. I'm Nikki McIntosh, N-i-k-k-i, M-c-I-n-t-o-s-h. I'm Senior Director and Chief Nursing Officer at Mercyhealth, and I'm here today to speak against the proposed NorthPointe project.

Our community in southern Wisconsin and northern Illinois is fortunate to have plenty of healthcare resources. We already have hospitals that can handle different levels of trauma care, along with over 22 emergency departments and urgent care centers in the area covered by this project.

But even with these resources, healthcare systems everywhere are facing serious challenges. There's a shortage of healthcare professionals, costs are rising, and reimbursement is a constant struggle.

Everyone is working hard to focus on patients and keep things running smoothly in this tough

environment. Adding another facility will only stretch our already limited resources even further. This could mean fewer services, increased strain on patient safety, and more pressure on our overworked healthcare providers.

According to HRSA, the proposed area is not a medically underserved area. Preventing unnecessary duplication of services is key to making sure we are using our resources wisely. We don't need more facilities when the ones we already have are capable and well-staffed to handle a variety of care levels.

Beloit Health System has proposed using their few existing surgeons to staff this new project. Their application does not mention these surgeons being on-site. With so few surgeons and their inability to be on-site, patient care will undoubtedly be delayed.

Beloit Health System is trying to justify the nature of this facility by pointing to their protected daily census numbers. At the same time, they claim that facilities in the Rockford area have seen big drops in patient volume, but they don't explain why.

They selectively use census data from 2018 to 2022 to make their case, but that does not show the whole picture. There are still 94 open medical-surgical

beds available in the area. They are using the drop in census of Mercy Health's Rockton campus, which the Board is already familiar with, to push their agenda for this new hospital.

They argue that because of the Rockton hospital losing patients, there is a need for more immediate care access. I suggest that is simply not true.

This project isn't about it stopping out-migration. It is about capturing specific patient payer populations and bringing them to Wisconsin. It is clear this isn't about what is best for our community. It is about what benefits the Wisconsin-based hospital.

I strongly urge the Board to vote no for the NorthPointe application. Thank you.

MR. SHIREMAN: Good morning. My name is Christopher Shireman. I'm Director of Physician Recruitment of Mercyhealth. S-h-i-r-e-m-a-n.

CHAIRWOMAN SAVAGE: If you can maybe get a little closer to the microphone?

MR. SHIREMAN: There we go. How is that?

My name is Christopher Shireman. I have over 25 years of working with physicians, running practices, and recruiting physicians. When you think emergency

room, what basic specialties come to mind? For me it is a general surgeon for an appendectomy for my child. I think of an orthopedic surgeon for a fractured hip patient. I think of a cardiologist for a patient with a racing heart.

In their application, Beloit Health System states they work with organizations like the Association for Advancing Physicians and Provider Recruitment, Medical Group Management Association, and others to benchmark physician recruitment and retention. They say they have a robust physician recruitment plan that meets the specific needs of the community.

Well, if indeed they are using this data, then they know that we have a current shortage of 64,000 physicians in the United States. We are talking about specialists needed to provide basic emergencies and hospital care. It is no wonder Beloit has no dedicated plans to offer these services at their proposed neighborhood hospital.

Not only are these basic specialties difficult to recruit, but when you can recruit them, it is difficult to make them available on nights and weekends at a specific time when you need them most in an emergency.

According to Becker's, the 10 most challenging physician specialties to recruit are Orthopedic Surgery, Cardiology, and Emergency Medicine.

On average, the AAPR documents that it takes over 220 days to recruit a physician. That is over six months. And that is just the average. This involves reaching out to dozens of physicians, interviews, offers, on-boarding them for their first day.

In many of these specialties there are over 20 opportunities for each physician completing their training. The supplies of physicians is not meeting the demand, and Beloit System is proposing to add to this problem in a community that is already designated as a physician shortage area.

Because of the strain that this proposal would add on successful recruitment of providers to existing facilities, and because of the lack of detail from Beloit Health System on their ability to staff a real hospital and emergency room, I would urge you to deny this project.

MR. UDY: Good morning. My name is Ladd Udy, L-a-d-d, U-d-y. I serve as Vice President for value-based care at Mercyhealth, and I'm here to speak against the proposed NorthPointe project.

It was stated in the initial hearing that this facility would help Beloit Health System to provide patient-centric value-based care. This is a puzzling statement to me for several reasons.

The goals of value-based care are to reduce the cost of care while maintaining or improving quality. So how do you do that? You provide the services to keep patients out of the hospital in the first place, namely primary care.

According to county Health Rankings, Winnebago County shows a ratio of 1420 residents to one primary care provider. The state of Illinois ratio is 1260 to one, and the national is 1330 to one. It is clear the need for more primary care exists.

Having primary care access is not as exciting for the community as getting a new hospital, but it is what most communities need more of, and it is how the lower costs from value-based care are realized. Beloit Health System says they will have primary care, but they don't need to build a new hospital to do that.

Having a small hospital that will mostly have to transfer patients out has no material favorable impact to value-based care outcomes. In fact, due to its lack of comprehensive services, NorthPointe will end

up transferring patients out of state, which actually adds a layer of cost and time. So it does the opposite of what a value-based-care-focused organization would do.

We are fortunate to have a wide range of acute healthcare services quickly accessible to the Roscoe community already. These existing facilities support a comprehensive healthcare system and ensure that people have access to the acute care that they need.

Having another hospital risks diluting the existing acute care infrastructure, will provide no realistic impact on value-based care outcomes, and undermines the stability of existing providers who are dedicated to offering meaningful access to value-based care.

For these reasons, I urge the Board to vote no on this proposal. Thank you.

MR. ANDERSON: Good morning. May name is Todd Anderson, A-n-d-e-r-s-o-n. I'm the Chief Financial Officer of Mercyhealth, and I'm here to speak against this proposed project.

One of the key points in the Board's process is to reduce the unnecessary duplication of services. Our community is better served by having the right

number of properly-staffed and well-designed healthcare facilities like the ones we already have.

Adding another facility that is designed to only serve a small number of Illinois patients by transporting them to Wisconsin only adds a financial strain to the Illinois hospitals. According to public reported dated, Mercyhealth, OSF, UW Swedish American currently care for a significant Medicaid population, representing up to 33 percent of each of our organization's respective activity.

The proposed facility will not provide care to a similar sharing size of Medicaid patients. Instead, it is intended to direct more insurance patients to Wisconsin, thereby reducing the insurance payer reimbursement that existing facilities rely upon to continue to serve our community and a significant Medicaid population.

We already have a health -- a shortage of healthcare workers. Staffing expenses have increased to double-digit rates year-over-year since the start of COVID. This is not news to anybody here today.

Because of this, hospitals may look to short-term staffing agencies to fill the needed gaps. These agency staff members cost hospitals five times

more than similar services from employed healthcare workers.

Building a facility, taking insured patients to Wisconsin, not serving a proportionate share of Medicaid, reducing the insured's payer mix that all of us rely upon, the existing hospitals rely upon in making the current healthcare shortage even worse, will hurt the already fragile stability of Illinois existing hospitals.

For these reasons, I urge you and the Board to vote no on this application. Thank you.

CHAIRWOMAN SAVAGE: I'm sorry. If you could give your prepared remarks to the Board Staff?

MR. JONES: Our next individuals are Jason Nelson, Laura Baluch, Sharon Daily, Kevin Briggs, Zach Brockman, and Zack Bockman.

MR. BRIGGS: So good morning. My name is Kevin Briggs, B-r-i-g-g-s. I'm the Deputy Fire Chief of the Harlem-Roscoe Fire Department. I'm here today in support of Beloit Health System's plan to open a neighborhood hospital with an emergency department here on its Roscoe, Illinois campus, which is in our fire protection district.

Our fire protection district in the region

have seen substantial growth, which has increased the demand for emergency services. As a direct result of this growth, increased call volume and roadway traffic congestion has increased first responder times. Last year alone, we responded to over 3800 calls, with 80 percent of those being EMS.

At any given time, one of our three advanced ALS ambulances can be out of service at a hospital, and it is not uncommon to have all of our ambulances out simultaneously on calls.

Having an emergency department in Roscoe will enhance access to vital community-based emergency services by reducing travel times and keeping our ALS units in the district.

NorthPointe and Beloit Health System already provide valuable health and wellness resources to our community and region. Adding a neighborhood hospital with an emergency department will make our area a safer and healthier place to live.

I strongly encourage this Board to vote to approve the NorthPointe Hospital, as it will greatly reduce ambulance transport times and enhance our fire department's ability to deliver life-saving care in critical situations. Thank you.

MR. NELSON: Good morning. My name is Jason Nelson, J-a-s-o-n, N-e-l-s-o-n. I'm a director at Beloit Health System. I'm here to discuss the NorthPointe Neighborhood Hospital project and why it is a crucial development for Stateline community.

First, I want to express my gratitude to the community representatives and others who are here today to support this project. This proposal has been meticulously crafted to address our community's healthcare needs while ensuring cost-effectiveness. We have taken a prudent approach by adding only 10 beds to the service area, ensuring we meet demand without overextending our resources.

In the context of healthcare delivery in the U.S. post pandemic, the concept of a small-format hospital is not novel. Despite what some detractors, primarily our competition, might suggest, this project is both sensible and necessary for the Illinois communities we serve.

A key advantage to this project is that many required services are already in place. We have existing imaging, laboratory, and pharmacy facilities that we'll seamlessly integrate with the new hospital. This approach allows us to leverage our current

infrastructure, reducing overall costs and implementation time.

Additionally, we plan to convert our existing immediate care center into an emergency department. This conversion maximizes the use of our current facilities while expanding critical emergency services.

Also, we will transfer one operating room from the NorthPointe Surgery Center to the new hospital, optimizing our surgical capabilities without unnecessary duplication.

These strategic decisions demonstrate our commitment to efficient resource allocation and fiscal responsibility. By carefully repurposing existing assets and adding only essential new elements, we ensure that this project will provide maximum value to our community while minimizing financial impact.

Thank you for your time and consideration. I stand with my colleagues in asking the Illinois Health Facilities and Services Review Board to approve this project.

MS. BALUCH: Good morning. My name is Laura Baluch, L-a-u-r-a, B-a-l-u-c-h. I'm a board member and the President of the Stateline Chamber of Commerce, which is the local chamber of commerce for Roscoe,

Illinois. I am here in support of Beloit Health System's proposal to add a small neighborhood hospital to the community.

Roscoe is the fastest growing area in Winnebago County and has grown nearly 75 percent since the year 2000. I fully expect this growth to continue into the future. There's also a larger area around that. Rockton, South Beloit, and other rural areas too that are also growing.

As a partner in an area business, an owner of one and a partner in my law firm as well, I'm thrilled to see the local community doing well and new families moving into town. However, such rapid growth also brings its own challenges, including its strain on our existing healthcare infrastructure.

Local businesses pay special attention to these issues because they can hurt our efforts to recruit valuable employees. We need robust healthcare offerings and other community resources to remain competitive and make our community attractive to those considering relocating from Chicago or other areas in the state.

For potential employees and their families, such infrastructure is of great importance when weighing

their options for relocation. This includes timely access to emergency services, and an in-town hospital; both of which are currently lacking in our community. For this reason, we welcome Beloit Health System and its proposed neighborhood hospital to the area.

The Stateline Chamber of Commerce and my business both fully support the proposed neighborhood hospital and any other efforts to improve access to healthcare services in Roscoe.

I urge this Board to vote in favor of the NorthPointe Neighborhood Hospital. On a personal note, my father is from one of these local area communities. He not so long ago had an emergency issue, and EMT said he had to go to the hospital. He passed away in the ambulance. If he had had this facility there, he would have been 20 minutes closer. It could have saved his life.

MR. BROCKMAN: Good morning. My name is Zach Brockman. First name is Zach, Z-a-c-h. Last name Brockman, B-r-o-c-k-m-a-n.

I'm the President of the Beloit Sky Carp. We are a minor league baseball team located in Beloit and affiliated with the Miami Marlins. Our team is proud to contribute to community development by creating jobs and

attracting tourism. I'm here to express my support for the NorthPointe Neighborhood Hospital.

Our owners, Quint and Rishy Studer, are deeply committed to community-based development and education. They have made significant contributions to enhance health care outcomes, supporting small businesses, and improving urban environments, and advancing early childhood education.

Their dedication to reinvesting profits into the community initiatives through both investment and philanthropy is evident throughout our community. Over the last year, Quint and Rishy have donated over $600,000 to local programs.

Beloit Health System has been an outstanding partner to the Sky Carp, embodying a strong commitment to providing excellent healthcare. Their dedication to maintaining a robust, independent health system is evident through their numerous community initiatives.

The health system hosts events throughout the year to benefit the Stateline community, such as Community Safety Day, which educates children and families on safety practices, and the Pulling for Hospice event, which supports the Beloit Regional Hospice.

Additionally, their annual Pro-Am Golf event and Doves and Diamonds Gala raise funds for healthcare services and celebrate the impactful work of the provider's hospice team.

The proposed expansion of services at the NorthPointe campus aligns perfectly with the health system's mission to deliver comprehensive care to all patients regardless of their financial situation. This initiative is a testament to their unwavering commitment to the community.

Thank you for allowing me the opportunity to support this important plan by being here today. Thank you.

MS. DAILY: Good morning. My name is Sharon Daily. That is S-h-a-r-o-n, D-a-i-l-y. I'm a resident of Rockton and stand with the Stateline community in supporting the plan and development of the NorthPointe Neighborhood Hospital on the Roscoe campus. This campus currently operates a birth center, a fitness center, surgery center, immediate care center, diagnostic facilities, and assisted living facility as well as physician offices.

What we are missing is a small hospital with an overnight stay and a 24/7 emergency department. The

investment is comparably small, but the impact will be extremely positive for the community. As a small hospital, it will strengthen competition while not harming any of the bigger health systems we have heard of today. They haven't brought many services to Roscoe.

A small hospital in Roscoe will provide us with a local alternative for emergency care and less complex inpatient stays. The closest emergency department is at Beloit Memorial Hospital. That program is extremely busy and can have long wait times.

The NorthPointe Neighborhood Hospital emergency department will not only be closer to home, but with a shorter wait time allow patients the ability to return home more quickly as well. Additionally, while the current immediate care center provides excellent treatment, I understand it cannot accept ambulances.

Having an emergency department in Roscoe will reduce ambulance travel times when time is of the essence and allow the ambulance crews to stay in their respective communities to better serve their districts.

For that reason, I fully support the NorthPointe Neighborhood Hospital and urge the Illinois Health Facilities and Service Review Board to approve

this project. Thank you for your time.

CHAIRWOMAN SAVAGE: Thank you. And if you could please give your prepared comments to our Board Staff?

MR. JONES: Our next individuals are Tanya Dworkin, John Dorsey, Christopher Wistrom, Matthew Smetana, Brandon Lieber, and Tyler Killpack.

MR. DORSEY: Good morning. I'm Dr. John Dorsey, D-o-r-s-e-y, and I'm here to speak against the NorthPointe project. I am the Chief Medical Officer of Mercyhealth, the Illinois division, and an internist by specialty with over 40 years of clinical experience, including inpatient hospital work.

Patients that are hospitalized today are very sick. Most healthcare is given as an outpatient. But those that need hospital care need complex care. Even seemingly low-acuity hospitalized patients can decline rapidly and without warning.

When hospitalized, patients need to be at a facility where various specialists are readily available to manage the specific healthcare crisis. Failure to offer such services can be disastrous for the patients and their families.

Given the description in the application for this project, this proposed hospital clearly will be

incapable of offering these absolutely necessary clinical specialties. This proposed limited-service hospital misleads the public about what services are available by calling themselves a hospital.

Patients will believe that they are getting full hospital services. That is simply not the case. Beloit will benefit by transferring, as we have heard, patients to Wisconsin. Appropriate hospitals already exist in Illinois in the proposed service area, offering the full range of services needed for patients at all acuity levels.

As mentioned, I too am acutely aware of nationwide staffing and resource shortages that are effecting healthcare. Recruitment of physician specialists, as you've heard, is not easy. It takes a long time. And even if successful, this facility will not have the capabilities to support these physicians.

This facility will simply be unable to offer the spectrum of care that is needed for a sick, hospitalized patient, and I ask the Board to vote no on this proposal. Thank you.

MR. KILLPACK: Hello, everyone. I'm Tyler Killpack, T-y-l-e-r, K-i-l-l-p-a-c-k. I'm the Vice President of Community Hospitals for Mercyhealth, and

I'd like to share my opposition to the proposed Beloit Health System hospital at NorthPointe.

In my role, I oversee the operations of Mercy Health's Crystal Lake hospital. While this NorthPointe project has been compared to our Crystal Lake facility as a small-format hospital, I believe there are important differences to consider.

First, the Crystal Lake facility was designed to serve about 60,000 residents in that community plus nearly another 93,000 from nearby towns who lacked access to emergency services. That is a much larger population, 150,000, with a greater need. Three times what is being proposed here, serving towns with a combined population of less than 50,000.

Another difference that I would highlight, that Crystal Lake project involved reallocating unused beds from other Mercyhealth locations to the most populous city in the county without increasing the overall number of hospital beds in that planning area.

The Beloit Health System project is not a reallocation of existing beds in the planning area, but is asking to increase the number of beds. Where in fact there's an excess of 94 beds in the B-01 planning area, which suggests we do not need another facility right

now.

Lastly, it is important to understand to the public a hospital is a hospital. And there's an expectation that an emergency room can handle whatever comes through the doors. It is one thing to be small format in terms of the number of hospitals beds, but another to be small format in terms of breadth and depth of specialists.

In Crystal Lake we built a small-format hospital with a large multi-specialty clinic that provides hospital and ER coverage from physicians in over 17 specialties from cardiology, to orthopedic surgery, to vascular surgery on-site 24/7.

In Beloit Health System's case, the small hospital will rely on surgeons and physicians in Wisconsin for coverage instead of in the Roscoe community, and we all know that surgeons cannot operate in two places at once.

The only other small-format hospital approved by this Board was in Quincy, Illinois, which was again a large multi-specialty physician group committed to staffing the only hospital within a 50-mile radius. I encourage you to deny this project.

MS. DWORKIN: My name is Tanya Dworkin. T-a-n-y-a,

D-w-o-r-k-i-n. I'm senior in-house counsel for Mercyhealth speaking in opposition to the NorthPointe project.

Before I began working for hospital systems, I spent 14 years working for the State of Illinois. During those 14 years, I spent five years with the Department of Healthcare and Family Services Office of Inspector General where I oversaw Medicaid providers and ensured their compliance with the Public Aid Code.

I spent another six years with the Department of Public Health where I had regulatory oversight of hospitals.

There are multiple reasons I believe Beloit Health System's proposal must be denied. First, Beloit is proposing to put not just two, but three facilities at the same location. The birthing center, an ASTC, and now a hospital. CMS does not allow this unless each facility has a different post office address, which as we can see from their application is not the case.

Second, if NorthPointe is truly a remote location of Beloit's main hospital in Wisconsin, then it is governed by Wisconsin laws, rules, and regulations, and must be considered a Wisconsin hospital.

Consequently, NorthPointe will not be required

to operate within the guidelines and strictures of Illinois law, and IDPH will have no authority to ensure compliance with Illinois laws and regulations, despite the hospital operating within Illinois borders.

Third, Beloit's attempt to reassure the public that it will comply with IHA's criteria for micro-hospitals is misleading and disingenuous. Not only does IHA not have criteria for micro-hospitals, but even if it did, the State of Illinois has not promulgated any laws setting forth the criteria for micro-hospitals. Consequently, even if IDPH could somehow obtain authority to regulate and oversee a hospital operating under Wisconsin law, it has no ability to enforce non-existing criteria for compliance in the operation of a micro-hospital.

With respect to Medicaid, Beloit tries to argue that building NorthPointe will increase access to healthcare for Medicaid beneficiaries. It made the same argument when it received approval for its ASTC, claiming in its CON application that the Medicaid population served would be 12 percent. In actuality, that percentage is a mere 2.1.

Beloit now claims that NorthPointe Hospital will serve a 10 percent Medicaid population. But if the

past is predictive of the future, the Medicaid population served will be 1.75 percent at best.

I urge you to deny this proposal.

MR. SMETANA: Good morning. My name is Dr. Matt Smetana, S-m-e-t-a-n-a. I am an emergency physician at Mercyhealth, and I serve as the EMS Medical Director for our Rockford-based EMS Resource Hospital. I'm here to express some concerns about the proposed project.

When a hospital is built, people understandably assume it will be a safe place to receive timely care for serious conditions. However, Beloit Health System's application primarily focuses on expanding access to primary care and mentions potential partnerships with orthopedics and neurology.

The proposed facility will not have trauma surgery or cardiology services, nor have they committed to adding these. Patients who come to this hospital in an emergency will not have access to these life-saving services.

As you've heard this morning, ambulances are finite resources. And locally I can say these EMS resources are already stretched thin. One of the central tenants of emergency medical services is getting the right resource to the right place at the right time.

Here, ambulances endeavor to transport patients to the closest appropriate destination. However, without a cardiac cath lab, trauma surgical capabilities, rarely will this proposed facility be the appropriate destination for critical patients to be transported by ambulance.

If a patient does arrive to this proposed hospital with a critical emergency, a transport by ambulance will then be necessary and a required step for patients to receive or reach definitive care.

This extra step for a patient to be transported away from this hospital will certainly lead to a preventable delay in reaching the hospital capable of treating their emergency. Unfortunately, these delays may have serious consequences.

Additionally, when an ambulance is utilized to transport the patient away from this proposed facility, that ambulance will no longer be available for other emergency responders, depleting an already limited resource in this area.

Simply put, emergency care without backup is not comprehensive care. Patients, as well as the EMS system, will be impacted by this facility. As a physician who cares about the well-being of this

community, I strongly urge the Board to consider the implications of this proposal.

MR. LIEBER: Good morning. My name is Brandon Lieber. I'm the System Director of EMS at Mercyhealth, and I'm here to express concerns about the proposed NorthPointe project.

I'm concerned about the perception of what this new community hospital will offer, and the potential disappointment community members may feel when they realize the facility cannot meet their needs.

In an emergency, people expect or deserve to receive comprehensive care close to home. However, if patients arrive at this hospital and must be transferred elsewhere for more advanced care, it could mean not only a delay in treatment but also additional costs at a time when they already are vulnerable and worried.

This creates even more risk when you consider that the proposed hospital will only have one OR, further limiting the ability to meet patient needs in a crisis if there is more than one surgery needed quickly.

As a practicing paramedic, I also have concerns about the negative impact that the proposed hospital will have on surrounding communities and the Fire/EMS providers. In today's practice, EMS

responsibility is to transport patients to the most appropriate facility when transporting patients with significant illness or injury. It is appropriate to deviate from this outlined standard? Is it in the patient's best interest that a community hospital like this may not have the capabilities to care for them and require transfer to one of the numerous, already established regional stroke, STEMI, or trauma centers designated by IDPH? Hospitals can't call 911 to transfer patients to another facility. They have to rely on private ambulance services.

Unlike urgent care centers, hospitals require patients to make arrangements with a private company, raising the question of who covers the cost. This ultimately adds more financial burden on both patients and the community.

I believe the messaging should remain clear and consistent. I'm a firm believer that there are already established local healthcare organizations that provide high-quality care regionally.

As an individual who lives and works in this community, I believe it's essential to ensure that any new healthcare facility should truly meet the needs of the people it serves, especially when time and access to

specialized care can make all the difference.

Thank you for your time and consideration. I urge you to vote no on this proposal.

MR. WISTROM: I don't envy you guys at all. I really don't. You've got a tough job ahead of you. I'm Dr. Christopher Wistrom, W-i-s-t-r-o-m. I'm the Medical Director for Emergency Medicine for Mercyhealth. And I'm the EMS Director on the Wisconsin side of the hospital.

I have some prepared remarks that are superfluous at this point. I have a couple things though that I think could contribute to your knowledge-based perspective. So I've been in emergency services 16, which is getting to be a lot of years now.

But that being said, we have a standard of care in these different communities. And the standard is different, by biography is different. When we talked about denser areas. We had a gentleman up here, one of the first speakers this morning talking about 10, 12, 14-hour wait times and the acceptability of that in these inner-city environments.

As a Level 1 trauma center, comprehensive stroke center, primary receiving cath lab, we have a very high acuity base at our Rockford hospital. True.

We often do have wait times. True. People wait because they can. As we go through that triage process, and we are busy taking care of truly sick folks. Something that we always pay attention to and always try to improve upon, but please rest assured that people aren't waiting because we are playing cards. The resources are being used.

I worry about the micro-hospital meeting the standard of care right in the middle of all of these Level 2, Level 1 trauma centers, that they're not going to be able to have the services necessary to truly support that emergency room.

I have worked in some really small ERs, and I can tell you it takes one sick patient to shut the thing down. And all your resources get devoted to that. Everything else waits. And especially since COVID, we have had a really difficult time transferring people anywhere and from those small hospitals. Not a minute into the bigger facilities. This is going to be a problem for them too, not to mention the resources.

I will leave it at that. I encourage you to really think about the implications in this decision. It is probably not the best idea.

STATE OF ILLINOIS )
) SS:
COUNTY OF C O O K )

I, GINA M. TOMASONE, a Certified Shorthand Reporter of the State of Illinois and Notary Public of the County of Cook, do hereby certify that I caused the proceedings in the above-named cause to be reported in shorthand and that the foregoing is a true, complete, and correct transcript of said proceedings as appears from my stenographic notes so taken and transcribed under my personal direction.

IN WITNESS WHEREOF I do hereunto set my hand and affix my notarial seal at Chicago, Illinois, this day of , 20 .

Gina Tomasone

GINA M. TOMASONE, CSR
C.S.R. License No. 084-003763
Notary Public, Cook County, Illinois

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

EXCERPT REPORT OF PROCEEDINGS VIA VIDEOCONFERENCE
held at the Bolingbrook Golf Course, 2001 Rodeo Drive, Taylor Ballroom, Bolingbrook, Illinois, on October 29, 2024.

BOARD MEMBERS:
CHAIRWOMAN DEBRA SAVAGE
MEMBER REX BUDDE
MEMBER GARY KAATZ
MEMBER DAVID KATZ
MEMBER DAVID FOX
DR. AUDREY TANKSLEY

IDPH STAFF:
MS. BLANCA DOMINGUEZ, LEGAL COUNSEL
MR. DENNIS BEEDLE, IDHS EX-OFFICIO
MR. JOHN P. KNIERY, ADMINISTRATOR
MR. GEORGE ROATE
MR. MICHAEL CONSTANTINO
MR. KENTON TILFORD

(The following was stenographically transcribed from WebEx audio recording.)

MS. SCACCIA: Good morning. My name is Kimberly Scaccia, S-c-a-c-c-i-a.

I am here today in opposition to NorthPointe. I am the vice president at Mercyhealth.

I believe the current request to add another hospital facility in the northern Illinois causes our already limited resources to be spread too thin.

I question whether or not the applicant considered factors such as population, payer mix, adequacy, location in relation to other hospitals, unused capacity of nearby hospitals and proximity to public transportation and highways to ease access to locations.

I believe this proposal is

not about improving care for Illinois residents. It's about attracting wealthier patients and their insurance dollars to Wisconsin.

Beloit Health Systems acknowledges in their application their intent to use this Illinois location to benefit their Wisconsin hospital.

As you heard today, the community already has seven hospitals and 22 emergency rooms and urgent care centers, one of which is a 24/7 urgent care center run by Mercyhealth, all ED physicians.

As you've heard from the EMS service team today, getting the right patient to the right location at the right time is critical.

I'm sure the Board is aware that a hospital cannot call 911

just as Dr. Dorsey mentioned, when a patient who does not realize is that the limitations of this facility has a condition that spirals, where does that leave them? It leaves them in a potentially valuable and critical situation.

If this project moves forward, it will set a bad example for other health systems showing them it's okay to pull Illinois patients and resources out of the state. That is not what is best for the communities and the nation we serve.

I ask the Board to vote no on this proposal.

MS. HOWARD: Kelly Howard, K-e-l-l-y, H-o-w-a-r-d. I am the chief nursing officer for Mercyhealth Hospitals in McHenry County. I am here to oppose this project.

At Mercyhealth Crystal Lake Hospital we offer comprehensive care with a highly skilled team of specialists, advanced technology and multiple operating rooms to serve a diverse range of patients.

Our state of the art emergency department is fully equipped to handle everything from minor injuries to life threatening emergencies, and we provide same day appointments for preventative care, diagnostics, surgery and rehabilitation all under one roof.

We also offer advanced procedures that patients would otherwise have to travel to Chicago or Madison, Wisconsin, to receive; for example, laser ablation of the prostate and bone anchored implants are both advance procedures that we currently offer to patients without the need to transfer to a major city.

In contrast, the proposed Beloit Health system facility lacks many critical services. Beloit's application mentions potential expansion in primary care and discusses about partnerships in orthopedic and neurology, but fall short in essential areas.

They offer no general surgery or cardiology, and patients who arrive at this facility in an emergency will likely need to be transferred for more specialized care.

This adds unnecessary delays and cost when existing hospitals like ours already provide comprehensive services close to home.

As an operating room nurse with over 15 years of experience, I have concerns about the NorthPointe project's proposal to

offer an emergency department without a safe way to handle emergent surgeries.

At our Crystal Lake hospital, we have four operating rooms with one of them available for emergent cases that may occur through our emergency department. This is essential.

When you only have one operating room, if you have a surgery already in place, there is no where for that emergent surgical patient to be cared for.

NorthPointe will not be able to offer an available operating room for emergencies with just one proposed for the entire hospital.

I urge the Board to consider this gap in services and vote against this proposal. Thank you.

MS. BENNING: Hi. My name is Joanna Benning, J-o-a-n-n-a, B-e-n-n-i-n-g. I am the vice

president of support operations and construction for Mercyhealth and I am here to oppose this project.

This Board has approved two small format hospital projects and you just heard why the Beloit facility has very different service offerings and the circumstances are very different than what is in consideration today.

The only other small format hospital group was in Quincy, Illinois, and the circumstances there were very different, in that Quincy was the sole community hospital and was the only hospital in a 50-mile radius.

The applicants for Quincy were an existing Illinois based large multispecialty group of physicians, not an out of state hospital health system.

Similar to what was just stated, we at Crystal Lake Hospital, Mercyhealth's Crystal Lake Hospital have a multispecialty group of physicians.

There were some similarities. The QMG applicants were also approved for a birthing center and an ASC near their proposed hospital. But importantly, the Quincy hospital was going to offer OB/GYN care in conjunction with the birthing center and would not be transferring patients out of state, and the Quincy ASC was able to document an historical patient faith to justify that facility, unlike Beloit, who proposed to perform a wide variety of procedures several years ago only to never do it.

The Quincy hospital was

going to have twice as many medical surgical beds, three operating rooms, one procedure room, an emergency room and 13 bays to treat patients.

The project before you proposes a fraction of the services that the Quincy Hospital will offer, highlighting just how ill equipped and, importantly, unnecessary that project is.

The applicants want this Board to believe this project should be approved because this Board has already approved two other small format hospitals, but those projects were different than this one, and your process requires you to evaluate each project before you on its own merits.

Please oppose this project.

DR. REMEDIOS: Hello. My name is Kimberly Remedios. I am a

board-certified neonatologist and a board-certified pediatrician. I'm medical director of the neonatal ICU at Mercyhealth Javon Bea Hospital. I'm here to oppose this project.

I'm sorry. I forgot to spell my name. Kimberly, K-i-m-b-e-r-l-y, R-e-m-e-d-i-o-s, Remedios.

The NorthPointe birthing center was licensed in January 2024, and the Beloit Health System projected over 400 births per year, with 96 births in the first year alone.

However, the recent community listing event from September 16, 2024, BHS admitted that only 13 births had occurred in the center thus far. This is 13 percent of what they initially predicted and 3 percent of the volume they claimed the facility

would reach.

The Beloit Health System now suggests that a nearby hospital would be essential in case of complications at the birthing center. This contradicts their original plan which promised an out of hospital experience for low risk pregnancies.

It also raises concerns about the safety of the care and whether a birthing center is essential especially given the low patient volume.

Furthermore, Beloit Health System does not explain how many births will require emergency transfer to their hospital in Wisconsin which follows the same transfer plan for this proposed neighborhood hospital.

As a neonatologist, I have experienced many low risk pregnancies that meet with

unexpected complications during delivery. When these complications cannot be quickly and properly resolved, otherwise healthy babies have suffered serious consequences.

In many cases, the availability of high level specialized neonatal care determines the fate of the compromised newborn.

The proposal of emergency transfer to a neighborhood hospital which lacks the capability to care for such birth complications is not in the baby's best interest. Indeed, the state has gone through great lengths to designate the uncertified providers with the levels of advanced care that they are able to deliver. In short, the state's effort to ensure citizens' access to high quality advanced care to

the mothers and newborn should not be compromised by desires for economic expansion.

I'm deeply concerned that this expansion of a hospital will put mothers and babies at risk. I urge the Board to vote no.

MR. CRANLEY: Good morning, Madam Chairwoman, members of the Board. My name is Patrick, usual spelling, Cranley, C-r-a-n-l-e-y, and I'm here to oppose the NorthPointe project.

More than a dozen elected officials, including the majority of the Illinois House and Senate members who represent this area have written to this Board to oppose this project. These public servants, members of both parties, recognize that this facility does not serve the community interests.

These elected officials would be Illinois State Senators

Dave Syverson, Doris Turner and Steve Stadelman; Illinois State Representatives Jehan Gordon-Booth, Adam (inaudible), Kam Buckner, Jay Buckman, Dave Vella, and Maurice West; DuPage County Chair Pat Conroy, Boone County Chair Rodney Riley, Rockford Mayor Tom McNamara and Rockford Alderman, Kevin Frost. In addition, Loves Park mayor, the neighboring municipality, Greg Jury is opposed, as is former U.S. representative and Illinois State Senator Glen Poshard.

This project transparently targets an affluent community like Roscoe only to transfer commercially insured patients to Beloit Memorial Hospital in Wisconsin for a level care that is routinely provided by community hospitals in Illinois, including all the existing facilities in the

Rockford area, but this facility cannot buy that level of care.

This will mislead patients and impose burdens on the remaining Illinois hospitals to form higher Medicare patient volumes and shift valuable funds out of state undermining our local communities.

NorthPointe already offers urgent care, a birthing center and ambulatory service. Licensing this facility as a hospital without adding any additional services will misstate to the public about its capabilities.

This Board protects Illinois consumers through costs imposed by unnecessary duplication of services and makes sure that the facilities are capable of meeting the public's ordinary and reasonable expectations. All of the elected officials agree with

the projects fails on both of those.

MR. SILBERMAN: Madam Chair and members of the Board: My name is Mark Silberman, M-a-r-k, S-i-l, b as in boy, E-r-m-a-n.

Every project has its own story. Every applicant has its own history before the Board, and this applicant and its historical support of the Board on its prior projects are important to consider when evaluating this project.

On multiple occasions Beloit has tried unsuccessfully to establish an emergency room in Illinois.

We all know emergency rooms act as the wide funnel to bring patients into your health system.

This proposed hospital, however, is not designed to treat emergent patients or even support surgical needs. It's only

predicting 500 surgical hours a year out of a 544-square foot operating room.

Now, this community is already well served by Mercyhealth's 24/7 urgent care center in Roscoe staffed by ED docs, so what it's proposing now is to convert emergent care into an emergency room creating an unutilized ASTC OR for a single hospital OR that cannot accommodate surgery for more than one patient at a time and then licensing all of this as a hospital.

So what is this project trying to accomplish if it's not to follow patients into the Beloit Health System to be cared for at a Wisconsin hospital?

It's certainly not to care for Medicaid patients, because for their ASTC, they predicted

12 percent Medicaid population and barely reached 2 percent Medicaid care, and it's not the only unfilled project of that ASTC.

Despite ensuring this Board that ASTC was needed, it never even reached 30 percent of this Board's standard for being fully utilized, and over half of the categories of service that they said were needed in this community and that they would provide, for over half of them they have never provided any of those services, and for this hospital there's no clarity as to what services they are going to be providing.

Lastly, I can't even -- I'm confused as to how this project did not receive a negative finding from the service to planing area presence.

They talk about the idea that this was somehow stem out

mitigation, but for their ASTC, the representations they made, you heard those here, only 30 percent of those patients served there were from Illinois.

Their failure to meet prior representations needs to be considered in the evaluation of this project.

We would ask you, in fact, urge you to deny this permit. Thank you.

MS. DOMINGUEZ: Thank you.

CHAIRWOMAN SAVAGE: Okay. Given our situation, we are going to have to break for lunch now and we'll have some of our issues resolved by then. We'll come back at 1:00.

(A recess was had.)

STATE OF ILLINOIS )
) SS:
COUNTY OF KANE )

I, Renee E. Brass, Certified Shorthand Reporter of the State of Illinois, CSR No. 084-004119, do hereby certify that I caused to be reported in shorthand and thereafter transcribed the foregoing transcript of proceedings. I further certify that the foregoing is a true and complete transcript of my shorthand notes so taken as aforesaid, and further, that I am not counsel for nor in any way related to any of the parties to this action, nor am I in any way interested in the outcome thereof.

IN TESTIMONY WHEREOF, I have hereunto set my hand this 13th day of November 2024.

Renee E Brass

CSR No. 084-004119-Expiration Date: 5.31.2025

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

REPORT OF PROCEEDINGS VIA VIDEOCONFERENCE
held at the Bolingbrook Golf Course, 2001 Rodeo Drive, Taylor Ballroom, Bolingbrook, Illinois, on October 29, 2024, at the hour of 1:02 p.m.

BOARD MEMBERS:
CHAIRWOMAN DEBRA SAVAGE
MEMBER REX BUDDE
MEMBER GARY KAATZ
MEMBER DAVID KATZ
MEMBER DAVID FOX
DR. AUDREY TANKSLEY

IDPH STAFF:
MS. BLANCA DOMINGUEZ, LEGAL COUNSEL
MR. DENNIS BEEDLE, IDHS EX-OFFICIO
MR. JOHN P. KNIERY, ADMINISTRATOR
MR. GEORGE ROATE
MR. MICHAEL CONSTANTINO
MR. KENTON TILFORD

CHAIRWOMAN SAVAGE: Welcome back, everyone.

We have a court reporter online so welcome, Madam Court Reporter.

Apologies for all the delays today.

We're moving to Item No. 6 on our agenda, which is items approved by me. The following requests listed in this item I have approved. Please let the record note that these items are (inaudible).

Next up. Let's see. We are going to have applications subsequent to intent to deny.

Please note that although considered independently, these next two projects are interdependent on each other.

The first one is going to be I-01, Peterson Surgery Center for establishment of an ASTC HSA 6 in

Chicago.

May I have a motion to approve Item 24-009 for the establishment of a multi-speciality single OR ASTC?

UNIDENTIFIED SPEAKER: So moved.

UNIDENTIFIED SPEAKER: Second.

CHAIRWOMAN SAVAGE: So noted. We have some folks here so if you could please talk very loud today, everybody in the room for our court reporter, so if you could introduce yourself, spell your name for the court reporter and then she will swear you in.

MS. SULTANA: Good afternoon. This is Naaz Sultana. I'm the administrator of Peterson Surgery Center. My spelling is N-a-a-z, S-u-l-t-a-n-a. Thank you.

MR. ANDERSON: Collin

Anderson, C-o-l-l-i-n,
A-n-d-e-r-s-o-n.

MS. FRIEDMAN: I'm Kara Friedman from Polsinelli, Kara Friedman, K-a-r-a, F-r-i-e-d-m-a-n.

MR. AMORMINO: John Amormino, A-m-o-r-m-i-n-o, president of American Medical Buildings --- -

CHAIRWOMAN SAVAGE: When you talk into the microphone, talk on top of the microphone.

If you could swear in our applicants please.

(Witnesses duly sworn.)

CHAIRWOMAN SAVAGE: All right.

Then Staff, if you could please give us our state board staff report.

MR. CONSTANTINO: The applicants are proposing to establish an ASTC at 2300 West

Peterson Avenue in Chicago. The project cost is approximately 1.6 million. The expected completion date is June 30, 2025.

No requests for a public hearing were made and the state board did not receive any letters of support or opposition. State board staff had two findings related to this project. Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you, Mike.

If you would like to proceed.

MS. FRIEDMAN: Sure. Just a couple procedural matters. The applications were filed in February, and so if possible, we would like to change the permit completion date to February 28, 2026. I don't know if that's a separate motion or just part of your motion to approve.

CHAIRWOMAN SAVAGE: What was that completion date?

MS. FRIEDMAN: February 28th, 2026.

CHAIRWOMAN SAVAGE: Now may I have a motion to amend the motion to extend the completion date to February 28, 2026, to the proposed amendment? Are there any objections?

(No response.)

CHAIRWOMAN SAVAGE: Hearing none, the amendment for this motion as stated is approved.

So is there any discussion on the amended motion from my board members?

(No response.)

CHAIRWOMAN SAVAGE: Hearing none, Kara, go forward.

MS. FRIEDMAN: Okay. And just the other procedural matter, I do not believe we will repeat our testimony for the closure of

the location so consider this to be that you would ask questions about the closure and the facility if you would.

CHAIRWOMAN SAVAGE: Certainly.

MS. FRIEDMAN: My name is Kara Friedman. I'm with Posinelli serving as counsel for Peterson Surgery Center. Joining me today are Naaz Sultana, surgery center administrator, Jack Amormino, consulting architect and my colleague, Collin Anderson.

Thank you for the opportunity to discuss these plans to relocate to a location approximately 2 miles from their current facility.

We appreciate that a majority of the board members present at the September meeting voted in favor of the relocation plan. Sorry I wasn't able to

attend that meeting myself, but I was able to review all the concerns that were raised and I believe that we have addressed those in a supplement to the board staff report. I'd like to emphasize that there has been no provider opposition or community members or stakeholders objecting to this relocation.

On the other hand, we received support from a nearby nonprofit community services organization expressing interest in obtaining the present space to operate a substance use disorder treatment services facilities. Having that organization expand into this space would address important community needs in the Rogers Park area. At a higher level, some of the reasons for this move were reviewed at that last meeting, but I will go into

details about both exterior and interior issues with the current location which is on North Paulina.

You are all hearing me? Okay.

Since this proposal was last before you and in response to feedback at the meeting with the input from your staff, we submitted supplemental information.

Let me review. Ultimately two primary factors compelled the surgery center to move. There's facility limitations and neighborhood safety and parking concerns. Despite significant investments and upgrading surgery center's physical plant after it received negative survey findings, the building's physical limitations preclude Medicare certification and agency

accreditation.

The facility was initially operated by a prior operator as a pregnancy termination clinic, so those Medicare rules were not operative.

Since the survey there were extensive infrastructure updates made as recommended by a different design consultant. The surgery center also stopped doing GI endoscopy procedures to eliminate site of infection control issues.

However, despite these efforts and investments, the facility failed to comply with two key conditions for coverage under Federal CMS requirements due to building constraints that prevent resolution of several issues.

Relative to the neighborhood and beyond the issues relating to the compliance of CMS code, there are significant safety concerns in

the immediate area around the center. These include the use of drugs and people loitering who are suffering from drug intoxication, drug related litter in the street and an increase in drug related crime.

The location, which is at 7616 North Paulina is particularly affected with frequent loitering around the building due to its proximity to the end of the CTA line. That's the Howard station. And being close to the free meal center operated by A Just Harvest, the organization that's interested in taking this space over.

The environment poses challenges for safety of the physicians and staff and their patients and patient chaperones.

Recently a shooting occurred outside building which, of course, highlights the severity of the

situation. Despite police efforts drug use and trafficking and other criminal activities around the facility are getting worse.

Unrelated to the crime and problems with loitering in the area, the operator that owns the parking lot that's used by the surgery center has indicated that some time in the next couple of years they are planning to take that space back to develop it.

This was outlined in the CON application in furtherance of limited information within the surgery center, recovery bays are too small and cannot be updated to meet size and structure clearance requirements due to physical plant constraints. Proper ventilation, lighting and exhaust as required by NFPA 99 and 68 cannot be fully achieved given the building configuration. There's

insufficient space for sterilizing equipment and other equipment, and the configuration of clinical areas, soiled equipment rooms and supply rooms cannot be remedied due to physical plant constraints.

Because of building limitations, the current location uses oxygen gas cylinders because of -- instead of an centralized medical gas facility. Pipe-in gases are now considered the standard contemporary practice and that's what will occur at the new facility.

Plant relocation will address all of these challenges and will do so cost effectively given the applicant has identified nearby available building that was licensed as an ASTC just a few years ago.

For project cost of $1.6 million, which is just about a

third of the capital expenditure minimum which otherwise brings projects to you and operations can be relocated from the difficult neighborhood, resolve parking issues and achieve AAAHC accreditation and enabling Medicare certification.

The applicant feels fortunate to identify this convenient relocation option. Real estate that works for contemporary healthcare facility is pretty hard to find in the City of Chicago.

I have my own personal experience working with a dialysis provider that really scatters its sites to be in different neighborhoods and thinking of the zoning, the building conditions and approvals of the city make it quite difficult to do development projects in different

neighborhoods of the community.

Did you want to talk a little bit about the information.

MR. AMORMINO: This is Jack Amormino speaking. My company and I work in medical buildings as a national developer of outpatient facilities. We have developed outpatient facilities and particularly surgical centers in over 41 states, including many, many projects in the State of Illinois.

We were engaged by the applicant to inspect the Peterson Surgery Center and to prepare a renovation plan and a budget.

Based on that work and our expertise in this field, it's our opinion that the facility will require modernization of finishes and upgrades of certain equipment. We don't believe there are going to be significant structural

changes to the functional flow of the facility. Once this work is complete, the facility will be a state of the art ASC. It will meet all required federal and state codes and regulations, including IDPH licensing and CMS Medicare certification program.

Also in our opinion this work would be accomplished within the budget provided by the applicant.

MS. FRIEDMAN: Thanks. So just to address the board staff findings. As you may be aware, the board does not have special rules for the relocation of an existing healthcare facility, so that's why the application is broken up into two applications, in fact.

We consider this to be the continuation of a business that's already serving a community.

The provider seeks permission to move its current operations to a new location and a more secure building, Medicare certified with added parking.

As for this provider's patient base, the majority of the center's patients have sustained injuries due to workplace incidents, auto collisions or other types of accidents and are uninsured by federal health programs or commercial insurance and most are Black or Latino.

The stark disparity in healthcare access between Chicago and its suburban counterparts is glaringly evident with comparing the distribution of surgery center operating rooms.

Based on your inventory in health service area 7, which is DuPage County and suburban Cook County, there are 1 operating room

for every 19,000 residents.

In stark contrast, health service area 6 which is the City of Chicago has only 1 ASC operating room for every 48,784 residents.

This means that city residents have about 40 percent of the access that suburban residents have.

This significant imbalance underscores the critical under servicing of Chicago's urban population. The potential closure of the surgery center without replacement would further exacerbate an already problematic disparity.

It's imperative to maintain these services at a new location to ensure this inequity does not worsen and to help ensure that Chicago residents have access to timely and adequate surgical care.

Supporting the continued operations of this surgery center aligns with the broader goals of health equity in providing that all residents regardless of their geographic location within the greater Chicago area have comparable access to essential surgical services.

As I mentioned earlier, it's really just by chance that the main center operator would be -- has expressed interest in using the current ASC location for a drug rehabilitation program.

I know that's not within the scope of this organization, but it seems like a plus in the -- with our move.

We thank Reverend Patti Banks for appearing today to support this application so her nonprofit may expand into the space once the surgery center

moves.

And that's all I have, so I'm happy -- we are happy to answer any questions.

CHAIRWOMAN SAVAGE: This is Debbie. Do our board members have any questions for this applicant?

Mr. Budde.

MEMBER BUDDE: Yeah. Rex Budde talking.

Will you -- in the new facility would you start doing the GI procedures again?

MS. FRIEDMAN: No, I don't think. That whole clean/dirty separation is important and I think it's just more straightforward to do GI at a specialized endoscopy center.

MEMBER BUDDE: Okay. Thank you.

MEMBER FOX: Do you currently take --

CHAIRWOMAN SAVAGE: Mr. Fox.

MEMBER FOX: Mr. Fox speaking.

Do you currently have a Medicaid contract and will you continue to have a Medicare contract if the facility moves.

MS. FRIEDMAN: Because the building has been -- not been able to achieve accreditation in Medicare enrollment, it is not eligible for Medicaid at this location, but the plans are to move forward with all those enrollments at the new location because Jack has told us that it can be Medicare enrolled.

MEMBER FOX: So at the new location, your plan is to accept both Medicare, as well as public aid?

MS. FRIEDMAN: Yes.

CHAIRWOMAN SAVAGE: Other questions? Okay.

Hearing none, George, if you

could call our roll, please.

MR. ROATE: Thank you, Madam Chair.

Motion made by Mr. Gary Kaatz, seconded by Dr. Tanksley.

Mr. Budde?

MEMBER BUDDE: Vote yes. I think the staff report and information provided based on that.

MR. ROATE: Thank you.

David Fox?

MEMBER FOX: I vote yes based on testimony today and also recognize that many of the surgery centers in the surrounding area do not accept Medicaid, so it's great to hear that your plan is to become -- to provide Medicaid.

MR. ROATE: Thank you.

David Katz?

MEMBER KATZ: Yes, based on the staff report and the testimony today.

MR. ROATE: Thank you.

Gary Kaatz?

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

MR. ROATE: Thank you.

Dr. Tanksley?

MEMBER TANKSLEY: I vote yes based on the state board staff report and testimony today and appreciate that the minister came forward in public testimony earlier and mentioned that you guys may potentially be looking to assist the community and help that building be utilized for behavioral health and substance use, so thank you for that as well.

MR. ROATE: Thank you.

Ms. Hardy-Waller?

MEMBER HARDY-WALLER: I vote yes based on testimony today and state board report.

MR. ROATE: Thank you.

Chairwoman Savage?

CHAIRWOMAN SAVAGE: I vote yes today based on the comments made by my colleagues today and the state board staff report and the testimony today.

MR. ROATE: That's seven votes in the affirmative.

CHAIRWOMAN SAVAGE: So that motion is approved, permit rather is approved.

MS. FRIEDMAN: Thank you very much.

MS. SULTANA: Thank you.

CHAIRWOMAN SAVAGE: Now we are going to move on to applications for initial review. This will be H-01, Peterson Surgery Center. One moment, please.

MS. FRIEDMAN: That's us again.

CHAIRWOMAN SAVAGE: Okay.

So H-01, Peterson Surgery Center, Rogers Park one-day surgery for discontinuation of the ASTC in H SA 6 in Chicago.

May I have a motion to approve Project 24-010 for the distinction of the ASTC?

MEMBER HARDY-WALLER: So moved.

MEMBER KATZ: Second.

CHAIRWOMAN SAVAGE: That was Ms. Hardy-Waller and then Mr. Katz, David Katz. Okay.

So now our folks are here, but they have already been sworn in. Do you have anything further to share?

MS. FRIEDMAN: No, we do not. I don't know if you need to reflect -- the court reporter should reflect that Kara Friedman, Jack Amormino, Naaz Sultana, Collin Anderson are here to present.

CHAIRWOMAN SAVAGE: Are there any questions for these folks?

Well, first we'll have our state board staff report. If there's anything you would like to share.

MR. CONSTANTINO: Madam Chair, you did fine.

CHAIRWOMAN SAVAGE: All right. I believe that meets all requirements. Does it, Mike?

MR. CONSTANTINO: Yes.

CHAIRWOMAN SAVAGE: Okay. Do any of our board members have any questions about this discontinuation of the ASTC relative to the previous project?

MEMBER BEEDLE: I would just like to make a comment.

CHAIRWOMAN SAVAGE: Hold on. In the mic.

MEMBER BEEDLE: This is Dennis Beedle. You guys really

have been persistent, and I was particularly impressed by your willingness to hire additional expertise. It's not easy for a small organization these days to meet all the regulatory requirements. I was really quite impressed by your willingness to keep on working on this, so we wish you well in your -- whether you receive CMS certification.

UNIDENTIFIED SPEAKER: Thank you so much.

CHAIRWOMAN SAVAGE: Hearing no other comments or questions, George, if you could call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Ms. Hardy-Waller, seconded by David Katz.

Mr. Budde?

MEMBER BUDDE: Based on the

conversation previous, I vote yes.

MR. ROATE: Thank you.

David Fox?

MEMBER FOX: Yes. Yes.

MR. ROATE: Thank you.

David Katz?

MEMBER KATZ: Yes.

MR. ROATE: Thank you.

Gary Kaatz?

MEMBER KAATZ: Yes.

MR. ROATE: Thank you.

Dr. Tanksley?

MEMBER TANKSLEY: Yes, based on the -- hope you heard that. Court reporter. Yes based on the testimony provided today.

MR. ROATE: Thank you.

Ms. Hardy-Waller?

MEMBER HARDY-WALLER: Yes.

MR. ROATE: Thank you.

Chairwoman Savage?

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

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

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

MS. FRIEDMAN: Thank you very much.

CHAIRWOMAN SAVAGE: Next up we are going to have H-02, Dialysis Care Center of Oak Lawn, it's an HSA 8.

May I have a motion to approve Project 24-023 to add 14 ESRD stations?

Tony Hardy-Waller said that.

And may I have a second from someone in the microphone?

MEMBER FOX: Dave Fox. Yes, second.

CHAIRWOMAN SAVAGE: Okay. We have some folks here, so if you could be very close to the microphone, not yet, and state your names, spell your name and

speak very loudly and then she will swear you in.

MR. MORADO: Juan Morado Junior, J-u-a-n, M-o-r-a-d-o, J-R.

MS. SHUMATE: Stephanie Shumate, S-t-e-p-h-a-n-i-e, S-h-u-m-a-t-e.

MR. SILBERMAN: Mark Silberman, M-a-r-k, S-i-l, b as in boy, e-r-m-a-n.

MS. O'DONNELL: Therese O'Donnell, T-h-e-r-e-s-e, O apostrophe, D-o-n-n-e-l-l.

DR. SALAKO: Babajide, B-a-b-a-j-i-d-e, Salako, S-a-l-a-k-o.

CHAIRWOMAN SAVAGE: Okay. When she swears you in, she would like each person to state their name and then your answer to her question.

Renee, you can go ahead and swear them in.

(Witnesses duly sworn.)

CHAIRWOMAN SAVAGE: Okay. Now if we could please have the state board staff report.

MR. CONSTANTINO: Thank you, Madam Chair.

The applicants are proposing to add 14 ESRD stations to a 14 station facility for a total of 28 stations. The cost of the project is approximately 340,000 and the completion date is expected as of December 1, 2024.

We have one finding regarding this project and it had to do with the submittal of a review, audit review financial statement instead of an audited statement.

There was no public hearing requested and no letters of support or opposition were received.

Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank

you, Mike.

If you would like to proceed.

MR. MORADO: Thank you.

Good afternoon members of the board. Pleased to be before you today with this project to add stations at the DCC Oak Lawn facility. You may recall this facility's name as we were before you earlier this year for the relocation of DCC Oak lawn. You approved that application.

We are happy to report that the facility has moved and with it all of its existing patients.

We would like to thank board staff for the state board report which had the one finding which you just heard about. That finding is for not providing audited financial report with our application. We had the same finding earlier this year, and at

that time we had submitted an independent accounting financial review for DCC for the year 2022.

We recently provided the updated 2023 report to the board staff as well for their review.

This independent accounting report is completed by Forvis Mazars, a top 10 accounting firm in the U.S.

A physician group of this size of DCC does not have the type of audited financial performed that you might see with large hospital systems or other publicly traded companies, but as a best practice they do have an independent financial review completed as part of their tax preparation process and in an effort to be responsive and meet the spirit of the board's criteria the applicants provide this report every year to staff.

Otherwise there's no findings regarding the substance of this application which is to additional stations to the facility.

With me today I have Stephanie Shumate, director of operations for in center facilities; Therese O'Donnell, director of operations for efficiency and DCC CEO Dr. Babidjue Salako, along with my partner Mark Silberman who is going to close out our presentation.

And with that, I'll turn it over to Stephanie.

MS. SHUMATE: Thank you. My name is Stephanie Shumate. I'm director of operations for our in center programs and facilities at DCC Dialysis, so I do want to thank you guys.

I also was here for the CON,

the initial CON for us to do our relocation, as well as for our 14 chairs that we do have -- the two chairs that we had added to our facility.

We did move into the facility April 4th of '24 of this year and the move was substantially well. It allowed our patients to have a newer environment to treat in whereas the other facility that we had had structural issues there.

It also allowed us to provide help in personal life balance for our patients whereas we were able to adjust some chairs for our patient chair times, where they were able to provide more functionality to their life.

Also, we were able to grow within the facility setting. When we first went to the facility, we had a census of 65 patients and we

had grew from there.

Okay. So we need the expansion of the chairs so that way it will allow us to be able to again adjust some of our patients who are on a waiting list to get earlier chairs at our location as well as for some of them to attend different programs and different activities that they have with their family members.

Also, once we moved into this facility as of April this year, we have been successful and very grateful and blessed to have had three of our patients that did transplant, so we do work with our nurses to educate our patients and to get our patients off of -- on the transplant wait list with most of their help with doing that. We are making sure they keep their appointments, that they are meeting their treatment

obligations to us. Also that they are going to the testing that they need to be able to be a viable candidate on the transplant list.

So we definitely do push transplants with our patients, as well as we had one prior before our move putting a total of four patients that transplanted within this one facility that we did have.

Okay. I think that's all that I have. I will be transferring -- I will be sending it over to Therese O'Donnell.

MS. O'DONNELL: Good afternoon, everyone. My name is Therese O'Donnell. I'm the director of our operational efficiencies at Dialysis Care Center.

So for our Oak Lawn facility we're currently utilizing at about 90 percent. We have three shifts,

Monday, Wednesday and Friday, with the 14 chairs and also three shifts on Tuesday, Thursday, Saturday.

We do have two patients already that are in the pipeline. We have had patients, as Stephanie said, who are on the waiting list to get to the prime Monday, Wednesday, Friday shift because a lot of patients do not feel like coming in on their Saturdays.

We have had patients come off the street to look at our facility. They love the fact that it's brand new and that it's close in the area. We have five patients that have come in that said they want to transfer. We do open additional chairs.

We have met with our medical director and physicians and they have assured us that if we are able to expand to another 14

chairs to make it 28, that they will have no problem filling these chairs up.

That's pretty much all I have. I'll pass it on over to Mark.

SPEAKER: And we really have made an effort to streamline our presentation out of respect for your schedules, but if there is anything we don't address, please raise that during our questions.

Given the single negative finding, the audited financials are just not part of their business plan which is why they were unable to meet this board's requirement for that and justifying the negative criteria.

The two things that we would ask you to consider in balancing that is this: One, it is a low expense undertaking that is going to be financed out of available

cash on hand and is going to significantly increase access to healthcare to patients in need; and then number 2, the fact that this applicant does have a history before this board. They have come before and made representations, and their performance in all of their projects, they've successfully completed multiple projects despite not having the audited financials, and given that, we hope that that would balance out any concern that might exist based on the financials they do provide other than the audited.

With that, we are happy to take whatever questions the board or staff may have. Thank you.

CHAIRWOMAN SAVAGE: I do have a question. This is Chair Savage.

So in terms of the construction, is there

construction to add these 14 beds and how do you mitigate that.

MR. MORADO: The layout of the facility is already designed where they can put these stations right in. There's no additional construction.

MR. SALAKO: Not at all. No, no. We have the space available. Just to add to what my colleagues have said here, what we have tried to do is in this new facility we are in, we have physicians' offices in the same building. We have a very robust home dialysis program in the same building.

We are less than a kilometer way from Christ Hospital, so we really -- we've designed this as something that the community would really -- one stop, come in. They can see their physician. We have a very robust home program. Even

that home program, it's at the same location with training. If they want to go in the center, at the same location, and I think because of that -- and to my other -- to what my colleague Therese said, that last shift on Saturday afternoon, a lot of our patients just want to watch football. Who wants to dialyze at 3:00 when you can watch Illinois lose, you know. I'm sorry.

CHAIRWOMAN SAVAGE: Now Doctor.

UNIDENTIFIED SPEAKER: We would like to officially object to that last comment.

CHAIRWOMAN SAVAGE: We're all from Illinois. We vote for Illinois people.

Okay. Do any of my board members have other questions for this applicant?

MEMBER HARDY-WALLER: I just

had a --

CHAIRWOMAN SAVAGE: And who are you?

MEMBER HARDY-WALLER: I'm sorry. This is Antoinette Hardy-Waller, and I just had a question of clarity, and that was I understood from the March presentation that there was going to be a completion date of 7-1-25. The proposal is to add these additional 14 stations, which should be completed by December of '24, so my assumption is that the earlier 14 stations have been completed and are being worked -- being utilized and the 14 will be completed in December; is that correct?

MR. MORADO: That's correct.

MEMBER HARDY-WALLER: Thank you. I didn't see that explained in the report. Thank you.

CHAIRWOMAN SAVAGE: Other

questions? All right.

Hearing none, George if you could call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Ms. Hardy-Waller, seconded by David Fox.

Mr. Budde?

MEMBER BUDDE: Yes. Based on the staff report and testimony I vote yes. Thank you.

MR. ROATE: Thank you.

David Fox?

MEMBER FOX: Yes, based on the staff report.

MR. ROATE: Thank you.

David Katz?

MEMBER KATZ: Yes, again based on the staff report and testimony.

MR. ROATE: Thank you.

Gary Kaatz?

MEMBER KAATZ: Yes, based on

today's testimony.

MR. ROATE: Thank you.

Dr. Tanksley?

MEMBER TANKSLEY: Yes based on today's testimony and state staff board report.

MR. ROATE: Thank you.

Ms. Hardy-Waller?

MEMBER HARDY-WALLER: Yes based on testimony today on.

MR. ROATE: Thank you.

Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes based on -- excuse me. Based on the state board staff report and testimony today.

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

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

MR. MORADO: Thank you very much.

CHAIRWOMAN SAVAGE: All

right. So now next up we are going to have H-03, DJC Healthcare Medical Clinics Building in Edwardsville which is an HSA 11.

May I have a motion to approve project 24-026 for the expansion of this MOB?

MEMBER TANKSLEY: So moved.

MEMBER FOX: David Fox, second.

CHAIRWOMAN SAVAGE: Thank you. And our folks are coming to present, so if you could talk extra loud into the microphone, spell your name for the court reporter and she will swear you in, and at that time she would like each of you to respond separately.

MR. BRATCHER: Hi, my name is Greg Bratcher, G-r-e-g, B-r-a-t-c-h-e-r. BJC Healthcare, all one word.

MR. AXEL: I'm Jack Axel,

A-x-e-l, with Axel & Associates, consultants to this project.

CHAIRWOMAN SAVAGE: Thank you.

Renee, if you could please swear them in.

(Witnesses duly sworn.)

CHAIRWOMAN SAVAGE: Thank you.

Our staff could give us state board staff report.

MR. CONSTANTINO: Thank you Madam Chair.

The applicants propose to build out a vacant space at an existing DKC healthcare medical office building in Edwardsville. For the applicants the build out will allow for expansion, a physician office space and auxiliary support services.

The proposed cost is approximately $23 million and the expected completion date is

October 31, 2025.

No public hearing was requested and no letters of support and one letter of opposition was received by the state board.

We had one finding related to this project, reasonableness of project cost.

Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you, Mike.

If you would like to proceed.

MR. BRATCHER: Hi. This is Greg Bratcher talking.

As Mike said, this is an existing medical office building. It has been very successful. We had 66,000 visits in 2023, and so we are using our modest growth strategy, we want to add 13 exam rooms, a little bit more lab space, a little bit more standard

x-ray space and a key, the key additions are MRI and CT. They have become the workhorse of modern medicine and they really are something to be had here.

To address the one finding, we think of ourselves as pretty aggressive when we go to price out construction work, so we asked a different contractor than a contractor for this, as to their cost estimate and said, you know, what's the deal here? He explained how for projects like 95 percent of the (inaudible) we are building brand new from the ground up. Our estimate's for modest, they call them modest. They have a medical office building, one story, medical office building two story, hospital two to four story, et cetera, et cetera, for a regular office building, apartments, you

name it, and they aggregate data from across the nation. There are a few parameters that you can modify to adjust for locality, et cetera, and you arrive at a price or this standard model.

In our case, we have a different sort of project. We have a unique project in that we built a building in 2021, and we are just going to add on to that building in '24. It's the same space, same contractor, same finishes, same everything for the most part, and so in a different part of RS means there is a historical cost estimate.

It allows you to say if I build a building in 2021, for example, and want to see what it would cost in 2024, it allows you to do that.

And so our cost per square foot, which was approved by the

board back in 2021, was $370. It's now -- this project is 389. That's a 5 percent increase. RS means historical cost estimator says that you would expect that to be 19 percent more expensive, so we feel pretty good about this price and this cost per square foot.

And if I didn't mention it before, the contractor we asked was not the contractor for the project, so they had no real input into that or any reason to put their (inaudible), and with that I will entertain any questions.

CHAIRWOMAN SAVAGE: Do our board members have any questions? All right.

Hearing none, George, if you could please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Dr. Tanksley,

seconded by David Fox.

Mr. Budde?

MEMBER BUDDE: Based on the staff report, I vote yes.

MR. ROATE: Thank you.

David Fox?

MEMBER FOX: I vote yes based on the staff report and testimony about the recent price since 2021.

MR. ROATE: Thank you.

David Katz?

MEMBER KATZ: Yes, based on staff report and testimony.

MR. ROATE: Thank you.

Gary Kaatz?

MEMBER KAATZ: I vote yes based on the staff report and today's testimony, and I think you had a particularly good answer for why your project came at higher than our standards call for.

MR. BRATCHER: Thank you.

MR. ROATE: Thank you.

Dr. Tanksley?

MEMBER TANKSLEY: I vote yes based on the staff report and testimony today.

MR. ROATE: Thank you.

Ms. Hardy-Waller?

MEMBER HARDY-WALLER: I vote yes based on state report and explanation of the cost analysis.

MR. ROATE: Thank you.

Chairwoman Savage?

CHAIRWOMAN SAVAGE: I to vote yes based on the state board staff report and the testimony today.

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

CHAIRWOMAN SAVAGE: And that permit is approved thank you.

Now we are going to move on. Let's see. Anybody need a break? Okay.

On to H-04, Northwestern

Medicine Huntley which is an HSA8. May I have a motion to approve project 24-027, oh. No. I lied. That's true.

May I have a motion to approve project 24-027 for the expansion of the MOB?

MEMBER KAATZ: So moved.

CHAIRWOMAN SAVAGE: Mr. Gary Kaatz. Second?

MEMBER FOX: Dave Fox, yes second.

CHAIRWOMAN SAVAGE: Thank you. If you folks again could introduce yourselves, spell your name and then you will be sworn in and talk extra loud.

MS. ORTH: Sure. Bridget B-r-i-d-g-e-t, O-r-t-h.

MS. HALL: Ann Hall, A-n-n, H-a-l-l.

MR. CALLAGHAN: Dan Callaghan, D-a-n, C-a-l-l-a-g-h-a-n.

CHAIRWOMAN SAVAGE: Thank you.

And Renee, if you could swear in these three people.

(Witnesses duly sworn.)

CHAIRWOMAN SAVAGE: All right. Now, could we please have our state board staff report.

MR. CONSTANTINO: Thank you, Madam Chair.

The applicants propose to construct a medical office building in Huntley, Illinois, at the cost of approximately, excuse me, $96.3 million.

A public hearing was conducted on this project on September 17, 2024, at the Huntley public library. Eight individuals attended with one registered in support, four registering opposition and the remaining three registering neutrality of the project.

The applicants have met all the requirements of the state board.

Thank you, Madam Chair.

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

MS. ORTH: Good afternoon. I'm Bridget Orth, director of regulatory planning for Northwestern Medicine. With me today is Ann Hall, vice president of community relations, and Dan Callaghan, director of planning and construction.

We are before you today with our proposed Northwestern Medicine Huntley medical office building, the project response to the high demand for cardiology and oncology services at Northwestern Medicine Huntley Hospital and will have an anticipated positive impact on the top two leading causes of death in

McHenry County, heart disease and cancer.

Northwestern Medicine continues to invest in our communities to improve residents' health status, to reduce health disparities and to provide increased accessibility to healthcare services for all residents. To do so we invest in programs, community partnerships and our people, as well as facilities.

A site such as the Huntley Medical Office building is only one version of this investment. Northwestern Medicine is strategically focused on providing ambulatory access points across our service areas to improve our ability to meet the needs of our patients where they live and work.

Many factors are evaluated in determining the location of

Northwestern Medicine medical office buildings such as proximity to a hospital, ability to recruit staff, the availability of appropriate space and community need, for expanding access to high demand services in Huntley, to building on existing community relationships, to identify and build an advanced outpatient center in the Bronzeville community on the south side of Chicago, we appreciate the support of this board for our projects throughout our service areas that enable us to better serve our communities.

We would like to thank the board staff for the review of our project. The project, like Mike said, is in full compliance with all applicable board criteria, which is reflected in an all positive state staff report.

We are happy to answer any questions the board may have.

CHAIRWOMAN SAVAGE: Does our board have any questions for this applicant?

Mr. Katz.

MEMBER KATZ: This is probably a totally unfair question to ask of you, and if you feel that way, you are not obligated to answer.

Were you here this morning during the public hearing?

MS. ORTH: Yes.

MEMBER KATZ: Any thoughts in addition to what you already shared with us? Any thoughts on some of the comments that were made with regard to this project?

MS. ORTH: Yes. Part of -- we do respond to some of the requests that were made this morning, and one of the ways that we have done that is to build this

advance outpatient center in the Bronzeville community which did not come before this board because it had an all positive state staff report and was unopposed, so Chairwoman Savage was able to approve that on her own, but that's almost double the size of what this project is, and it has I want to say almost three times the amount of specialists in the building. I have a list if you want to hear the specialties that will be in that building, and a diagnostic imaging center and it will be a beautiful building that is going to be opening -- it will open in September of 2025.

MEMBER KATZ: The presenters today, were they aware of that?

MS. ORTH: I'm not sure.

MEMBER KATZ: Unfair to you, but thank you very much for advancing that.

MS. ORTH: You're welcome.

CHAIRWOMAN SAVAGE: Any other questions for these applicants?

Yes.

MEMBER HARDY-WALLER: Antoinette Hardy-Waller. I don't have a question, but I'll have a comment that I'll follow on my colleague and that is I too had the same concerns that the testimony earlier today was given regarding the approved amount of services that are provided in the suburbs versus those that are in the city. I think not just Northwestern, but there are health systems that do the same thing, but happy to know because the Bronzeville community is my community, so I have watched the facility grow there and be built, so I'm hopeful that those same kinds of services that will be

provided to that community in addition to the community partnership that that facility will bring to the community as well.

CHAIRWOMAN SAVAGE: From these medical office buildings, will you have some community relation events that you do for the Bronzeville neighborhood as well as in Huntley?

MS. HALL: Yes. This is Ann Hall. We have extensive community relationships and partnerships in both McHenry County and Bronzeville and activating these sites involves community voice throughout the process and then celebration when the sites actually open.

CHAIRWOMAN SAVAGE: Any other questions?

All right. George, if you could please call our state

board -- or call the roll rather.

MR. ROATE: Thank you, Madam Chair.

Motion made by Gary Kaatz, second by David Fox.

Mr. Budde?

MEMBER BUDDE: Based on the staff report and then the information that was just shared with us about the (inaudible) facility, I vote yes.

MR. ROATE: Thank you.

David Fox?

MEMBER FOX: I vote yes based on the staff report.

MR. ROATE: Thank you.

David Katz?

MEMBER KATZ: I vote yes based on the staff report and the testimony and this picture that Chair Savage just pulled up on her computer of the beautiful new facility that's going up in Bronzeville and I'm perplexed as

to why that line of questioning happens at this point, but good luck with you on this one.

MR. ROATE: Thank you.

Gary Kaatz?

MEMBER KAATZ: I vote yes. Thank you for your testimony.

MR. ROATE: Thank you.

Dr. Tanksley?

MEMBER TANKSLEY: I vote yes based on the staff report.

MR. ROATE: Thank you.

Ms. Hardy-Waller?

MEMBER HARDY-WALLER: I vote yes based on the state report, as well as the testimony today.

MR. ROATE: Thank you.

Chairwoman Savage?

CHAIRWOMAN SAVAGE: And I vote yes today too based on the state board staff report and testimony today.

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

affirmative.

CHAIRWOMAN SAVAGE: And so that permit is approved.

Now we are really only going to take a five-minute break and then we will come back with our last project, NorthPointe Neighborhood Hospital in Roscoe, but well -- we have some staff comments when we get back.

(A recess was had.)

CHAIRWOMAN SAVAGE: Now before we move on to this next agenda item, Mr. John Kniery here would like to provide some comments.

MR. KNIERY: In the following project there are issues that have been presented in the application and by its opponents and proponents. They concern licensing.

I want the board and the public to know that licensure

rules and the board's rules while similar are not identical. The biggest issue is that licensure can approve two facilities under a single license under certain circumstances. The board rules do not do that. Each project is considered independent and is considered upon its own merit.

If during the proceedings if there are questions, please ask and between myself, board staff and our ex officio members, especially Karen Singer, we will all do our best to answer those questions and concerns. Thank you.

CHAIRWOMAN SAVAGE: Okay. So now we are going to move to H-05, NorthPointe Neighborhood Hospital in Roscoe, HSA something.

May I have the motion to approve project 24-018 for the establishment of a 10-bed

hospital?

MEMBER HARDY-WALLER: So moved.

That was Ms. Hardy-Waller.

MEMBER TANKSLEY: Second.

CHAIRWOMAN SAVAGE: We're getting it.

That was Dr. Tanksley.

You folks, if you could please extra loud state your name, spell your name for the court reporter and then much like last time she'll swear each of you in and then you will individually answer you do, yes, or something like that.

So go ahead.

MR. MCKEVETT: Thank you. Tim McKevett, president, CEO of Beloit Health System, T-i-m, M-c-k-e-v-e-t-t.

MS. FRIEDMAN: This is Kara Friedman, K-a-r-a, F-r-i-e-d-m-a-n, counsel for the

applicant.

MR. KAPOOR: Roger Kapoor, R-o-g-e-r, K-a-p-o-o-r.

MS. WETTER: Bonnie Wetter, B-o-n-n-i-e, W-e-t-t-e-r.

DR. ABERNETHY: Dr. Michael Abernethy, A-b-e-r-n-e-t-h-y.

DR. EGBUJIOBI: Dr. Leo Egbujiobi, L-e-o, E-g-b-u-j-i-o-b-i.

MS. COX: Sharon Cox, S-h-a-r-o-n, C-o-x.

MS. KOVARIK: Nicole Kovarik, N-i-c-o-l-e, K-o-v-a-r-i-k.

MR. HOLZHAUER: Jeff Holzhauer, J-e-f-f, H-o-l-z-h-a-u-e-r.

DR. HATTIS: Dr. Paul Hattis, P-a-u-l, H-a-t-t-i-s.

MS. COOPER: Anne Cooper, A-n-n-e, C-o-o-p-e-r, counsel for the applicant.

MS. DONALD: Nommo Donald, N

as in Nancy, o, M as in Mary, M as in Mary, O, Donald, D-o-n-a-l-d.

MR. BIRD: Jim Bird, J-i-m, B-i-r-d.

SPEAKER: Dawn Hudson, D-a-w-n, H-u-d-s-o-n.

CHAIRWOMAN SAVAGE: Renee, if you could please swear in our large group of people and they will each individually answer.

(Witness duly sworn.)

CHAIRWOMAN SAVAGE: Okay. Now, if we could have our state board staff report.

MR. CONSTANTINO: Thank you, Madam Chair.

The applicant proposes to establish a 10-bed acute care hospital in Roscoe, Illinois. The estimated project cost is approximately $21 million and the expected completion date is October 1, 2027.

State board staff conducted

a public hearing on August 13th, 2024. A total of 221 individuals registered their attendance at that hearing.

State board has also received 220 support letters and 138 opposition letters at the time of this report.

The applicants addressed a total of 23 criteria and failed to meet three of the state board's criteria listed on page 2 of the report.

Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you, Mike.

If you would like to proceed.

MR. McKEVETT: Good afternoon. Again, my name is Tim McKevett. I have had the honor and privilege of working for Beloit Health System for the past 39 years, last 10 as president and

CEO.

With me today are members of our team that are proposing of the project and each of them will go further into detail explaining their roles and providing information for you to make an informed decision which we truly hope you support.

The community partnership that we have made certainly make us stronger as an organization. We appreciate all of the community's support that you have heard today, that was heard in the public hearing, and for their endorsement of the changes we are proposing on our NorthPointe Illinois campus.

For some history on the campus, it's important to know that Beloit Municipal Hospital has been serving the residents of Illinois. We are directly on the

state line since we were established in 1928. So for almost close to 100 years we have been providing services to the south Beloit, at the time much smaller, of course, Roscoe Rockton area, but since our inception we have been providing care and been in the market.

We established a physical presence in Illinois in 1988 with a primary care clinic that's still in operation today in South Beloit. In 1991 we further expanded that primary care access by establishing a new Roscoe Rockton Medical Center which ultimately moved into our new campus, the NorthPointe Health and Wellness campus, which has a focus on primary care, specialty care, medical based fitness, high level immediate care, diagnostic and assisted living and our newest

addition, our freestanding birth center.

The campus has been there and committed to the community since its inception and we stand firm on continuing our unwavering commitment to the Illinois communities that we serve.

Our commitment to excellence is evident by our quality and focus on quality is a benchmark of our mission. We deliver expert compassionate care, centered care enhanced by our prestigious affiliation both with the University of Illinois Medical -- College of Medicine serving as a training site at NorthPointe at our main facility and our longstanding relationship with the University of Wisconsin hospital and clinics and most notably with our Northern Illinois Swedish American facility.

I'd like to reiterate, the current operations at NorthPointe, since it was established in 2007, we have consistently expanded our services at NorthPointe campus creating a broad scope of outpatient services to meet the immediate needs of the community. These include physician clinic services offering a wide range of specialty, representing 25 specialists, including primary care and surgical care. Our outpatient ambulatory surgery center was approved by this board in 2015 and opened in 2007 and is headed in the right direction. We were hindered from a buying perspective because of our commitment to withdraw, stop doing outpatient elective surgeries during the COVID crisis, so that now has come out and the volumes have returned and we're going very

strong in that area for ambulatory surgery, but really if you look, the volumes of that facility was hindered by the COVID crises and our commitment to not do elective surgeries there be compliant with the CDC and State of Illinois.

Our urgent care center is ensuring immediate medical attention for over 1,150 visits. Our diagnostic lab and imaging services is equipped with the state of the art technology, including imaging and laboratory services.

Our NorthPointe Chairs, which is a senior residential facility for assisted living for 24 occupants, 23 of the 24 are full.

At our NorthPointe birth center, which is our newest addition, welcomed its first newborn in March of 2024. Since

the public hearing, we have now had 26 births and over 50 clients have signed up and committed to have their births there, so well on our way to achieving 100 births within the first year of operation.

I'd like to renew the scope of the existing project and benefits to the community. We are proposing that the NorthPointe neighborhood hospital is not just an extension of our Illinois campus. It's a combination of our vision for competence in community care. The state of the art facility will feature 10 inpatient beds, fully equipped 24/7 emergency department that will accept ambulance transfers and, of course, the essential ancillary services.

By leveraging our existing infrastructure and space in

Illinois, we can efficiently convert some of the current NorthPointe services into this vital neighborhood hospital, ensuring cost effectiveness. Our costs per hospital bed are projected to be much less than the two other small format hospitals that have been approved in the state, Quincy Crystal Lake facility and the Quincy Medical Group. This will also allow for rapid implementation by this (inaudible).

Importantly with access to inpatient care in this community, we will help reduce the flow of patients leaving the State of Illinois and coming to Wisconsin for their inpatient care. Our plan is to keep Illinoian's stay in Illinois.

Approximately 15 to 20 percent as I look at our daily

census every day and I do, 15 to 20 percent of our patients at the Beloit main facility are from the State of Illinois.

By creating this 10 bed, we will have an average census budget of 51. Last week alone we had an inpatient census of 80 and 20 percent of those so you're looking at somewhere between 8 and 16 inpatients from the State of Illinois. By creating these beds in Illinois, this will bring care closer to home and will also allow us to expand to all private rooms on the main facility which is the standard of care for a new facility.

Other benefits to the program, creating that inpatient care closer to home will allow greater involvement with families of loved ones that have been inpatient in the northern Illinois

area. Creation of these beds at NorthPointe will allow a system again to focus on creating all inpatient project rooms at our main facility.

As I was doing my rounds yesterday morning, you will hear a little bit later in the presentation about having just an horrific day and horrific year as far as volumes from the standpoint of patients needing care, but overwhelming physical ability to house patients in private rooms.

I was rounding on a patient and he told me, he said I could use his name today and his name was Rodrigo Reedreck (phonetic). He's from South Beloit, and I asked him how his stay was going. He said he loved Beloit Health System. He had his care. He went to our South Beloit Clinic. He grew up in the South Beloit area.

He goes, it was frustrating with the fact that he had to board in our ER.

We have never had to board in our ER in our 39-year service. And over the last two years, we have had to board inpatients in the ER. Despite that he was very happy with the his care, except for his roommate. He was put into a double room, but he was very happy with his care. He focused on some of the issues that we can improve upon, but it was nice to have that -- I think it exemplifies a perfect example of what we are trying to achieve getting that care close to home.

Also improved -- the project will improve by a implementation of a 24/7 365 emergency services, the emergency care in the community.

You heard earlier today at

the public hearing support from EMS services in the community about getting that emergency care close to home. The difference between a 10-minute ambulance ride and a 20-minute ambulance ride could mean life and death. The difference between keeping those ambulances in the Roscoe/Rockton area to respond to other calls would be a matter of life and death, so improving access to lifesaving emergency care is definitely a part of our focus and expansion on care for our new NorthPointe Hospital.

The other thing I want to point out is that we will be a safety net. We have held ourselves out to the Impala standards at our immediate care. And, of course, in the emergency room situation, we will hold ourselves out to the Impala

standards, meaning that we will take and treat anybody that requires care regardless of their ability to pay at our NorthPointe facility.

This will have minimal impact on the Rockford hospitals because we are already seeing inpatients in Beloit. Moving that inpatient care down to our NorthPointe campus will simply shift those patients that we're already seeing down to our new facility.

Now, we have heard a lot of opposition, a lot of arguments to that and I think there's a lot of do as I say, not as I do and despite Mercy's claims that the precedent for the Crystal Lake Hospital or the Quincy Medical Center Hospital, they are very similar, and our focus on creating that neighborhood hospital to

bring care closer to home will have an impact on providing and improving the care in that community.

We will have surgical coverage. We will have specialty coverage at new facilities. The same specialists that have been providing coverage will be able to provide coverage at the new hospital as well that are currently providing (inaudible).

There are also -- it's important to note we as look at the -- do you look at the do as I do -- do as I say, not as I do scenario, Mercy Hospital also has freestanding ERs in the State of Wisconsin. In fact, they're building one adjacent to our hospital property in Beloit, so the standard of care that they argue of not having a full backup of the hospital really is

disingenuous and really from the standpoint is just (inaudible) when they make that argument because they've had those facilities. I understand they border just like in the Crystal Lake facility providing that care closer to home, they're still going to use that argument in front of you today to help make the case when it benefits them, but when it doesn't benefit them -- when it has no benefit to them, they certainly have gone through and established those types of facilities in our state, most recently adjacent to our -- you can actually see the ER across the yard.

Also the arguments as far as transfers, Mercy has a freestanding ER in Janesville. That is about 15 minutes from the main hospital. This new

neighborhood hospital down in (inaudible) are only 15 minutes from the main hospital, so working with the same parameters, it's important to note that those kinds of system as evidenced by our opposition and supporting it in other areas certainly makes the case, it helps make the case for our project.

As we go forward, I want to also emphasize the importance of the community support. We heard from local EMS providers noting today at public hearing how it would help them, how it would help enhance our inpatient services, provide strong community support. Again, you're hearing that really from the community, from the residents that you heard from today or that were at the public hearing, from the local city council, from the local mayors

from Roscoe, Rockton, from South Beloit.

I think it's important to know that the references on the cherry picking that was asserted that we would be doing appropriation behind the project is no one mentioned South Beloit. South Beloit is a vital part of the Northern Illinois community and their socioeconomics that is far less than a lot of -- more of our patients come from South Beloit both at our NorthPointe campus, as well as our main facility in Beloit, so the argument that we're cherry picking, we have 74 percent of our business is either Medicare or Medicaid, so cherry picking when we have been there -- when we have been there physically present for close to almost 30 years in the community. It is certainly not a

cherry picking opportunity. Again, do as I say, not as I do. When you look at what Mercy did in Rockford when they vacated the west side facility, downsizing inpatient beds, turning that emergency room to a stand by, leaving the whole west side of Rockford uncovered which is a lower socioeconomic status, certainly not indicative of what we would ever do. New projects are what we would do in Beloit.

I think it's also important that in the beacon of major consolidation of major health systems, keeping us as an independent health system, providing those services to the community is important for us to have an alternative for that community.

Again, I think some of the arguments that we're hearing from

our opposition and certainly from Mercy Hospital are disingenuous and hypercritical and are truly disrupting your process here, the commission's process.

When Mercy -- I received a call from Javon Bea, the president and CEO, when it was announced that they were going to be building a freestanding ER directly adjacent to our campus in Beloit. We discussed it. We discussed potential opportunities to cooperate in that manner and he rejected those and then he sent me an email that I think is really important that I'd like to read to you. It's been in your testimony given to you. This is directly from Mr. Bea.

He said: Tim, after we talked about the email, in conclusion there is no real need for BMH to fear competition. I

think their word today was they were greatly concerned about competition because competition, it approves -- it improves access and can often -- it can offer a choice for patients in a growing community.

So that's his words right there. I think that's a strong -- one of the strongest arguments for approval of our facility expansion of our services down on the NorthPointe campus.

I'd like to thank you for your time today. Thank you for your strong consideration of our project. We hope that you do support it because we think it will improve care within our community.

Thank you very much, and I'd like to it turn over now to our chair of our board, Ms. Bonnie Wetter.

MS. WETTER: Good afternoon. My name is Bonnie Wetter. I'm proud to serve as the chair of the Beloit Health System board.

Our mission at Beloit Health System is to lead in regional health and wellness services, delivering high quality care and satisfaction to those we serve.

One way we achieve these goals is through the community health needs assessment process. This comprehensive review identifies healthcare challenges facing residents in our service area, including South Beloit, Roscoe and Rockton. The proposed expansion of the NorthPointe neighborhood hospital is an initiative critical to meeting these goals.

Our organization operates in a healthcare ecosystem with other market players, with Mercyhealth

standing as one of our primary competitors. Unfortunately, Mercyhealth has resorted to questionable tactics to spread unwanted fear and indicates improprieties in our legitimate mission-based efforts to enhance healthcare quality in Illinois where we have operated since 1988 when we opened our South Beloit clinic, and since 1991, as the Roscoe Rockton Medical Center, and out of our NorthPointe campus since 2007.

Such baseless accusations not only misrepresents our intention, but also detracts from the critical mission of improving patient care throughout the state.

Javon Bea's complaint about our provision of care in both Wisconsin and Illinois is particularly perplexing given that his dual state operation is

precisely their business model.

As Mr. McKevett mentioned, we share markets with his system on both sides of the state line. And in Wisconsin, Mr. Bea has asserted that it is healthy competition for them to open a freestanding emergency center next door. Only when a state approval process can be limited, that its competition become problematic to him.

Let's be unmistakable presuming -- preserving healthcare access all hinges on maintaining health systems as nonprofits and mission driven entities to the greatest extent possible. The conversion of 12 Illinois facilities from nonprofit to for profit status is currently pending before the board.

It is crucial to approach this trend with caution and to

prioritize safeguarding healthcare access proprietary interest.

Other state operations do not in any way inherently threaten healthcare access in Illinois, but the nature of the operating entity is paramount.

Consider the case of Advocate Aurora, which recently became part of the North Carolina based nonprofit, mission based Atrium system. Since that affiliation Advocate Health has presented nearly a dozen capital projects to you promising to invest nearly $750 million in its Illinois facilities and programs.

While our investment is smaller due to the minor campus expansion we propose, we hope that you will welcome our investment as well.

We plan to expand access at our NorthPointe campus in Roscoe

for all patients regardless of their ability to pay. Doing so ensures that more Illinois patients can receive care within the state. This is critical as we see that out migration for this care is growing. We want to keep these patients in Illinois and serve them at our NorthPointe campus. Beyond need or patient care, our community health needs assessments revealed a shortage of primary care providers in northern Illinois. To address this we have an active practitioner recruiting plan and now have over two dozen professionals practicing at our NorthPointe campus. This expansion will help attract physicians to the area ensuring residents have timely access to essential healthcare.

This initiative is vital for managing chronic conditions,

preventing disease and promoting overall health.

We also identified a significant gap in emergency medical services within our community. The new neighborhood hospital will include a full service emergency department providing immediate and critical care closer to home for the state line community residents. This will significantly reduce transit times in emergencies, improving outcomes and potentially saving lives.

We will also retain our urgent care services at this location to ensure every unscheduled patient receives the care they need and want.

I thank you for your time and consideration. I hand it over to Dr. Abernethy to discuss his experience with managing emergency

care for the state line community.

DR. ABERNETHY: Thank you very much.

Good afternoon. I'm Dr. Mike Abernethy. I'm a board-certified emergency physician for the Beloit Health System. I have cared for patients at NorthPointe and also Beloit Memorial, so this gives me sort of a front row on the urgent need for services in the emergency department in the community.

Now, I was sitting in this exact same place about 10 years ago requesting expanded emergency care at NorthPointe. Unfortunately, it was denied.

I'm back again because things are challenging. They are not there for our patients. If anything, we are seeing more patients, more converting, more stress on the system than we had

10, years ago. And I'll elaborate about that in a minute, but over the last three decades I've worked in over probably all the state line regional emergency departments at one time or another. I've spent a lot of time at Beloit Memorial. I'm also a preceptor and educator with the EMS systems, so you can say I have a pretty good handle on the ins and outs of regional healthcare, the politics and economics of the day-to-day operations.

But this is what really matters. I live in the community. I have raised my family. I have taken my 98-year old father with a febrile urinary tract infection and had to sit in Rockford emergency departments on a Saturday night for several hours and that's not always a good thing.

I said, I've raised my family here, so when I speak to you today, I'm not wearing a hat about possible spokesman, administrative or manager. I'm the guy who works in the trenches.

I'm speaking as an emergency physician who lives and works in the community.

Now, I was sort of just amazed at the last hearing we had in Roscoe when they talked about one of the administrators, I think it was from Mercy. They did some sort of survey, and they said there were as many as 94 excess surgical and medical beds in the Rockford area that are available, said we don't need any more med surg beds. And I just want to know really, where are you hiding these beds? Because that's not what I'm seeing day in and day out.

Over the last year -- again, I've doing this for 30 some years in the community. I haven't seen the degree of boarding and stress on our inpatient and emergency departments that I have seen.

You know, I'll come in in the morning and we may have 8, 10 bends. That's almost 50 percent of our emergency department capacity is held up by patients who are boarding, and it's not only just wait an hour for a bed, two hours. No. It's 8, 12 24 hours. These patients are there. Therefore, they reduce the capacity of my emergency department, so wait times are longer, but as a physician and my nurses we have to care for these critical care patients.

Normally I get a sick trauma or a sick diabetic patient. I can admit them to the ICU and my work

is done. I don't have to worry about them, but now they are in my emergency department for hours and I have to take care of them while along with everything else that comes in the door.

We have 100 some beds I think at Beloit Memorial, and they're full. They do their best to move them, but it's not an isolated thing because in the past when my emergency department would get full, we would transfer patients. I would call Rockford. I would call Madison. I would call Rockford looking for these legendary 94 beds. There's nothing.

In the last few weeks I think I have had one or two patients accepted at one of the three Rockford hospitals. No one is taking transfers.

I know for a fact that

Rockford, Javon Bea, OSF and Swedes, they are transferring patients out. Things beyond their capabilities, they are sending patients to Madison. They are sending patients to Milwaukee and they are sending patients to Chicago.

But these beds, again, are very rarely -- it's hard. I spend -- I had one patient last week, 10 separate phone calls to try to get them accepted to a critical care bed in Milwaukee, and this was in addition to, again, taking care of all of my other patients, so it's not just us.

All the hospitals are seeing increased volumes and increased boarding. They talk about this excess of emergency care in the area. We don't need any more. I don't know how -- I guess you

heard from some emergency physicians earlier with a straight face they could say, oh, no. We got it covered. We don't need any more emergency care.

Well, you know, waiting room times, waiting room volumes, I don't know, but if there's such an excess of emergency care and beds, again, why is Mercy building a freestanding emergency department literally in the parking lot of Beloit Memorial Hospital? It's bizarre.

And they did the same thing in Janesville. You have two large hospitals. You have St. Mary's and you have Mercy Hospital and right smack in the middle, 4 miles from each of those hospitals, they put a freestanding emergency department.

They did one in Walworth County. It's about 7 miles from

the existing hospital, so as Tim was saying, do as I say, not as I do.

So I am proud to work. NorthPointe Immediate Care is a really top notch facility. Currently we operate 12 hours a day. We don't take ambulances, but I'm amazed at the thing that Beloit doesn't realize, they think a doctor or urgent care is the same as an ER, and I have seen my share of serious traumas, heart attacks, stroke, septic patients and we do a good job stabilizing and transferring, but that's sort of the essence of emergency medicine.

You know, all these hospitals, they make it sound like if you are in the emergency department, you have to have a surgeon, you have to have a nephrologist, you have to a

pediatrician. Yes, for critical care access hospitals that operate in rural Illinois or Wisconsin, that ER doc is probably the only physician within 20 miles. His job is to stabilize the patient, admit them if needed or transfer, so we can always evaluate and transfer.

And I think at NorthPointe we do a really good job. We have a full service laboratory, a CT scanner, full radiology and, again, I have seen some very sick patients and (inaudible) here doesn't do it justice, but to really serve our community, we need to expand to 24 hours to be able to take care of ambulances as they come in.

So to me this is an easy decision. Our community needs this level of care, and Beloit Health System is willing to supply

that. They have got the commitment to the community, so I'm asking you just not as a doctor, but as a resident of the community to green light this so that we can improve and serve our communities better.

So thank you for your time and attention. Next I would like to turn it over to Dr. Leo Egbujiobi and he's going to talk about emergency services.

DR. EGBUJIOBI: Thank you so much. My name is Dr. Leo Egbujiobi.

As an interventional cardiologist for about 30 years in the Beloit Health System, I can assure you that the NorthPointe campus emergency services will be more than comparable to other premier programs around.

Our planned emergency room will be fully equipped to handle

critical cases such as heart problems, strokes, acute breathing problems or shock, like anaphylactic shock.

We will have the latest technology. Our ED physicians are all board certified. They work both in the NorthPointe campus and the Beloit campus.

At the Beloit campus, most residents serve as clinical instructor to younger doctors who are completing their residency and fellowship training in emergency medicine through the University of Wisconsin emergency program.

Life threatening emergencies listed require immediate assessment and treatment. Our team at NorthPointe would provide this care in collaboration with our coordinated specialty network. Our physicians are at the forefront of medical renaissance

with offering cutting edge treatments that were unimaginable just a few years ago.

By bringing the advanced services to the Roscoe, Rockton neighborhood, we are revolutionizing the local community.

I was really impressed to hear the president talk about our commitment to Illinois for over 100 years. I didn't know that until today.

And I've been around and I can tell you, 20 percent of my patients have Illinois address.

In the past 30 years, every patient, about 2 out of 10 patients I see go to all the local hospitals for their care.

The greatest thing a doctor has is a phone call from another doctor in an emergency room, from Nebraska. I saw a young man

driving by came to us, had a heart attack. Said thank you, Doctor, I appreciate that.

So any situation where the care is closer to the patient and the physician who can take care of the patient chronically, and I speak on behalf of our doctors, our paycheck is the outcome with our patients. It's not why we do it.

I work with doctors from across the board, from Mercy, from Rockford Memorial Hospital, Advocate Mercy, from St. Luke's, from Madison, from OSF.

My job is to just make sure you know that the emergency room that they are proposing will be able to do, if not better, the same measures as anywhere else and the patient care will not suffer.

To illustrate these life emergencies, let's say somebody

comes in with suspicion for stroke. There are two things that are part of it. Stroke is one that all my patients are afraid of. They don't mind dying from heart attack. They don't want to have a stroke because the stroke, they can have half side working and they say, Doc, Dr. Leo, don't let me have stroke. But let's start with stroke.

Within 20 minutes of anybody suspected of having a stroke arriving to this campus, they will be assessed with all the images that is to be done and in communication with the early stroke center at the University of Wisconsin. I say, well, they complete it. Within 30 minutes the stroke bad. Most patients with stroke require medication, stabilization and rehab.

About 20 percent of the

patients require a clot buster called TPA. We give it, but unfortunate, less than 1 percent will bleed in the head. It doesn't matter where they go. The result is not good, but we have to consult and discuss with a neurosurgeon.

So the next thing is heart attack. Some patients -- for most of the patients, the most important thing is EKG. When I get a (inaudible), get it in the emergency room, it's good to have it in the emergency because the doctors there are trained to what you do in the next 20 minutes that make the whole difference.

For stroke, time is brain. For heart, time is muscle. The more muscle you lose, the less likely to turn it around, and the head, the more muscle in the head you lose, the less function you

are going to have in your life.

So the electrocardiogram will be processed on arrival and determination and will be done right away whether they need emergency intervention or STEMI or cath lab.

At NorthPointe to my cath lab is just 10 minutes. This cost in half because as the patient is coming, all the critical labs are already delivered to assess the care of the patient. They will proceed to under the standard of care including oxygen, as necessary, aspirin, all these medicines we know about.

To be assured one more time that for stroke and for heart attack, they actually are not going to be in a better place, because, again, we have board certified, educated, skilled individuals who are not into the

politics of medicine, but in the business of delivering care to our patients.

With our expansion, we will undoubtedly save lives and prevent many individuals from suffering severe disabilities like in stroke.

If we give the TPA early enough symptoms -- actually, I was at UVA in Charlottesville when the stroke trial was being conducted. I was impressed to see somebody with left hand damage and within 20 minutes after the drug is given, so you can make a difference. Only 30 percent of the patients we observe that.

Those are disabilities often resulting from serious emergency medicine conditions. I think it would be reasonable to say this will help me and my colleagues deliver better care to our

community.

Thank you for your time.

MS. COX: Good afternoon. I'm Sharon Cox. I'm the vice president and chief nursing officer of Beloit Health System. I began my year with this organization in 1999 -- 1998 as a certified nursing assistant. I became a registered nurse in 2000 and have worn many hats and various leadership roles culminating in my current position.

Beloit Memorial located in Beloit, Wisconsin, has experienced significant growth since its opening in 1970. We have continuously adapted to meet evolving and community needs of our patients.

In 2010 we expanded our emergency department, making it one of the busiest in the area.

In 2017 we renovated our fourth floor to operate the Hendricks Family Heart Hospital to enhance our cardiovascular care.

In 2021 we renovated our women's and pediatric unit creating the Packard Family Care Center. Our most extensive expansion has been to develop the NorthPointe Health and Wellness campus in Roscoe, Illinois.

We have been opened since 2007. This comprehensive facility offers lab and imaging, outpatient surgery, outpatient physician services, immediate care services, medically integrated fitness center, a birthing center and assisted living.

With this description we hope you and the audience appreciate our already longstanding health system operations in Roscoe and our

strong commitment to Illinois residents.

The planned neighborhood hospital at NorthPointe is a natural evolution of original vision to serve local northern Illinois patients closer to their home. Like other acute care facilities, including our own in Beloit, Wisconsin, NorthPointe's inpatient program will prioritize accessible care for acute health issues, requiring ongoing treatment and monitoring. To illustrate the broad range of services our hospital would provide for the area, I'd like to highlight some of them.

Acute respiratory conditions, such as asthma, pneumonia or COPD, uncontrolled hypertension, complex urinary tract infections, particularly those that may

involve some delirium because the patient has waited too long for care; GI disorders, complications diabetes, and even oncology complications from treatment. These hospitalized patients depending on their diagnosis and their specific needs will receive IV medications including antibiotic therapy, vital signs assessment, other types of monitoring and, of course, pain medication if needed. Immediate access to diagnostic labs and imaging, wound care, symptom management and nutritional support, that would be parental nutrition, or other dietary needs and of course physical therapy. As for discharge planning, patient and family education will be aimed at helping the patient manage whatever chronic or acute condition they are dealing with on

an outpatient basis.

The community impact of our clients will address current service gaps in the community and meet patients where they are in their life and their healthcare journey. It has garnered tremendous support from the community and represents a crucial step in enhancing patient care across our system, supporting our medical staff and addressing community needs.

Beloit Health System remains committed to advancing healthcare and addressing the shortage of beds in the area which is driving inpatient emergency care to Wisconsin. Strengthening hospital service in Roscoe will also help attract more physicians to this area which is a federally designated healthcare professional shortage area.

We believe these plans are a testament to our commitment to the Illinois residents of the state line community and that you will help us in advancing our plans.

I would like to turn the presentation over to Nicole Kovarik who will discuss emergency care at the NorthPointe campus.

MS. KOVARIK: Dear members of the board. I'm Nicole Kovarik, emergency department nursing director for our health system. I appreciate the opportunity to address you today regarding our pressing need in our community for the establishment of a full service emergency department in Roscoe.

As you know, we operate one of the busiest emergency departments in the state line community serving a significant number of patients from Illinois,

particularly those traveling from the Illinois B01 planning area to seek emergency care in Wisconsin.

For the past three years we have seen a 14 percent increase in the patient population, which has created substantial challenges for our emergency services.

To illustrate the urgency of this situation, just last week we faced a distressing reality of having 11 patients boarded in our Beloit emergency room due to the lack of available beds in our hospital. Over 20 percent of these patients were Illinois residents. Our attempts to transfer these patients to Rockford area hospitals were unanswered, a scenario that has unfortunately become all too common. I'm not here to criticize what Rockford hospitals told us they have heads and 10 minutes

later they denied us from speaking to their transfer coordinators about our boarded patients. Some of these hospitals wouldn't even tell us if they had open bed capacity. They informed us that they no longer will share their bed capacity.

Through this whole process and application process we have heard there's an excess of beds in the Rockford area, but that has not been my experience. In October alone we boarded 49 patients in our emergency department due to staffing shortages and bed availability. We were unable to transfer these patients. This compromises patient care, leading to longer hospital stays, contributes to overcrowding in the emergency room and increases employee burnout.

Establishing a small

hospital with a comprehensive emergency department in Roscoe will address these issues by keeping patients closer to home when they require the acute care.

Our plans include upgrading an existing NorthPointe immediate care department to provide both emergency and urgent care services. Patients will be triaged based on their medical conditions. Those with emergent needs such as uncontrolled hypertension or pneumonia will receive emergency treatment, while those with less urgent concerns such as sore throats or respiratory figures infections, ear infections, will be treated as immediate care patients.

Importantly our current outpatient services at NorthPointe will remain unchanged, ensuring that the rates for these services

stay consistent despite expansion of our offerings. We already operate diagnostic and treatment ancillary services at NorthPointe as an outpatient department of our main hospital. We'll maintain urgent care capabilities and ensure that urgent care services are correctly classified as urgent care visits and not uploaded to an emergency room visit.

This is an important fact based on the commentary about our plan. The design of our planned emergency department allows for flexibility. Should demand increase we can move our immediate care bays to accommodate emergency cases promptly.

We are committed to upholding compliance with Impala regulations which means we will continue to accept all patients regardless of their ability to

pay. The new emergency department will be designed as a comprehensive level ED by the Illinois Department of Public Health equipped to handle a wide array of specialty consults.

During peak hours we will ensure that each shift is staffed with a balanced mix of physicians and midlevel providers to deliver optimal patient care. We continuously evaluate staffing needs based on volumes of patient check-in times to ensure that we provide safe and efficient care.

Our commitment is to adapt our staffing strategy as necessary to meet the demands of our patients effectively.

A substantial scope of emergency and stabilizing care will be available to treat patients presenting to NorthPointe emergency department regardless of

walk in or ambulance transport.

In 2022 and '23, only 12.5 percent of patients presenting to our Beloit Memorial Hospital emergency department were admitted for inpatient care, reflecting a trend that is consistent with statewide hospitalization rates for nontrauma patients. It is essential to recognize that the majority of emergency services involve treating and releasing patients who do not require hospitalization. Local EMS providers are well trained in the field of triage ensuring patients are transported to facilities that can meet their specific needs. NorthPointe emergency department will be well equipped to stabilize and treat most medical emergencies effectively.

My respected physician colleague, Dr. Leo, has joined us

today to explain the benefits of having an emergency room in the community including initial cardiovascular and stroke intervention.

Patients that require advanced care will have transfer options including nearby facilities such as Beloit Memorial, UW Health, OSF, Mercyhealth. If specialized services are necessary, patients will be transferred to the closest available option. This will be a similar process that the freestanding emergency rooms do when they are transferring to hospitals.

Establishment of a hospital in Roscoe will alleviate service gaps and reduce the over utilization of Beloit Memorial Hospital.

Most importantly, it will

facilitate access care closer to home, enabling patients to receive support from their families during critical times.

Thank you for your attention to this matter. I will now hand the presentation over to Jeff Holzhauer, our architect for the project, who will provide an overview of the design plan.

MR. HOLZHAUER: Good afternoon. My name is Jeff Holzhauer. I'm an architect and associate with Eppstein Uhen Architects.

My role on this project is as senior project manager, so I'll be working with the team that is familiar with Beloit Health System.

I have had the privilege of working with Beloit Health System for some 20 years, either at the current firm or previous. I was

actually part of the original development in 2004 when Mr. McKevett and I worked together on that project, so it's really great for me to be able to be here and see how this has transitioned over time.

I was also involved in the recent NorthPointe birth center project, so I'm happy to hear that it's doing so well as well.

My role today is really just to give you a little bit more on the physical environment of the campus. You have heard a lot of it already so I'm going to change my presentation a little bit. Mr. McKevett talked a lot about all the facilities that are there, as well as Sharon talking about the various departments within.

I think I'm going to focus a little bit more instead on what was done initially. As part of

the original project, Beloit Health System team was very interested in planning for the future. With healthcare we never know what's going to come around the next day, hence COVID, right. We never knew what to do and never had a plan for that. Couldn't have planned for that as easily as we could, so they planned ahead. They said we want to make sure that we implement things now that will help us in the future, so some of the things that they did is making this transition a little bit easier than it would be and more cost effective than other facilities that might be building a brand new 10-bed hospital.

They took into account fire ratings. We built the building to a higher level of construction classification to support the needs of that. We put in fire

separation walls needed to be in advance so that we knew that if did need to separate, if there was a need for that in the future, it was in place. Granted, a lot of years have gone by and we will go back through and double-check all those. Smoke compartmentalization was put into the project originally to support that so that if it ever did need or have a desire to become a hospital some of those portions were already built into the building.

We also looked at the HVAC for the building. As we can imagine going from a business occupancy facility to a fine-tuned hospital facility, there are new regulations and additional ventilation requirements needed, so the air handling that were put into the building had the capacity to support this new endeavor, so

we don't have to make those costly changes. We don't have to build in new air handling systems for that.

Medical gases were part of the original complex. They were sized appropriately. They were expanded upon with the ASTC that was added in 2015 and extended to areas that were (inaudible).

Many of you may recall, there's a photograph here I put up that you can see a little better. That's the second floor overlooking top of the ASTC. That was approved, first CON at that time with the cap. (Inaudible) come back to us before you design anything and put anything into that facility, how we plan to use that space on the second floor would be utilized for the 10-bed inpatient unit, so that's roughly about 13,000 square feet. That

will fit that beautifully.

Other things that were done initially were emergency tower system for the campus. The original complex was not required to provide all three branches of power for life safety critical and equipment branch. They said we want to have that separate now. That's going to be impossible to do in the future if there's ever a change, so let's implement that. Let's get that all ready. That was built into the project originally. It was even set up for space for future transfer switches and things needed when emergency power is brought on to the campus. That was then implemented as part of the ASTC project, so now we have emergency power capacity for the campus which will also support the new proposed small format hospital for

the NorthPointe hospital.

So all great things that a brand new facility would have to deal with are already in place. That makes it very efficient.

The only addition that's being proposed for the new neighborhood hospital is about a 4200-square foot addition to the east side of the campus which will abut the immediate care center and that immediate care entry.

The immediate care entry will now be proposed to be the new emergency department main hospital entry, if you will. That addition will then provide a two-bay ambulance garage, additional treatment spaces as required by the Illinois Hospital Code for treatments stations like sexual assault treatment spaces, a secured ED treatment room, not only to support their physical but

also behavioral needs of those patients. We will also have an airborne isolation room so many of the things that are required being built into that addition to supplement the immediate care and increase that capacity to be a full emergency department.

Talk about the 10-bed unit, one of the benefits is the way that the hospital is designed with vertical capacity, patients that come into the ED will then have a direct vertical shot directly up to this unit, but they don't have to cross over. The separations will be put in place from the emergency part and diagnostic imaging, as well as from the surgical side for the ASTC, so we have great connection between there. Patients never leave. It's once you're in the hospital portion, you are there.

So was going to go into a little bit more detail, but I think you've heard quite a bit about that. If there's any other questions later on, I'm happy to help. Pass it on to Nommo.

MS. DONALD: Thanks, Jim.

Good afternoon. My name is Nommo Donald. Thank you for the opportunity to speak with you this afternoon.

I serve as the vice president of professional services, professional support services at the Beloit Health System with over 20 years of experience in mission based not for profit healthcare administration. I will receive critical services for the communities we serve.

Our proposed has brought community support to the state line community. It aligns with

the board's objectives to provide comprehensive community care. Our mission, to be the leading system that delivers high quality, value and satisfaction to our patients in the communities we serve. We are a not for profit tax exempt organization which makes us an excellent candidate to address the needs we have identified, namely the increased out migration to Wisconsin for inpatient care. This out migration, as some of the testimony as you heard today, gave the impression that the utilization for Winnebago hospitals is flat. The reality, per providers and their capacity limits is shifting care out of the State of Illinois.

Just as you heard our director Nicole mention about last week and some of the things she said today was new information was

disheartening actually to hear that it wasn't about the availability, but even the lack of concern for the community and the needs that we shared when we held 11 patients in our emergency room for two days and there was no response or no support from Freeport, UW, Swedes, Mercy or OSF.

I thought it was a capacity issue, but it sounds like some folks just didn't want to answer our call. That's disheartening. Let's please all remember why we're here.

Our focus, our system has implemented a comprehensive approach to address social determinates of health. We have identified patients' health related social needs, including housing, food insecurities, transportation and social support.

We conduct sensitivity training to conduct screenings and interpret results accurately. When needs are identified, we connect patients with appropriate community resources and support services.

One example, the team identified a decline in breastfeeding in our minority and underserved population. Our care team created educational and support services to increase that important number.

We provide staff culturally competent and implicit bias training to ensure our services are accessible and culturally appropriate. We provide stabilizing services for all regardless of their ability to pay.

Some fun things that I found out during this journey, even our

emergency room and our commitment to our citizens in our community, we are not a homeless shelter, but we serve as the last resort warming shelter for unhoused individuals during extreme weather conditions. For those experiencing the trauma of not having a place to stay, we try to provide a sleeping area in the ED waiting room with blankets and pillows, access to restroom facilities and meals when we can. Why do we do this? One, it's the right thing to do, but we know that the emergency room is also the least path of resistance. Folks who are out in inclement weather will present themselves in the emergency room for care that they may not necessarily need, but will need if they remain out in those inclement weather conditions.

So I'm proud to say that our very own emergency department social worker, Dawn Hudson, is here with us today. She will answer any questions you may have about how we manage underserved and vulnerable patients in her emergency department, including those experiencing mental health crisis which we know is a big issue in the world as a whole.

And as it relates to quality and satisfaction among our other accolades we are proud to hold a four star rating under the Medicare compare quality and satisfaction assessment. This rating -- I'm staying on script. I'm not bragging. This rating surpasses all three operating hospitals in Winnebago County and also exceeds the ratings of Mercy Janesville Hospital. This is your small little community hospital,

that's us.

NorthPointe Hospital in this proposed project will be an integral part of the healthcare system. Our goal, to continue collaborating with the even broader medical community. Anne Cooper will provide more detail in a moment on the patients out migration to Wisconsin for patient services that Winnebago is currently experiencing.

The hospital on the NorthPointe campus will help steer the out migration, keeping care local for Illinois residents. None of us want to transfer to another state to receive the care that we need.

I thank you all for your time on this very long day and your consideration. I will now turn it over to the Beloit Health System CFO, Mr. Jim Bird, to talk

to you more about our commitment to community.

MR. BIRD: Before I speak I'd like to have Dawn say a few words about our community.

MS. HUDSON: Hi. My name is Dawn Hudson. I'm a licensed clinical social worker. I'm licensed in Illinois and in Wisconsin. Can you hear me?

CHAIRWOMAN SAVAGE: Louder.

MS. HUDSON: My name is Dawn Hudson. I'm a licensed clinical social worker and I'm licensed in Illinois and Wisconsin.

Clearly I do not do a lot of speaking into mics, so forgive for me that.

I'm the social worker in the emergency department. I'm not manager. I'm not a director. I'm not in leadership. I'm the social worker. I work with the patients. I work with the families.

The reason I'm here and the reason I wanted to speak with you is to tell you about their experience and why this hospital is so necessary to the people that I work with who come up from Illinois.

There are things that are very unique when a person or a family has to cross a state line, particularly when we are dealing with people with mental health. There are laws that change dramatically when we go from Illinois into Wisconsin. It is such a massive change for people.

I want to get right to the point because one of the biggest issues is when we take people from Illinois and they come into Wisconsin, getting them back into psychiatric care inpatient in Illinois is a huge concern, and I heard all this talk about the

distance and how far they have to go. I'm like, okay. Well, let's put the brakes on because if they are put on a police hold in Wisconsin, they are going to go all the way up to Winnebago, three hours into Wisconsin, into the state psychiatric hospital. The reason, because they would be involuntarily, and you can't transfer an involuntary person across a state line. It's not (inaudible). That's a problem. It's a problem for their loved ones. It's a problem for the patient. It's a problem when they get discharged because how do they get home? There's nobody to pick them up.

That might sound insignificant, but it's huge. It's a big issue for these people who are already struggling.

For the people who are

voluntary, they come in. They say, hey, I need mental health treatment. Can you get me inpatient? Can you help me? Yes, I can, except now to get you back into Illinois, I have to fill out paperwork that says you are involuntary just in case you change your mind in route to the hospital that I am going to send you because then if you change your mind, they can flip that and keep you into whatever hospital I'm sending you to.

It's complicated and it's scary and they then are like maybe I won't go after all that. Right. I don't have enough to force them to go. Their voluntary status just changed.

That's a big issue for people. It's a big issue for their family.

For privately insured

people, we need children, getting a SAS assessment across the state line, I'm not sure if that's a term that any of you are familiar with. It's a challenge. These kids are left in the ER for a good while waiting for them to track down somebody and get approval from some supervisor for them to be able to come across the state line. It's access that's denied to them.

When we have the emergency room in Roscoe available to them, that changes. The practice that I do in the ER in Beloit is going to be the same practice that I do and my colleagues do in Roscoe. It's going to look the same.

We don't have to people sitting in our ER for hours on end because that's not the way we have designed it. I don't have them sitting for four or five days in

Wisconsin and I don't -- even the Illinois residents don't have to sit that long, right.

But what will be accessible to them is being able to go to whatever hospital is closer to them, usually within about an hour of Rockford. Why is that? Because the one and only psychiatric facility that does inpatient in Illinois saves their beds almost exclusively for their emergency department. Mercy, who used to have inpatient psych services, got rid of that service. They don't do that any longer.

I can't transfer people -- addiction or AODA and addiction treatment. They come into Wisconsin. Getting them to detox, massive challenge, right. They can't go to Wisconsin. Wisconsin is like, hey, listen that's for -- those services are for our

residents, right. So how do I get them back into Illinois? It's a huge burden.

If they were already in Illinois, the infrastructure is there. It's easier to put them in transportation and get buses, get cabs, cab vouchers, whatever. It's easier to do. It's easier for their families.

So all the things I have heard are so important and they matter, but the people that I work with in this mental health group, they are struggling.

We have such a significant number of people in the state line area who are homeless, who struggle with mental health and a good number of them are on the Illinois side, and I see them all the time.

We do wrap-around services. It was -- they mentioned how we --

in the wintertime, we are the only hospital that has a warming shelter for men, women, doesn't matter. They come in and they get case management services, which is why they come. That's a replicable service that I have no expectation wouldn't be replicated in Illinois.

I have been with the health system for almost 24 years now and that's what it's been like my entire career with them.

So that is, I guess, kind of the gist of my point. These are real people. These people in South Beloit, Roscoe and Rockton come. They see me. They see me frequently right. They're struggling and they need better access. I need better access to be able to help them, and having a place where I can utilize my Illinois license and my colleagues

can utilize their Illinois license freely would make a big difference to them and the quality of their lives.

Thank you. Thank you. I hope you could hear me.

MR. BIRD: Thank you, Dawn, for those points that somehow someone, they always seem to get put in the corner and we appreciate your passion taking care of our patients.

Good afternoon. I'm Jim Bird. I'm the chief financial officer of the Beloit Health System. I appreciate the opportunity to address some of the allegations made regarding the planned neighborhood hospital at NorthPointe.

First, I would like to address the cherry picking allegations. Our competitors have claimed that our new hospital is

solely being developed to cherry pick the commercial insurance in the Roscoe area.

This assertion is not only inaccurate, but also deeply misleading. Allow me to present some facts.

Our nonprofit system is fully enrolled and actively participates in the Illinois health and family service Medicaid programs. We except Healthcare Choice, Medicare advantage plans in the area, including product from Molina, Meridian and Blue Cross and Blue Shield.

These services are available at both our NorthPointe campus and our hospital in Beloit.

In stark contrast, Mercy, one of our main critics, canceled those contracts in 2020, effectively abandoning those patients.

This nonparticipation remains largely unchanged today. As a direct result of Mercy's actions, our system experienced a 300 percent increase in Molina Medicaid visits between 2020 and 2023. We also received a 200 percent increase in Blue Cross/Blue Shield community health plan visits in 2020 through 2023, and also a 70 percent increase in Meridian visits. We took care of those patients when no one else would.

It's crucial to note that our system's payer mix consists of about 74 percent government payers, including Medicare, Medicaid, and self pay patients.

We have stepped up the care for the very patients abandoned by the health systems now accusing us of cherry picking, an allegation I find both disingenuous and quite

frankly insulting.

I'd like to address the claim that the hospital would have devastating hospital on the Rockford hospitals. Some have expressed concern that the community hospital at NorthPointe would have a devastating affect on the hospitals in Rockford.

As a CPA, with an MBA and 10 years of public accounting experience before entering healthcare, I find this claim to be without merit. Consider the following: One of the Rockford hospitals boasts an operating margin of $325 million. Another has an operating margin of $52 million. Both have hundreds of millions in cash reserves.

I should also mention that based on publically available data, several news reports, Javon Bea made over $11 million as his

organization CEO in 2023, and an estimated 36 million in compensation from 2021 to 2023. Just his annual salary is well over our system's margin last year.

We have really had to spend a lot of resources advocating for this project based on his keen interest in protecting his large market share.

The notion that a 10-bed hospital opening 12 miles from Javon Bea and even further from OSF would devastate such financially robust institutions is quite frankly absurd.

To put this in perspective, we currently have an average daily census of about eight patients from Illinois at the Beloit Health System. Even if all the patients at the new hospital were new to our system, which is extremely

unlikely, it would amount to approximately 400 discharges annually.

This translates to about 3 million in net revenue, a negligible factor of either Rockford hospitals.

The conclusion is in light of these facts, we urge the committee to treat the comments of these speaking against our proposal with skepticism.

These individuals are not under oath, as we are, and their participation in these proceedings is a pure attempt to keep market share which this board is not charged with protecting.

Consider the vast disparity in size, resources between our system and the two larger systems opposing us. Recognize that our planned facility will add only an emergency room and 10 beds as a

modest expansion of our existing significant operations in Illinois.

We are committed to serving our community, including those patients Mercy has chosen to abandon.

A community hospital at NorthPointe represents our continued dedication to providing accessible high quality healthcare to all members of our community regardless of their insurance status.

Thank you for your time and your consideration. I'll turn it over to Phil.

MR. HATTIS: Hi. I'm Paul Hattis. I'm a senior fellow with the nonpartisan Lown Institute Healthcare Policy Intake in Massachusetts and I also contribute to CommonWealth Beacon as an opinion writer and podcaster

on health policy.

Previously I was a senior associate director of public health programs at Tufts Medical School in Boston focusing on hospital community benefit, healthcare affordability, consumer engagement and policy, decisionmaking as part of my research.

I'm returning to my home state today which is significant to me. I completed my training as a physician and a lawyer at the University of Illinois. I'm coming here today to offer some insights on the state's health planning review process, I do so having served as one of the inaugural commissioners on the Massachusetts health policy commission, a body that shares common goals with this commission, commendable charged to work to

optimize healthcare services and facility planning to prove access, quality and cost efficiency.

The U.S. healthcare system faces a significant challenge due to market dysfunction and high cost all being driven by large healthcare systems with substantial market power are a big part of the problem.

Supporting smaller independent nonprofit providers is crucial to addressing these issues.

Massachusetts just recently we went through the debacle of Steward Healthcare, its bankruptcy, and what we found as the solution and turning not to our largest nonprofit, but some of our small intermediate size ones to take over the surviving hospitals and even across the state, Rhode Island, the nonprofit

system to help us with this problem.

So with this perspective, I'm here to advocate for the expansion of NorthPointe campus to include inpatient emergency services which will benefit Illinois residents.

Beloit Health System has evolved from a city owned facility into a diverse nonprofit system serving the state line community for strategic growth, including NorthPointe health and wellness campus and hospital. Beloit is a Medicaid disproportionate share hospital with about 70 percent of its patients being government sponsored. It has only a modest operating margin of about .3 percent. You heard from our CFO how that's glorified by some of its competitors.

This proposed 10-bed

hospital with emergency services is logical given the patient utilization rates of Beloit Memorial and the increasing trend of Illinois residents seeking care in Wisconsin.

The expansion will enhance access for state line residents, something you heard highly desired from folks this morning and from the professionals on the table with me how important it is delivering the kind of care that people need.

There is also a potential for healthcare spending savings for Illinois residents with private insurance.

We shared with you publically available data developed under a Rand Corporation study which compares what hospitals are paid to care for commercial patients relative to

Medicare.

Most recent available data shows that the Beloit Health System is paid 11 to 27 percent less than the Rockford hospitals for inpatient care. Often real potential savings for state line employers and residents who (inaudible).

As some of the patients who come to NorthPointe may already be on Medicare or Medicaid or are crossing the border to be hospitalized in Wisconsin, at most at any level of operation of a new facility, any lost patient care dollars for these high revenue Rockford hospitals will be minimal. You just heard that.

As for objections from other providers in the state who are against the concept of a 10-bed hospital, those comments are only self serving in a broader sort of

way to try to help other providers in the state who could be under a similar threat, I suppose, to hold on to their significant often dominant market share.

Look, the need for additional beds in the state line community has been talked about today. The increasing trend of state line patients crossing the border into Wisconsin for hospital care is resulting in capacity challenges and contributing to problems like ED boarding at Beloit that you just heard about today from Ms. Kobarik and Dr. Abernethy.

What can be better evidence for the need for this project than listening to those pieces of testimony and information.

This proposal at NorthPointe is a value adding one. While respecting existing healthcare

systems is important, transformative improvement should not be hindered by efforts to protect market share. This expansion offers significant benefits without any meaningful negative affects with competing providers.

I appreciate your opportunity to testify before you today and offer this evidence. I really do hope you will approve this proposal for the benefit of state line residents and Winnebago County residents even more broadly. Thank you very much.

MS. FRIEDMAN: I'm going to try to keep this real brief.

CHAIRWOMAN SAVAGE: Who are you?

MS. FRIEDMAN: This is Kara Friedman. I'm going to try to keep my comments really brief because I think we've really

covered a lot of the opposition's testimony.

This map, you have seen it before. The only difference it's what Mercy put up. We removed all the urgent care centers because we are trying to establish hospital services emergency department, so here in Janesville you have two hospitals. You have Beloit Memorial here. You have got the Rockford hospitals, 12 miles plus south and our NorthPointe campus is right in the middle, so it's a really nice compliment and it already exists.

The picture that you see there is the existing campus. That's not a rendering of what's going to be built.

I'm going to just stick to a couple technical issues that were raised by the opposition. And I'm not sure if I have a seat, so I

guess I'll just walk to the other end.

The building for the current location, the current location is already a hospital outpatient department of Beloit Memorial Hospital, so it is receiving what's called the outpatient perspective payment system reimbursement, so that will not change when inpatient services are located there. It will stay the same.

The remote location concept, while we have discuss with IDPH that this doesn't have to be a remote location, that's the choice of this provider, we reviewed -- and I have been supported by my Medicare specialist in my office, we reviewed that it is permissible as long as you put all the components in place with an interagency reciprocal agreement

between the two states and you otherwise comply with the remote locations requirements. We believe that this will.

There will be clinical integration, financial integration and administrative integration.

We also reviewed the configuration of the building to demonstrate that we can have a licensed facility despite the fact that there are other occupants in the building that can be separated so that we won't have a co-location issue.

Two final points, there is a legal precedence in an Appellate Court decision that Mercy was successful in obtaining to operate its Crystal Lake hospital, 13-bed hospital, so that actually is a technical legal precedent for approving this project despite the fact that it's smaller.

And, finally, we really do feel like the hospital association guidelines that they put out about three years ago for what a small format hospital should be, that we really meet them in every respect.

It's going to be Medicare enrolled. It's going to have a comprehensive emergency department. It's going to be anchored by another nearby hospital, and it's going to be an acute care hospital. It's not going to be a surgical hospital or some sort of limited boutique hospital.

And of course, as you have already heard, it's a nonprofit hospital. They will be continuing their policy of treating all patients regardless of ability to pay.

I hope I was pretty succinct there. I think Anne Cooper needs

to discuss the negative findings of the board staff report and then Dr. Kapoor will conclude. Thank you.

MS. COOPER: I'm Anne Cooper. I appreciate the board's past thorough review of the NorthPointe CON application and the largely positive staff report.

Notably this plan with only three negative findings is otherwise generally compliant with the board's 23 review criteria and it comes closest to general compliance with this board's criteria when compared to the other two recently approved small format hospitals including the one developed by Javon Bea in Crystal Lake.

Relative to financial viability and economic feasibility, it meets all the review criteria, so I'm going to

now focus my presentation on the part 1110 criteria.

The first one is the planning area need. The formula for the bedding calculates an excess of medical surgical and pediatric beds in this area based on the 2021 utilization, 2026 perspective population and that migration between Illinois planning areas. What I want to drill down to more accurately describe what is driving the identified need for this proposal.

First, we need to consider the pediatric beds. Inpatient pediatric beds are a separate category, but the associated pediatric bed need is rolled up into the need figure we are examining. Of the 22 pediatric beds in the VO1 planning area, only five are justified based on the average daily census of

pediatric patients over the past three years. Of the 17 unused pediatric -- if the 17 unused pediatric beds were removed from the calculation, it reduces the excess to 77 beds.

Importantly there are now rules regarding inpatient care of children in general acute care hospitals without a dedicated peds unit, and typically the demand in the region for low acuity hospitalizations for kids is very modest. Given this, most small pediatric programs in general hospitals are modestly used and the contemporary practice is to send most children requiring hospitalization to specialty children's programs in Chicago and to American Family Children's Hospital in Madison and Children's Wisconsin, in Milwaukee.

Many hospitals have closed

their pediatric units in the last decade, and in the future this board might consider separating the demand for pediatric inpatient care from the adult bed need figure due to the recent shift.

The second one -- secondly, there are unused medical surgical beds in the planning area. Currently there's 34 unstaffed beds in the inventory for this planning area, which is the full complement of one hospital, which further reduces the excess to 43 beds, if those unused beds were removed from inventory.

And then, finally, we should consider across border migration. Board's calculation does not account for out migration from Illinois to Wisconsin.

In 2023, 2,640 Winnebago County residents were admitted to medical surgical units in

Wisconsin hospitals accounting for 16,134 patient days. To recapture this out migration, the planning area would need 56 beds. These adjustments result in an overall need for 13 beds in the planning area, and notably there are also approximately 4,500 Winnebago County residents receiving emergency services in Wisconsin hospitals annually, and this figure has increased 14 percent since 2021.

It is unclear to us why Mr. Bea is adding emergency room services in Beloit when having ED services in Roscoe would significantly stem out migration for this care.

The second criteria was unnecessary duplication of services. The need analysis in the North Pointe 17 mile GSA applies to uniform 90 percent

occupancy rate to come up with an excess of beds. With the following calculation, we have applied a particular occupancy standard which is set out in the 110520 rules for this board that is based on the hospital unit side.

Javon Bea is authorized for 84 med surg beds and the corresponding utilization target is 80 percent. Based on its 2023 average daily census of 73.3, it can justify 92 beds.

OSF St. Anthony Medical Center is authorized for 190 med surg beds with a corresponding 85 percent state standard. Based on its average daily census of 146.3, it can justify 173 beds, and then, finally, Swedish American Hospital is authorized for 199 med surg beds with a corresponding 85 percent

utilization standard. Based on its average daily census in 2023 of 154.3 patients, it can justify 182 beds.

Collectively these three hospitals can justify a total of 447 medical surgical beds resulting in an excess of 26 beds.

Importantly, as noted before, to curb out migration to Wisconsin while allowing hospitals to operate to state board standard, an additional 30 medical surgical beds would be required. And note, we are only asking for 10.

Finally, the last negative criteria pertains to the performance requirements, otherwise known as the 100-bed rule. We concur with Mercy's previously stated position that the 100 bed standard is not a mandatory one and should not be

determinative.

Both of its newest hospitals have less than 100 medical surgical beds. The healthcare landscape has evolved enormously since this criterion was established over 35 years ago. Both technology and other medical advancements shifted care towards an outpatient setting. These issues represent the sole departure from complete adherence to the board's established criteria.

As this board's former administrator and board member, Ms. Avery, has testified today, the minimum threshold criteria serves as just one element in a comprehensive set of review criteria for planned hospital facilities.

We appreciate this board's exercise in its discretion to

approve application that may not meet every review criteria. Your discretionary power has been consistently upheld by Illinois courts which have emphatically expressed that no single criteria should be given undue weight over others. Instead our Illinois courts have ruled that the board should assess a facility plan on the merits in its entirety.

This is a critical expansion plan for the benefit of Illinois residents of the state line community who would appreciate your favorable consideration.

I'll now hand the mic over to Dr. Kapoor to conclude.

DR. KAPOOR: Thank you. And I'm Roger Kapoor. I'm the senior vice president of the system and I'm sure you are happy to hear that I'll be closing out our testimony, and I appreciate your

careful consideration of this proposal.

I do want to take a moment and specifically mention and humbly appreciate the board's staff for their diligence, for their traveling to the state line community to see and hear what was essentially very overwhelming community support expressed at our August public hearing.

I also want to take a moment to just express my gratitude to the state line community representatives that came here today and their presence and the presence of the individuals behind us really demonstrate the unity that define our community, and personally I'm profoundly moved by it.

Our proposal, as you heard, represents a near evolution of our vision in Roscoe. As you have

heard many times, we're a nonprofit mission based organization and proud to continue to invest in the health and wellness of Illinois, and this investment does address a growing need for local healthcare services, reducing a necessity for residents to travel to Wisconsin for admission.

The smaller footprint that we are presenting is ideal for this geography. It fills the needed gap for emergency services and inpatient admissions in Illinois that's evident based on the out migration that you just heard from Anne.

Additionally, despite what you heard, NorthPointe is in a healthcare desert. It's confirmed in that board staff report as we are federally designated healthcare professional shortage

area. It's important for you to recognize that because it's not only important for us to address it, it's actually essential for us to do this to improve the health outcomes for this community to ensure timely care, fulfill our mission as a community based hospital.

And so this 10-bed proposal is a measured proposal based on genuine need, actually addressing the Illinois patients that are already leaving the state line community and coming -- already leaving the state and coming to Wisconsin for healthcare.

As you heard, our system does centralize our care on patients. We're patient centered. We are value based. We're high quality. We meet patient's needs close to their home and their family's support.

We think that this project will certainly further that mission.

Updating our Illinois outpatient hospital campus into an inpatient acute care facility will also keep those Illinois residents again close to their home and in state.

We align with the Illinois Health and Hospital Association guidelines as you heard Kara discuss. We're a small format hospital and we have been a member of that organization since 2015.

As a nonprofit, again, mission based health system, we see all patients regardless of their ability to pay, and despite how our competitors may recognize and label us as interlopers, I want to emphasize that our system, again, already operates many of the broad range of hospital

outpatient services. We have done so for many, many years.

As a physician, I have got a dual role at this organization, working both in our clinic and in our administration. I'm personally from Illinois. I'm closely tied to this state, but as such, I'm one of approximately 25 doctors that routinely see patients at NorthPointe.

In size our proposal is very similar to Javon Bea's recent new hospital in Crystal Lake with a big difference since his communications indicate they be designated that format to be a one-night hospital stay for surgical needs.

Again, we aim to serve existing patients more broadly and locally by serving them in the State of Illinois where they reside.

Our Illinois operations are fully subject to Illinois regulations and Illinois oversight with Illinois licensed nursing staff and Illinois licensed physicians. This investment will bring broader economic growth and development for the state line community, and, again, as you heard with respect to Javon Bea's objections to the proposal, we find them disingenuous given their own investment in this model. Their expansion of urgent care hours was announced in this region after we filed our application, but it falls short of meeting the community's comprehensive needs, and it still leaves gaps in healthcare access which we aim to fill.

Quite remarkably as you heard, Javon Bea's currently building that freestanding

emergency center literally adjacent to our Beloit emergency room. The facility is being erected actually a short distance from my office. I can actually see it right outside my window everyday. I can hear the cranes.

If approved, we are going to accept ambulance transports. We are going to provide comprehensive stabilizing lifesaving care, offer those benefits of inpatient hospital care, the scope of which Ms. Cox said earlier. We're going to enable seamless transfers when tertiary care is needed based on patient choice.

Beyond stakeholders personally showing up to do letters and testimony, I want to remind the board humbly that we submitted a petition that was signed by 1,400 community members backing this plan, demonstrating

again that organic local support for this project.

Our success here in growing those helpful resources in Illinois really strengthens our support base. I think that's reflected in what you have seen before you.

I think this represents a significant step forward in healthcare accessibility for the state-line community. We believe that we are going to continue to provide that high level care and we aim to deliver an efficient, accessible and high quality healthcare services in Illinois which aligns with this board's stated mission.

We want Illinois patients to receive the right care at the right time at the right place.

I want to thank you again so much for all of your service here

today and for being here, for your consideration. Frankly, we hope you support our proposal and we're very happy to take your questions.

CHAIRWOMAN SAVAGE: Okay. Well, I'm going to have Blanca Dominguez say something first.

MS. DOMINGUEZ: Hi. Just for the sake of a complete record, as far as the 34 beds that were referenced that are unstaffed at this time, the provider, there's an intent to get those beds staffed. Whether that happens, I don't know, but as of now, there's an intent, so I just wanted to make sure that the board has the full picture to consider when it's making its decision.

Thank you.

CHAIRWOMAN SAVAGE: Thank you, Blanca.

Okay. So mostly today I heard from you all about the ED

aspect, and we appreciate that being that I have run an ER before, so when you are talking about as a remote location from Beloit, so I'm assuming you're going to be part of that. You have the same name, but because you focussed so much on the ER, I think the one young lady -- I can't remember what her name was -- but she talked about like acute asthma, complex UTIs, uncontrollable hypertension, diabetes, maybe some wound care, diagnostic care, parental nutrition, those are the things I'm assuming that would go on with the ED to be admitted to the hospital because you only have 10 beds.

So if a patient comes into your ER, obviously you are going to stabilize them. You have to do all those good things as good ER

doctors and nurses would do, but if they truly need ICU, I'm used to boarding the ICU in the ED until you find yourself an ICU bed, which, as I imagine, your hospital is not going to have.

So how are you going to get -- with all of these other EDs being overrun with people staying in the ER forever and not giving you beds, how are you going to get those ICU patients out of your hospital if you don't have any ICU and get them to the care that they need after you stabilized them as much as you can?

MS. KOVARIK: I can speak to that. So first of all -- I'm sorry. My name is Nicole Kovarik.

We offer the patients or their family or their legal representative the option of where they want to receive their services and that's something we

currently do in the urgent care that exists there, and then we would work to get the patient transferred just like we do now out of the emergency room if we don't have an ICU bed, so we do not plan to have the ICU beds there at the neighborhood hospital, so that would require us first to ask what their preference is and we would transfer to their preference if we can get them accepted.

Then if not, we would look for the hospital that provides the services that that patient needs and work to transfer them.

Currently many of our critical care patients, trauma patients, go to UW or Crater (phonetic). Certainly if their preference is to be in the Rockford area, we'll work to do that.

CHAIRWOMAN SAVAGE: Kind of where I was getting at with that is the ambulances, you know, law enforcement, EMS, fire, and you folks in the doctors' world have talked about not being able to get the patients fast enough to these other sites. It's a common problem we have in this area too.

You are taking your ambulance, your ALS ambulance, out of service for a very long time, so now if you have a patient, you've stabilized them in your ER. Now they need to go to ICU. Are you calling the EMS system to get that or do you have your own ambulances you're going to have that are ALS, because that's what you're going to need if they're ICU patients; how are you going to facilitate that?

MS. KOVARIK: So currently for our ICU patients we either use

Flight. That's available. That would be an option, and then the thing is we have a preferred provider for our ambulance transports out of the Beloit Memorial system, and so we are looking to establish that relationship as well for the neighborhood hospital, not using the local EMS to transfer out of the hospital.

CHAIRWOMAN SAVAGE: Beloit ambulances are ALS ambulances that provide that care?

MS. KOVARIK: So we use a private ambulance service to provide critical care transport.

CHAIRWOMAN SAVAGE: Okay. That was one question.

Something else that came up, I had a thought about this. Will this hospital have its own board with Illinois members? Like a board of directors of that

hospital, the neighborhood hospital?

MR. McKEVETT: Current proposed structure -- oh. Tim McKevett, Beloit Health System president, CEO.

The current corporate structure being proposed would be our existing health system board. It does have four residents of Illinois on it.

CHAIRWOMAN SAVAGE: In this area?

MR. McKEVETT: Yes, right out of the Roscoe area, yes.

CHAIRWOMAN SAVAGE: Okay. Something else I had. All right.

So in your ER you talked about having the ability to have TPA to stabilize them. Do you have cardiac enzyme testing in your ED expected?

MS. KOVARIK: Yes.

DR. ABERNETHY: We already

do. We take care -- you brought up your one patient, critical patient. Just last week, I had a very sick young lady who was in diabetic ketoacidosis, I mean scary. These are people that arrest, and no ICU beds available anywhere.

I personally managed her for my entire shift while managing other patients. Nursing did a great job.

We eventually did get an ICU bed 10 hours later, but by that time, she had very much stabilized.

We had done critical care and we're capable of doing that in the emergency department, but yeah. We can do all -- the full laboratories, the D dimers, troponin, venous blood gases. We have a full laboratory.

CHAIRWOMAN SAVAGE: Okay.

And then OB and neo, being that you just have a birth center on site and anesthesia, so are all of these specialists coming from Beloit from your mothership, NorthPointe, is what I call it, is that where the doctors are? Because you are going to have an ER that's staffed by an ER doctor, ER nurses and stuff 24 hours, but where are these other specialists going to come from if you need like somebody's delivering in your ER, what are you going to do with that?

DR. ABERNETHY: We would call them in. Again, most community hospitals and rural access hospitals, you don't have the specialists available to begin with. We do.

We could call them in, you know, and as far as anesthesia, anything like that, I am not sure

when we would need an anesthesiologist, but yeah, precipitous delivery or something like that, we would be able to call. There would be an OB on call or literally across the street, so at the birthing center.

CHAIRWOMAN SAVAGE: Okay. Then a question about your Medicaid and charity care, so in the state board report you have zero charity care and about 2 point something Medicaid, so what is your charity care policy for the mothership?

MR. BIRD: So for the mothership -- this is Jim Bird.

Our charity care policy is -- it follows the 501R rules that need to be done to be a charitable organization. The reason why zero is on the application is because we currently don't have a hospital at

NorthPointe, so there was no data to put on that.

CHAIRWOMAN SAVAGE: Yeah. And the surgery center, do you take charity care, Medicaid in the surgery center on site?

MR. BIRD: We do. Right now we don't separate that out. It all gets rolled into an administrative bucket.

For us to be able to separate that out by department is very complicated.

DR. KAPOOR: Roger Kapoor talking. I'll just add that we have -- auditors use a very prescriptive definition when it comes to charity care, and many patients have to fill out those financial forms, which they just generally don't do, and so we roll that up into bad debt.

And if you really want to take a look at charity care that

the health system provides, a better form is the Form 990, Schedule H, Line 7, in which the amount of financial assistance that we provide to this community goes up to 5.5 million compared to Javon Bea, same line, 1.5 million.

CHAIRWOMAN SAVAGE: Thank you. Let's see. There was something else.

I'm just going through my notes that I developed while you guys were talking all this time, so let's see. Oh.

So the social worker, she was talking and she testified really well, so thank you for that.

Talking about the mental health and the detox and all of that sort of thing, so is there an expectation that some of these 10 beds are going to be used for these patients in Illinois who

really, really need these beds?

Are you going to be able to do detox in these 10 beds or are you going to take people who are trying to commit suicide or whatever, mental health bedside, after they go through the ER?

MS. COX: This is Sharon Cox. We would take admissions that need medical stability that would -- what we currently do at the Beloit Health System. If it's strictly around mental health where they would be a voluntary or involuntary, we would want to find the correct organization that would meet their needs best, which is again the same process of the Beloit Health System, which is what Dawn spoke to earlier.

But if they did need medical stability, we would admit them and care for them, stabilize them and then get the mental health care

that they would need.

CHAIRWOMAN SAVAGE: Okay. All right. Well, now I open it up to my fellow colleagues. Who has some questions for this applicant?

Rex Budde.

MEMBER BUDDE: My name is Rex Budde, board member (inaudible).

What would be the staffing model for the inpatient beds for physician coverage? Are you going to have an hospitalist model or how are you going to handle it?

DR. KAPOOR: Yes. We will have a -- Roger Kapoor.

We'll have a hospitalist model and our emergency room will also have -- it will be comprehensive in terms of having one physician on site along with specialist access to things like plastic surgery, ophthalmology, dermatology, along with a

complement of lab, imaging and pharmacy that's already on site.

MEMBER BUDDE: Are you going to use mid levels or physicians in your inpatient?

DR. KAPOOR: We have certainly at the Beloit campus and may elect to do at the NorthPointe campus in collaboration with an M.D. physician.

MEMBER BUDDE: In terms of the emergency department, right now you are open 12 hours in your urgent care center, and so you will have a 24-hour 365 ED. Will that be a board-certified ED doc if you can find him? What's the status?

DR. KAPOOR: I'll allow Dr. Abernethy to speak to this as we already have board-certified emergency room physicians staffing our urgent care, so they're simply going to go ahead and staff our

emergency room as well, so to answer your question, absolutely yes.

MEMBER BUDDE: Okay. In terms of it's -- I'm a former hospital administrator. I remember how excited physicians got when you said would you cover this building now. That's why I -- totally gray hair.

It's easy to say that, but the reality and execution is -- unless you're better than I was -- is a whole different ball game in terms of a comprehensive ED and access into the specialists.

They're not looking to go to lots of different places generally. Physicians aren't. So is the reality different than --

DR. KAPOOR: I think you raise a good point and, again, the benefit of this proposal is we already have a lot of those

necessities in place.

Again, there are 25 physicians already serving this NorthPointe campus, many of which will assist and synergize with the emergency room establishment.

Again, the emergency room physician who is sitting here, Dr. Abernethy, can certainly speak to your question a little bit better than myself in terms of the logistical challenges that no doubt are a reality, but the benefit of having that physician cohort already on site to serve these patients exists, and the health system has a very comprehensive recruitment provider plan to try to address the needed healthcare professional shortage area that exists currently in this area.

It's not lost upon us that we need to continue to

aggressively recruit and have physicians continuing to serve South Beloit, Roscoe and Rockton, so our recruitment plan is based on those community needs assessment that we routinely do do at our health system and is founded in very great question that you're asking about the needs that we currently are providing and will continue to provide.

But Dr. Abernethy, would you like to add anything to that?

DR. ABERNETHY: Yeah. This is Mike Abernethy.

Yeah, we currently staff 12 hours a day, about 365 days a year, closed on one or two holidays, but once we go into the emergency department, it will be 365 24-hour coverage.

We obviously would be 24-hour physician coverage. We may have overlapping nurse

practitioners or physician assistant.

I don't think we'll have much problem recruiting for this.

Again, it's not going to be a huge volume where I foresee physician double coverage or anything like that.

Fortunately, we have a great pipeline for our work with the University of Wisconsin emergency medicine residency. Once they finish residency, they stay on with Beloit Memorial, so I don't foresee any, as far as the physician staffing, any gray areas.

MEMBER BUDDE: I applaud your optimism.

What IT system do you use and will it be -- you know, the main IT of the hospital be in place at this hospital too?

DR. KAPOOR: Roger Kapoor.

Yes, Cerner.

MEMBER BUDDE: I think that's all I have got.

CHAIRWOMAN SAVAGE: How is the nursing staffing, are you anticipating based on this shortage area?

MS. COX: So this is Sharon Cox. We would base our staffing ratios on the California laws that we try to follow, that we follow regularly even in the Beloit Health System with the acute care. Four to five on the med surg unit and, of course, we would have ancillary help with nursing assistants, clerks depending on the acuity.

Of course, that would make a difference, but that's how we would staff.

CHAIRWOMAN SAVAGE: And do you anticipate having like dual licensed nurses from your Beloit

campus and then --

MS. COX: Yes.

CHAIRWOMAN SAVAGE: -- having to rotate?

MS. COX: Yes.

CHAIRWOMAN SAVAGE: And staff --

MS. COX: We already do that.

CHAIRWOMAN SAVAGE: -- is amenable to that?

MS. COX: We already do that in our immediate care. We have that in our primary care also, was that we have Illinois licensed individuals that help in the physician offices, so that would be the same model.

CHAIRWOMAN SAVAGE: Okay. Other questions?

DR. KAPOOR: If I could add, Roger Kapoor.

One third of our employees

are already from Illinois, and so just that will again allow them to work closer to home. We are already staffing NorthPointe, so, again, there would be actually greater efficiencies on our end because we already have the staff in place at NorthPointe to assist with some of these operations, and we don't believe it will have an material impact on the surrounding competitors where there are claims of nursing shortages limiting their operation because, again, our small footprint hospital for which we already have staff for, which many of our employees are from Illinois, will be able to staff effectively for -- to provide high quality care.

CHAIRWOMAN SAVAGE: Thank you.

MEMBER HARDY-WALLER: Antoinette Hardy-Waller speaking.

First and foremost, I want to say thank you for all of the time and attention and resources clearly that you have put into preparing for this testimony today and then all the community showing up. We really appreciate that.

I wanted to say because I'm a little slow on the uptake and we have been here for several hours regarding this, so I might have to go back into some of the information that we got.

First of all, I want to say as a nurse clinician, I clearly appreciate all the concerns and issues with the ED services in the area, but from what I understand, the purpose of this discussion and proposal today is to establish a 10-bed hospital at NorthPointe as a remote location for BMHS.

I heard a lot of discussion today that was interchangeable

between Beloit and NorthPointe, and so I've gotten a little confused who is on first and who is on second.

Karen, I think you began to explain the definition of remote a little bit in some of your discussion, so I have an early fundamental question, because in my experience, most small format hospitals that I have seen have been in remote rural or healthcare deserts or critical access hospitals.

From what I have heard and what I have seen, NorthPointe does not sit in a clearly defined remote area, so my early fundamental question -- and this is probably for my IDPH colleagues -- is how is an Illinois small format hospital licensed in the state as a remote location for an out of state

health system?

I ask that question because we are here today because we're the Illinois Department of Health and our concern is for Illinois residents and Illinois facilities, and so I'm a little confused and I would like to get a little bit more clarity on how we clearly separate the two and define remote for an out of state health system in the State of Illinois.

MS. FRIEDMAN: Karen has left the room. This is Kara Friedman. Perhaps she will return and she can talk about that a little bit more, but if I could try to.

MEMBER HARDY-WALLER: Sure.

MS. FRIEDMAN: So part of the confusion here is that every acute care hospital that's admitting patients that isn't sort of consolidated on a campus like

you see at Northwestern where they're got multiple buildings across the street from them, every Illinois hospital location has to have an Illinois hospital license, so we will be under the jurisdiction of Karen and her agency as an Illinois licensed hospital.

The remote location terminology is a Medicare term, and what it means is that there will not be a new enrollment under Medicare. It will be under the same CCN enrollment number as the main hospital.

The remote does not refer to population served. It just means that it is not on the same campus, and so for purposes of accreditation, which you see a lot of times, like, you know, Endeavor Health has four hospitals that are all in one. They are accredited

as a single hospital despite the fact they have four separate licenses, so this would be accredited under the Joint Commission accreditation of the main hospital and then also Medicare enroll.

That will enable it to begin to see patients quite immediately because we don't have to wait for -- Joint Commission may come in after it's opened to do a validation survey, but they will be able to start operating right away after they get their license.

MEMBER HARDY-WALLER: Thank you. Repeat the question.

Antoinette Hardy-Waller speaking again. Thank you, Kara, for that explanation.

I was asked to repeat the question, and the question again was how is an Illinois small format hospital licensed in the

state as a remote location for an out of state health system?

That was the question.

MS. SINGER: This is Karen Singer from IDPH. I missed part of Kara's answer, but yes. Under Medicare there would have to be a reciprocal agreement between the two states to manage that type of a relationship.

Obviously you would need the designation to be a secondary campus under a primary Medicare provider in Wisconsin, but we'll have to have an arrangement made with the Wisconsin Department of Public Health, along with IDPH to determine whether -- how that survey process would occur because the states can't cross borders to survey each other. You would need to be licensed in Illinois, and then you're looking to seek to become a Medicare provider base,

so all of your billing would be done through your sister hospital as what you are trying to accomplish; is that correct?

MS. FRIEDMAN: This is Kara Friedman.

Correct.

MEMBER HARDY-WALLER: Again, Antoinette Hardy-Waller.

So, again, for clarity, those patients that cannot be serviced in your 10-bed hospital for whatever reason, whether it's acuity or whatever or the beds are full, transfer of those patients -- can transfer of those patients happen to your Beloit facility crossing state lines from one Illinois licensed hospital to a Wisconsin licensed hospital?

MS. FRIEDMAN: This is Kara Friedman.

That can occur, and it would be the ambulance service that

contracts with Beloit Health System that would transport that patient as Nicole described.

DR. KAPOOR: Roger Kapoor. If I could also add, that EMS control for South Beloit, a town in Illinois, currently transfers patients from Illinois to our Wisconsin emergency room to be seen.

MEMBER HARDY-WALLER: Thank you.

CHAIRWOMAN SAVAGE: Other questions?

MEMBER BEEDLE: This is Douglas Beedle. I'm ex-officio so I won't be voting, but I do have some questions.

One is do you just have the single hospital or are you independent or do you have other hospitals?

MR. McKEVETT: Independent.

Tim McKevett, Beloit Health

System, president and CEO.

Independent, one hospital system.

MEMBER BEEDLE: And so you're a border situation, but people see -- in Illinois see the Beloit Hospital as their hospital; is that correct?

MR. McKEVETT: Approximately 20 percent of our inpatients are from Illinois.

MEMBER BEEDLE: And for people that are in your clinic on the Illinois side, they need admission and they don't need an EMS ride, they can simply go to your campus, correct?

MR. McKEVETT: Absolutely, done all the time.

MEMBER BEEDLE: So those are the few people that really need to be in advance life support transport to go -- and those are kind of predetermined available

and can, in fact, cross state borders like the situation in St. Louis with Missouri, so it seems to me that the border communities of Illinois have special challenges, but the question is this does seem to me to be a difficult way to accomplish a better approach to your regional healthcare issues; that in like the St. Louis area where I'm familiar, it's pretty easy because the level -- the trauma centers and higher level system tend to be on the Missouri side, and so these -- this is a pretty well worked out system on that border.

It seems like and it sounds like almost like battling emergency departments, you know, in your area, and I understand from your descriptions and testimony under oath that there is two sides to this story, but it

does seem like this remedy of the problem is one that will have its own complexities and potential to not -- I mean, the way I look at it is if a person in Illinois wants to go to your hospital in Wisconsin, they ought to be able to go. You know what I'm saying? That's the patient making a choice.

To a certain extent I don't know if I want to keep the people in Illinois in Illinois if they really need your Level 3 emergency department, right.

I drive by your town a couple times a year to go see my mother. If I'm in a serious car accident, I want to go to a Level 3, right, and you guys have that, which is impressive considering you are an independent hospital.

It does seem to me that

there are perhaps models so that people aren't really like essentially poaching, you know. It doesn't make much sense to me to have these independent emergency departments because it's going to increase the problems with people getting stranded in places they can't get care.

The other question -- I'm a psychiatrist, so do you guys have psychiatric services?

MR. McKEVETT: We do.

MEMBER BEEDLE: You do. So like for voluntary admissions, you could handle that issue yourselves?

MR. McKEVETT: From a mental health we have no -- I've already given my name. Tim McKevett, Beloit Health System, president and CEO.

We do not have an inpatient mental health unit.

MEMBER BEEDLE: You don't.

MR. McKEVETT: We do not. We have outpatient, psychiatry AODA health services.

To your original question, too, is that a large -- the justification and the need for this project are those 10-inpatient beds, and it's for those Illinois residents that we are currently seeing, that 20 percent, getting that care closer to home from a general acute care standpoint. Everyone in the ER then supports that hospital.

We transfer out of our ER now to the most appropriate place the patient would be, whether that's to Rockford, whether that's to Madison. They need that additional care, so it's really driven by the need for those inpatient beds to be able to move

the patients up to -- the Illinois patients for staying down back into Illinois and the ER would support those services.

MEMBER BEEDLE: That's all for now. I do want to encourage all hospitals to consider having general psychiatric units. It's the need of the community and one of the major difficulties in emergency rooms.

People are getting stranded there and what I would describe as the real importance of good faith acknowledgement of complexities so people don't get stranded in emergency rooms, but that has to do with the leadership culture of hospitals and hospital administrators in terms of remembering these are a professional service.

These are people's lives, and certain types of competitive

business practices are perhaps inappropriate.

MS. HUDSON: Hi. This is Dawn Hudson, the social worker, and I would like to address the idea about the mental health service being available to patients.

So we do -- the clinical social workers, we do the mental health assessments with support of the doctors.

We do have access to the on-call psychiatrist should we need support. We are able to complete those assessments. We place those patients based on those assessments in inpatient psychiatric placement and that will continue at this new hospital. That service will be available to patients.

If they show up at that emergency department and they are

in need of that, those assessments will be done.

For patients who are determined to need safety plans, those things will be completed. We have access to a psychiatrist to support us with medications that can be started.

We have our own outpatient mental health clinic that we have access to for wrap-around services as well, so we do have a very good infrastructure.

We don't have inpatient beds. For patients who are dealing with addiction problems who are intoxicated and suicidal, which is a common thing that we see, we hold those patients. They do not get discharged. They stay with us until they're cleared of their substance. They're re-evaluated and then their mental health component is addressed, so

we have a very active program in place that deals with that.

Just wanted to clarify that that is a big part of this hospital that we're asking.

MS. FRIEDMAN: This is Kara Friedman. Sorry to be in the back here.

But when we talk about mental health services at Beloit Memorial, Dawn, you indicated that you don't have enough demand to have your own unit, but I think you mentioned that there are some new resources dedicated specifically to psych, but it wouldn't make sense for you to have your own unit.

MS. HUDSON: Say that again.

MS. FRIEDMAN: That your average daily census, if you were just admitting your patients that you were triaging and treating in the emergency room, you couldn't

validate a psychiatric unit.

MS. HUDSON: Exactly, so if our hospital -- while we see a good number. If we were specifically to open up our own unit, we would not be able to support a unit independently based off what we see, which is why the health system hasn't moved to open that up and we utilize the facilities around us, UW, which has a larger unit, and Meriter and St. Mary's, it has a tiny unit.

Even though we see a large -- a good number, it's not enough to maintain and support very expensive inpatient psychiatric unit, so I think that's important to note.

MEMBER BEEDLE: Put it this way, you are kind of a referral source from other places too.

It's one of the major problems for a lot of emergency

rooms. People with substance use disorders and psychiatric abuse disorders come to or are brought to emergency rooms, and I have accused some people of having the negative fill the drain response. If we don't have that service, they won't come here, but that's not how the health system works, and even though the emergency room physicians don't receive as much training in substance use, psychiatric disorders and developmental disabilities services as perhaps would be optimum.

MS. COX: Which is why I was stunned when Mercy closed their inpatient psychiatric unit in Rockford.

MS. FRIEDMAN: This is Kara Friedman again.

There was just a brand new hospital opened nearby that's

dedicated to psychiatric services called Shorewood.

CHAIRWOMAN SAVAGE: Karen.

MS. SINGER: This is Karen Singer again from IDPH.

I just have two questions. One, I know this is going to be a 10 bed and you talked about how that's going to be patients coming from -- that are now going to Iowa or wherever those services were -- the Illinois residents going to Iowa, that you might be able -- I guess I want to say, what do you think your average daily census is doing to be and are you going to be able to make sure that these are going to be the average like stay for patients that you are looking for this 10-bed unit?

DR. KAPOOR: Roger Kapoor.

Based on the data of -- the out migration data, we expect an average daily census of 8 from

Wisconsin back to Illinois.

MS. SINGER: Do you know what your average length of stay would be with only having 8 that you're going to be able to not have to turn patients away? I guess that's what I'm looking at.

Small number of beds. If you're looking that you are needing this service, will there be a turn away of patients if your --

DR. KAPOOR: General standard is about four and a half to five days. Again, that would -- we're trying to right size this proposal based on need presently, so we appreciate that question.

MS. SINGER: With the way this is built, would there be any room to be able to expand if you feel that you need to have more beds at this --

DR. KAPOOR: That would be difficult. Jeff Holzhauer is here, our architect, could speak to that more definitively, but the plan currently would really optimize the current resources that we have to put this up.

We're very close to the minimum capital expenditure even needed to come to this board.

The amount, the total amount that we're about to spend is quite low when you look at a large investment, but I'll turn it over to Jeff Holzhauer.

MR. HOLZHAUER: Hello, everyone. My name is Jeff Holzhauer.

Yes, the building currently as it stands has structural support to support a widening of the second floor to expand it to 14 beds.

DR. KAPOOR: Roger Kapoor,

but if we did do that, it would disrupt some of the services of the ambulatory surgery center below it.

So, again, we are trying to be mindful of expansion that we currently have and the space that we currently have that as you saw from one of the photographs is just vacant space sitting there that we could easily construct 10 beds.

MS. SINGER: This is Karen. Thank you. One last question.

Have you reached out to the Department of Wisconsin to address the interstate agency arrangement? Are they aware that you are looking to have this secondary campus in Illinois?

MS. FRIEDMAN: This is Kara Friedman.

Karen, in speaking with my Medicare specialist, we understand

that we really work with the two of you, both agencies, and that you would take the leadership on deciding who is going to be the lead agency and such and so.

We are definitely there to coordinate and help, but until we are ready to open the hospital, that's not a discussion that we have had.

CHAIRWOMAN SAVAGE: Okay. Gary.

MEMBER KAATZ: Gary Kaatz, board member.

Tim, I think everyone is abundantly aware of the good things that have happened at the Beloit Health System under your guidance, and I want to state that firstly.

Secondly, I have a series of questions. Please be patient with me. You might think some are more educated than others, but please

bear with me.

And the context in which my questions will be presented is looking at $21 million and I'm looking at what is the corresponding benefit, marginal expense to margin, and I'm struggling with a couple of things.

As we mentioned earlier, there's a lot of criteria that everybody here on the board applies to a decision such as this.

My first question is I find that you're -- the area of Rockton, Roscoe, right, is robust medically. You have Swedish American, OSF, Beloit, now Mercy, Physicians, Media Care. Pretty well saturated, lots of different doctors.

And so my first question is when a patient from Roscoe goes to

your emergency room and is subsequently admitted, does that patient's doctor get to follow the admission? Say the patient is hospitalized. I'm an internist and I'm managing somebody that's got Type 2 diabetes. Gets out of control. He's in your ER and you end up admitting him. Will I get to follow my patient or do I lose my patient to somebody else?

DR. ABERNETHY: This is Mike Abernethy.

Between any health system they don't talk. If I'm in the UW system and depending on the insurance, I'm admitted to Mercy, there's usually not a lot of communication between health systems, so as far as following the patient -- I mean, as a courtesy certainly.

I imagine the hospital would call you and you'd know that

patient, but as far as having any input, just the health system sort of operates in silence. It's not like it was in the old days.

MEMBER KAATZ: So as a primary care doctor, I might lose some of my patients?

DR. ABERNETHY: You are not going to lose the patient. The patient would be hospitalized and then upon discharge, the patient -- you would get a discharge summary, absolutely. The patient would go back to you.

MEMBER KAATZ: Okay. Next question is you have Cerner and a lot of other players have Epic. Does Cerner talk with Epic? If I'm a patient in Rockford and I get hospitalized in Beloit. Next day, can you guys find out what tests I had 24 hours ago even though you're on two different systems?

DR. ABERNETHY: I know Epic has Care Everywhere where they can do that, but is there anything between --

MS. FRIEDMAN: This is Kara Friedman.

So does Cerner. My son is actually being seen by four different health systems right now. Everybody sees all of his lab results and they also communicate with each other.

MEMBER KAATZ: So they are integrated?

MS. FRIEDMAN: It's getting better every year, but yes. The general experience is that everybody can see everything and I find that people communicate with each other also.

MEMBER KAATZ: The point that was up earlier today, I think it was in the public forum, is today we are seeing sicker and

sicker patients.

Let me start from the beginning. Today's public forum, it was mentioned that patients that are being admitted to hospitals are much sicker than they used to be. Therefore, there's an even stronger dependency on specialty and subspecialty care.

One of my big concerns with your independent ER is how quick are you going to get people to respond to you if you need a nephrologist or if you need a neurosurgeon?

I'm a patient in the ER. Am I going to get seen within the next 30 to 60 minutes? Am I going to be seen the next day? How quick is the response going to be? Do you have specialty coverage, on call schedule at Beloit that will also include this?

MR. McKEVETT: We do. There's a 30-minute response time. They have to live within that call time, the specialities that are required to be on call.

Tim McKevett, Beloit Health System, president and CEO.

MEMBER KAATZ: Thanks, Tim.

Dr. Egbujiobi, what is currently your ER to cath time? If you get a patient that's coming in and having an MI and needs to go to the cath lab, what is your current time to the cath lab?

DR. EGBUJIOBI: It's Leo Egbujiobi.

It's 90 minutes. 60 minutes or less.

MEMBER KAATZ: In the ER, in this ER, assume it's approved and you're operating --

DR. EGBUJIOBI: Oh, in the ER, probably shorter.

MEMBER KAATZ: No. Not --

you answered it. I thought it's under 50 minutes.

So will this ER, if I present with an MI in your new ER with a 10-bed hospital, is my ER to cath lab time going to go up?

DR. EGBUJIOBI: No. Actually, we are there. Once you get to the new, to the NorthPointe, by the time you get to the new hospital, I have their EKG myself. The cath lab is already activated.

We have three cath labs, so there is always going to -- and there are four of us, so always somebody there.

MEMBER KAATZ: Next question. I'm sorry, Madam Chair, I have just two or three more questions.

I am really bothered by watching what happened with now University of Wisconsin, Swedish

American and their Belvedere, whatever you want to call it, and it just reminds me of your project.

It's a freestanding ER. It was about 10 or 12 beds, right, and they just couldn't make a go of it. They had to close all the inpatient beds. They never had any patients in there, and the ER, just they couldn't service people because of the lack of consultation in the ED.

I don't know if you followed that. It's in the same market area.

Mike, do you know, what's the planning area?

UNIDENTIFIED SPEAKER: B1 planning area.

MEMBER KAATZ: B1 planning area, but they did almost exactly what you're proposing to do, and it just didn't work.

MS. FRIEDMAN: This is Kara Friedman.

I'm somewhat familiar with that situation, and what I generally -- what I have generally seen with emergency services providers that really just want to be portal to transfer to another location is that Medicare allows that. You can have zero patients.

State of Illinois does not allow that, but I know that it's been more than 10 years, probably 12 years, so I'm not -- you have been in the community for a long time, but my general perception is that this has been a portal facility and that's what it's intended to be for a very long time.

MEMBER KAATZ: They actually -- it's a hospital in Belvidere. They bought it, I think, for 16 or 18 million and

they intended to have it be a small hospital with an ER, and I believe it's still open to this day as we speak here, but there are no patients, and I just draw a comparison. Maybe it's an unfair question to you guys.

I draw a comparison to what they did and what you are going to do, and is there something there that I am missing?

MR. McKEVETT: I do think it's two separate issues from the standpoint of what they are doing in Belvidere versus what we're proposing here is we have the Illinois patients in our hospital and we need -- have the need for those individual beds, so transferring them down to the location of those 10 beds because it's different than what -- I can't speak on behalf of UW and what they did in Belvidere, but

our situation is such that we have the demonstrated need. The patients are there.

Transferring them down to newly created beds will help us maintain facilities as well.

MEMBER KAATZ: Last question. Same rates, same rates, you know, across the system, hospital rates, ER rates?

MR. McKEVETT: Tim McKevett, president and CEO.

Yes.

MEMBER KAATZ: Thank you.

DR. KAPOOR: Roger Kapoor. To the same rates question, it's very intriguing when you look at Rand data and Sage data, we're much cheaper than the three Rockford hospitals for the same level of care, so not only are we going to be able to provide high level quality service and care, (inaudible) and our CMSR rating

before, but we are actually going to do it at a lower cost than hospitals in the area.

The other points I just wanted to mention, you brought up some very nice questions, and I do want to push back very respectfully on the notion that Rockton is oversaturated.

It really genuinely is not as this map up here demonstrates. In terms of urgent cares and those types of facilities, as you mentioned, the map would be different as was presented during public comment earlier today.

When you look at the actual hospitals in this area, you do see that it is generally a desert. We are in the middle where there's no hospital level service care there, and so, again, remember we are a federally designated healthcare professional shortage area, so I

just want to bring those points to your attention.

The other one comment I'll make is regarding losing or the notion that you may lose your primary care provider when you're admitted to a hospital.

Generally the practice of medicine is such that when a patient comes to any hospital, regardless of where they live, you are seen by the ER physician. You are, if God forbid, admitted, seen by the hospitalist team and then you are discharged with a discharge summary accompanying that patient back to their primary care physician, so in no way would this hospital or proposed hospital be cannibalizing or taking over any patients that don't currently have a primary care provider located at the NorthPointe health and wellness facility.

If they came from, let's say, some other state and they have a primary care provider or they're coming from Rockford, they would maintain their primary care provider upon discharge from the hospital.

I just want to make sure that is clear.

MEMBER KAATZ: Thank you. I was referring to doctor's practice, not hospital.

DR. KAPOOR: Thank you.

MEMBER TANKSLEY SAVAGE: Dr. Audrey Tanksley.

I just wanted to just ask a few questions to clarify for me some of the statements that were made.

Thank you for making your most recent statement because I adamantly disagree that we don't talk to each other in the healthcare system. We do.

And I'm not familiar just again with Cerner speaking to Epic. If that's something that's happening, that's pretty new. Doesn't happen in the systems I work in.

MS. KOVARIK: Nicole Kovarik. I could speak a little bit to that, so currently when a patient presents to the urgent care or the emergency department, we do have an option for our Care Everywhere and we request outside records. That gives access to recent visits, summaries of their visits.

And then also we have the pharmacy requisition so we get them medications, so from -- I can't speak to how it looks on Epic side. I can only speak to how it looks on the Cerner side.

MEMBER TANKSLEY: And that's specific to you guys, right? If

I'm a provider in the community, do I have that same level of access?

MR. BIRD: This is Jim Bird, and we subscribe to Common Well which -- I'm pretty sure that's the name of it. They share data between a lot of systems.

A lot of systems subscribe to that service and they give those data -- it gets downloaded and shared to all the facilities.

MEMBER TANKSLEY: So that clearinghouse, if I'm a part of that clearinghouse, I have access to the data. If I'm not a part of that clearinghouse, I don't, correct?

MS. COX: This is Sharon Cox. That would be normal for any organization that has two different EMRs.

We have the ability to pull in external documents and accept

them as part of our record of truth also, but yes, you do have to belong to a clearinghouse, as you stated, for if you are McKesson, if you're Meditech, all those.

But as Kara stated, it is getting better every year, so there's some intra-operatability between Epic and Cerner, so we do have some of that, but it is not as robust as any organization can say across the nation right now.

MEMBER TANKSLEY: Agree. I just wanted to make sure I was not working in some system that didn't -- that you guys have something we don't have. Okay.

So I just wanted to again make sure that I'm clear on the mental health and substance use services.

So your new hospital, 10-bed hospital, would generate a net

zero, like access for more mental health beds, right?

It would not change -- basically your testimony is saying we are going to continue doing what we do, but we would be on the Illinois side doing it?

I'm trying to understand what your testimony -- what the relevance of that was.

MS. HUDSON: So Dawn, Dawn Hudson.

So the point that I was wanting to make is that when people come into Wisconsin, it's significantly complicated to get them back into Wisconsin or back into Illinois, so the services that are provided will match what is done for them when they come.

The difference is that they are able to stay in their community. They are able to access those services more quickly

and they are able to access things that we can't get them to now, whether that's shelters. We can't get them into shelters. We don't have the ability to do that. Wisconsin won't let them stay in their shelters. They take Wisconsin residents over that.

In Illinois, they are able to go to their shelters. We don't have a means to get them there. When they are in Illinois, that's an easier thing to do.

The police won't transport. Once they bring them into Wisconsin, they won't come back and pick them up, so the relevance of that is showing the difference of just that line and how complicated that is.

And with education within the community, particularly that population, they learn very quickly. They learn very quickly

about resources and where they can go to get the best help for themselves, and when they learn and when they become educated on the fact that, listen, when I'm in Roscoe at that emergency department, they are going to be able to get me to the Rockford rescue mission, they are going to be able to get me to those types of facilities instead of telling me that I can't. I don't have an option, then we'll have better ability to get them to what they need and all those services follow along those same kinds of lines.

That really was the point, is replicating services and the commitment and the level of care will continue to be the same. It will just be better access for the people when they are in that community.

MEMBER TANKSLEY: When they

are brought -- and that's if they present to Wisconsin, right? Because if they're in your urgent care in Illinois, for example, then you don't have that issue?

MS. HUDSON: Exactly, exactly, because then they are already in Illinois and I can ask the police, say, hey, listen, partner with me to get them to the rescue mission. Let's use whatever community services are available.

That line, that state line when it comes to community services is a very powerful thing, and it doesn't bend.

MEMBER TANKSLEY: And then the other question that I wanted to just clarify, how far away is this proposed facility from your hospital, like your current hospital?

MS. COX: This is Sharon

Cox.

It's 16 miles.

MEMBER TANKSLEY: How long does that take? I'm not from that area. I'm sorry. 16 miles in Chicago could take you an hour and a half. Trying to understand like what's traffic like.

MS. COX: 10 to 15 minutes.

MEMBER TANKSLEY: I'm asking that because, Doctor, door to balloon time is 90 minutes, right, and so I'm trying to understand if I present to the emergency room, this won't be a certified stroke center or cardiac center, correct? You will utilize a higher level for that.

So if I present to the emergency room with an active stroke or with an actual MI, the time to get me from this low level hospital to one that can actually provide the care, trying to

understand, will that be within -- just trying to understand from my colleague's question, I don't think I understand the actual answer.

Will that delay the -- I understand you'll be there ready and waiting, but will that period of time that it takes to get that patient in -- all the things that go along with the nondoctor parts, getting them to the hospital, would that be delayed in stopping at this one, in being at this particular hospital instead of going to one that can already provide that level of care?

DR. EGBUJIOBI: Thank you so much. This is Leo Egbujiobi.

As I said, a stroke is actually better because we are small and the more tests completed, the care is better. They come in with stroke like

symptoms, within 20 minutes you can send to whatever they need, TPA, clinical admission, stabilization, rehab, 50 percent of the time.

Unfortunately, for stroke, you know how that goes. It doesn't matter where they go. The outcome is not necessarily different, but reach out to any facility around with neurosurgical service, so that's about stroke.

You get all the medicines that everybody else would get, and stroke, we like to hold the blockers of medicine, but all the treatments are available.

For cardiac, as soon as the ambulance picks them up and they are landing in the ER, I have the EKG, that's 3 minutes. Within 2 minutes, I know they're STEMI. It's let us work, get the labs, and off they go.

By the time they get into my cath lab, it's 40 minutes, so because they have preference, they have the room, the cath lab itself for emergencies.

Or if they do in South Beloit -- or they come there from South Beloit. Between South Beloit and NorthPointe, it's a few minutes. So I speak only because that's what I did for three years.

MEMBER TANKSLEY: So these patients would be able to receive these services at the NorthPointe location?

DR. EGBUJIOBI: Yeah. They get the stabilization. For stroke they get all the treatments.

MEMBER TANKSLEY: So they would get TPA at NorthPointe, they would get cath lab at NorthPointe?

DR. EGBUJIOBI: No. There's no cath lab. Talking about for the cath lab, from NorthPointe to

my cath lab in Beloit, they would be in the lab within 40 minutes.

The door to balloon time, sometimes is 90 minutes. Push the envelope to 50, 60 minutes. They have one room. It's straightforward. They will be there. We will be there for them because we don't have the time to wait for the lab because they don't know what hospital they're going to.

If they are -- probably the patient, they know, they are needing to go, not a complicated place. By the time they get to cath lab, the result of the tests are already there, so the lab is ready.

MEMBER TANKSLEY: And then I wanted to clarify one of the statements made earlier about deliveries, about labor and delivery. You mentioned we have a

birthing center on site where individuals -- and so I'm wondering what is your plan for like a high risk emergency birth that's not appropriate for a birthing center?

MS. COX: This is Sharon Cox.

That's already in place. We have transfer agreements with UW, Swedes, Northern Illinois for anything that would come in from that perspective.

MEMBER TANKSLEY: Thank you.

For the president and CEO, I just have one quick question. You mentioned 20 percent of your population that you are seeing there, essentially the rationale for this is 20 percent are from Illinois and you want to be able to service them, and thank you for that, by the way, because people do want to be serviced closer to

their home and so you want to service them closer to their homes.

My question is why are they at your hospital already? Are they being -- are they electively going there? They don't want to be serviced by their home or -- because they are hospitals around, so why are they there?

MR. McKEVETT: Preference for our health system is one. Proximity, we are literally Beloit and its sister city is South Beloit, and there's that invisible state line, so we are the closest health system to them, so we get a lot of those referrals because of the proximity.

We have primary care clients in those areas that generate those patient relationships, so yeah. It's patient choice.

In some cases it is

especially because Mercy has dropped some of their Illinois public aid HMO patients. It's driven by that, referrals that are coming up to us from that perspective.

MEMBER TANKSLEY: Thank you guys so much.

CHAIRWOMAN SAVAGE: Mr. Fox.

MEMBER FOX: Yes, board member, Dave Fox.

The concern that I have is actually the size of the hospital, 10-bed hospital. My experience in managing smaller units, for example, obstetrics or pediatrics, is that you get a very wide variation in census with the small numbers. You could have 2 inpatients on one day. You could have 8 patients the next day.

Number one, that could be a staffing challenge, and as I look at your financials, I know you're

working hard to get back to a positive bottom line, but it's tough.

It could be very difficult to manage the right number of nurses with your census if, in fact, the census bounces around, which tends to be the case with small size units, but then maybe even a bigger question I have is that in a larger hospital, you will have nurses who are specialized in certain areas.

I'm not talking about ICU or med surg, but even med surg, you may have a group of nurses that focus on GI issues or postoperative patients, and in this 10-bed hospital, your nurses are going to see everything. They are not going to see critical care, but there's going to be, I presume, a real mixture of patient type, and in that sense, you

really may not have the kind of specialized nursing that a patient in the 10-bed hospital might get in your home hospital in Beloit. That's just a concern about the overall, I guess, quality of care and nursing expertise beyond your ability to attract specialists to actually come to the hospital when you need them to come.

MS. COX: This is Sharon Cox.

In regard to nursing care, we currently have different departments, you are correct, that may specialize in med surg which is also our surgical departments, and then we have what we consider our intermediate care which is more our cardiac, stroke department.

However, all of our staff get regular training, regular compliance training per Joint

Commission. They get regular competencies. We have skills days on a regular basis, so we would incorporate the need of what those patients would be into that nursing department's curriculum throughout the hospital.

DR. KAPOOR: Roger Kapoor. I'll just also speak to the fact that the design of this hospital or proposal is to focus on low acuity medical care, so the specialization that you are referring to at a tertiary care center might be required in those types of facilities, but here those people that would be admitted would be of low medical acuity, and it does speak to the doctor's point about the cath lab.

Just be reminded that EMS will be triaging these patients in the field, and if they do see like a STEMI, they will not be coming

to the neighborhood hospital. They will be going directly to whichever hospital they decide to do in the field independent of us, so -- but in terms of stabilizing care, that's lifesaving.

To what Dr. Egbujiobi was referring to, getting stroke intervention immediately which can be delivered at a neighborhood hospital which is why this map is so important, because there's nothing in this desert. There's no emergency room visible there, so if you're an ambulance that picked up a patient that does need lifesaving care, you can't get it in Rockton, Roscoe or South Beloit. Have to get on the highway and go to Rockford or decide to go across state lines, across this cheddar curtain we've heard described between South Beloit and Beloit, that's what

we're trying to establish here is that lifesaving low medical acuity care with partnerships with EMS who are all here in support of the proposal, local EMS, because again we're going to trust their ability to triage in the field to make sure that those patients that come to visit the neighborhood hospital are appropriate for that level of care that we can provide.

CHAIRWOMAN SAVAGE: Any other questions?

MEMBER TANKSLEY: I have one more. I'm sorry.

CHAIRWOMAN SAVAGE: I'm sorry.

MEMBER TANKSLEY: This is board member Audrey Tanksley again and maybe this was mentioned and I missed it.

I know a good part of your presentation was that the bed breakdown -- this is the breakdown

of like the excess of beds. This number -- and please correct me if I'm wrong. This number comes from the state, right? Like our planning, so the 94 bed excess, I guess I'm just confused as to how like -- why do we need these 10 beds? I'm still not -- I'm sorry.

I'm still not wrapping my head around like why we would need 10 beds for such low acuity conditions that with early intervention could possibly be treated somewhere, like UTIs and stuff, like in an observation unit and then go home or something.

Like I'm -- please help me understand why Illinois would add 10 additional beds on top of 94 excess that we have calculated. I get maybe the calculation may be old, but help me understand why we need this.

MS. COOPER: This is Anne

Cooper.

So basically the prior issues is that when the board calculates their bed need, they are looking at net migration which is inpatient and outpatient migration, but they are only looking at the migration among the various planning areas because they don't have access to that Wisconsin data.

And we were able to get the Wisconsin out -- in migration data from the Wisconsin Hospital Association that showed us there are like 1,400 patients every year that are -- they are going from specifically Winnebago County to various hospitals in Wisconsin for care, so that's a big part of it.

The other piece is that the bed need calculation is not just med surg beds. It also includes pediatric beds, and there's a

significant number based on the fact that if you have a very sick child, they're probably going to like a Children's Memorial -- I'm sorry, Lurie Children's or a children's hospital. They are not going to the local hospital for that specialized care, but those pediatric beds that are not being used and cannot be used for adults are still in that 94 bed calculation, so that was another 17 beds that really probably shouldn't be counted when you are looking at the med surg need.

And then the third component is we don't know what's -- I mean, Blanca had mentioned that UW Swedes had said they were going to get their inpatient bed unit up and running, but we don't know if that's actually going to happen, and that's 34 med surg beds that currently are not available in the

planning area.

So a combination of those three factors is how we determine that there was a need for beds in the state-line community.

DR. KAPOOR: Roger Kapoor.

I'll just remind, these are -- it's based on the fact of genuine need. There are 8 to 10 patients daily coming from the State of Illinois choosing to chose a Wisconsin based hospital, and, frankly, we are overwhelmed.

We need to decompress, and that's where a project like this can actually help and have regional impact on healthcare for these patients that need it, because to your point, low medical acuity, why should it take up a tertiary care emergency room.

Those low medical acuity cases can actually decompress surrounding emergency rooms to see

the care that needs that type of attention, and so this project is based on need.

If there are 8 to 10 patients that are choosing to come to Wisconsin, all we are trying to do is return them back to the State of Illinois, and that's really what we are attempting to do at this point with this project.

CHAIRWOMAN SAVAGE: Other questions? Comments?

Hearing none, George, if you could call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Ms. Hardy-Waller, seconded by Dr. Tanksley.

Mr. Budde?

MEMBER BUDDE: Obviously there has been a lot of conversation today and appreciate

an incredible presentation in terms of outline.

I take it at face value competition has already occurred because the 8 to 10 patients a day are in the Wisconsin hospital.

This isn't about drawing more and more patients to Wisconsin hospitals. It's about keeping them more local.

Not a huge fan of these tiny little hospitals. Just concerned about what board Member Fox was talking about with the complexities of nursing care.

I'm going to vote to support the project with some trepidation, but with what I heard, I think I can support the project.

MR. ROATE: Thank you.

David Fox?

MEMBER FOX: I would like to compliment the team, the applicant team, for the presentation today,

its comprehensiveness, but also the -- I'd like to compliment all the people from the morning, both those who spoke in favor, but also those who spoke in opposition.

Obviously this is a very hot topic. Lots of passions. However, I have concerns about the size of the hospital and the ability to achieve high quality, and so I'm going to vote no.

MR. ROATE: Thank you.

Gary Kaatz.

MEMBER KAATZ: I do, like David and Rex, I really appreciate the teamwork that you guys displayed here and the time and effort that you put into everything today.

I don't think that innuendos from competitors and the issues around market share are factored into at least my decision. I doubt they were factored by

anybody else's decision.

I'm going to have to vote no because my concerns are with the size of the hospital, the excess capacity and the market currently, unnecessary duplication, and I have big concerns about accessibility.

I'm not sure that a spend of $21 billion provides a significant benefit with regard to the patient, so I'm going to have to vote no.

MR. ROATE: Thank you.

Dr. Tanksley?

MEMBER TANKSLEY: I too want to thank you for an amazing presentation. I think there's a lot of thought that went into this project, and perhaps there's a role for services like this at some point.

My concern is that this sounds like a super urgent care as

opposed to a hospital, and I'm also very concerned that there would be an ability to care and respond quickly if these services went from lower acuity to higher acuity which can happen very quickly in a hospital setting, especially in an emergency room setting.

I think your staffing model sounds okay, but I'm going to say I would love to have or would love to see some more oversight to ensure that those patients would be safe.

I am going to vote no on this project for all those reasons and also because we have a high number of beds in Illinois that we don't need already. That's just my opinion, and we need to be looking at how do we work better together and make our services more efficient in more

comprehensive ways as opposed to adding more to an already excessive system, so with that, I thank you for this presentation, but I am going to vote no.

MR. ROATE: Thank you.

Ms. Hardy-Waller?

MEMBER HARDY-WALLER: I too thank you for your efforts. I think what you're doing is applaudable. I didn't get a chance to say this earlier, but I do think that particularly for NorthPointe and all of the nonacute services that you have added, really, really makes Beloit have a robust continuum of care, which is what we really need in our health system, so I applaud you for that.

I have been working really hard to make this make sense to me, and I have not been able to do that.

I would agree with my colleague, Dr. Tanksley, in that as I think about the low acuity level for the very small hospital of 10 beds, it really feels like a super urgent care center. And in my head, I kept trying to figure out what is another alternative to do this without building a $20 million hospital facility.

That in addition to I also struggled with sort of untangling -- understanding that Beloit is the parent, but I really had a hard time untangling Beloit, Wisconsin from NorthPointe, Illinois, particularly since my -- what I do is for Illinois, so I had a hard time untangling that as well, but, again, applaud your rationale for wanting to do this and for your care and concern for the patient population in the area, but I will have to vote no

for those reasons.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN SAVAGE: This has been a very hard decision to make. I thank everybody for all your testimony. You guys had a great presentation, especially appreciate our physicians and social worker. I think you guys did a great job and all the people here who participated.

I think there are still some questions. I don't think some of the negative feedback that came earlier influenced me because you spoke to that. I think you spoke to that fairly well, but I still have questions like my colleagues do and, unfortunately, I'm going to have to vote no to this, but it will be something you can come back and shore up perhaps.

MR. ROATE: Thank you, Madam

Chair.

That's one vote in the positive, five votes in the negative and one absent.

CHAIRWOMAN SAVAGE: So then, unfortunately, that is an intent to deny, so the board staff will be in touch with you in the near future. Thank you.

Okay. Do any of our board members need a break before we continue on? Okay. So we are going to have a five-minute break and we will be right back.

(A recess was had.)

CHAIRWOMAN SAVAGE: So we are going to start again, and we are going to move on now to other business. Yes.

So John, you are going to talk about some financial reports.

The rules?

MS. DOMINGUEZ: Number 8.

CHAIRWOMAN SAVAGE: Okay.

Scratch that, Renee. We are going to move back to number 8. That's going to be the rules development, an update to change in the cardiac cath category of service rules.

And who is doing that? Don, is that you? Don Jones.

MR. JONES: Thank you, Madam Chair.

This is just a very brief update. As you know, the board has been working on changes to the cardiac cath rules for some time.

We have assisted the input from a number of industry providers and we have gotten a lot of responses back from them.

We have also sent a draft to the Illinois State Medical Society, Illinois Hospital Association, Illinois Freestanding Surgery Center Association and gotten their input as well.

One of the things we're

waiting on at the moment, the Department is also beginning to revise its ASTC licensing rules in regards to cath because their rules were somewhat out of date as ours are, so Karen and her team have created a draft. The ASTC Advisory board meets I think it's December 11th to consider that -- the rules and approve that and the Governor's office would review and approve and the Department will start the rule-making process.

What we would probably do is once their draft is done, we will incorporate or cross reference what we need to from their rules into the board's rules and most likely will present that to you in January for your approval, and then we will also begin the ruling-making process in a formal sense.

CHAIRWOMAN SAVAGE: Very

good.

Any questions anyone?

Mr. Fox.

MEMBER FOX: Don, when we talked about this six or eight or nine months ago, somebody presented some of the standards that had been adopted by other states and in terms of approval procedures required in order to establish cath labs, et cetera. I was pretty impressed with some of the work and some of the outcomes that those states had come up with.

Have we informed our own process of coming up with new rules by what other states have done as compared to we are sort of in a bubble creating our own set of standards without looking around to see what other people have done?

MR. JONES: Right. In

Pennsylvania and Michigan, for example, they have recently -- those states have recently revised their cardiac cath requirements. They are more focused on physician usage is what I would call it. It's where a physician has to perform X number of caths per year for proficiency before that physician will get credentialed to provide service at a new site, let's say, for example.

At the moment the board's rules are more focused on facility utilization, and the Department's draft rules are more focused on physician usage, so that's something we will need to look at and potentially reconcile between their draft and our draft.

MEMBER FOX: Okay. Thanks.

CHAIRWOMAN SAVAGE: Other questions? Go ahead. This will be Gary Kaatz.

MEMBER KAATZ: Don, with where we're at, we've probably already taken this into consideration. Did we ever reconvene that group that you had I think you a year ago?

MR. JONES: That was last December.

MEMBER KAATZ: Last December and reconvene that group and present them the rules changes as we --

MR. JONES: We could do that. What we have done in the background is that a lot of those individuals in those facilities that are here in December, they are part of the group that we have shared the information with and gotten feedback from them.

MEMBER KAATZ: Very good.

CHAIRWOMAN SAVAGE: All right. Thank you on that, Don.

Would you please share your

2024-FSHRB legislative report.

MR. JONES: Thank you, Madam Chair.

Once again, this will be brief. Early this year you had gotten reports from us with various bills that we were tracking that potentially affects the board. None of those bills materialized except for one and, John, the building -- state made -- it's about the long-term care issue.

CHAIRWOMAN SAVAGE: 3155.

MR. JONES: That did pass. That will become law January 1st, I believe. None of those other bills moved forward.

At the moment the General Assembly is scheduled to have an all veto session November 12th through the 14th, 19th through the 21st.

We heard that veto session

would be reduced or potentially canceled altogether, but nothing formal has been -- either it hasn't been decided or it hasn't been announced, so at the moment the fall veto session is scheduled, and then the 104th General Assembly will convene in January, but the General Assembly has not established a schedule for when that will be done.

CHAIRWOMAN SAVAGE: All right. What did the long-term care bill -- I don't remember. What was that entailing? Anything important?

MR. JONES: It was about safety.

MS. DOMINGUEZ: That bill was just asking -- IDPH is required to provide certain information when there's a transfer of nursing homes regarding the transfer, the

operator and homes.

MR. JONES: Had to be a transition.

CHAIRWOMAN SAVAGE: That's Blanca Dominguez.

MR. JONES: This is Don Jones again. That bill which will become law is going to require the seller and the buyer of a nursing home to create a transition plan. The Department will have to be involved with -- the Department will have to sign off on that transition plan because that plan needs to be in place while the change of ownership is transitioning to ensure a certain quality of care is being provided to the residents of the facility.

CHAIRWOMAN SAVAGE: That would be nice. Okay. Thank you.

Now, Mr. Kniery, would you like to give us our financial report?

MR. KNIERY: Yes, thank you. Just the highlights. The report is in your packet.

The expenses were up 18 percent from fiscal year end 2023, but the expenses were well under fiscal years '21 and '22.

As related to you, previous financial reports, fiscal year '24 was a slow year. Revenue was probably the lowest it's been in about five years, so we are addressing, trying to address that issue.

We've received Governor's office approval and to update our rules, we are looking at settlement fee increases, proposing to increase the base fee from 2,500 to 5,000. Increasing post permits from 500 to 1,000, a $500 increase on those. Those that are 1,000 will go to 1,500. Very minimal impacts.

I think the biggest thing will be the going from 2,500 initial fee to 5,000 because all the exceptions, those are essentially 2,500 fees, period, and we are spending that in just making -- doing the postage to newspapers, so there's nothing left after that typically.

Overall, we're significantly under our budget appropriation. Our cash balance in the board's fund is sufficient when there's some of these slow times.

I would expect this lasts probably another year given the markets and high interest rates, inflation rates. Right now everyone is trying to figure out if we can -- if we spend it, can we pay for it, so I just think that we are going to see a little bit more.

We still have some staffing

needs. Overall staffing costs have been increasing as with everything else. We may ultimately need to reset the thresholds. Projects have to -- been going up every year because of inflation. We are looking at possibly resetting those. That would be a legislative task. And we may have to come back for additional fees, but I just want to see how these will affect us and if we can get by by changes that we're suggesting that we can do through rule, so that's it.

If there's any questions, be more than happy to answer any questions.

MEMBER BEEDLE: This is Dennis Beedle. Do you think you could stratify the fees for the size of the organization?

I realized when I was reviewing the packet that we were

not talking about thousands of dollars. We were talking about millions of dollars, so it does seem like for some of the small players, this is kind of a high risk expense thing. For some of the larger players, they have a lot of resources. They provide a lot of material for us to read, I would point out, and just their financial could be a 45-minute read, so I would think that that might be another approach.

MR. KNIERY: I think there is on just the percentage, the general fee is .0022 of the project, total project cost. The higher the project cost, the higher the fee.

We are looking at possibly increasing the caps, so on those big projects, the big systems so we'll have a little flexibility in that, so we are trying to look at

those things that we can do through rule first, but I think it does -- it really already lends itself to the bigger a project in the system, the more the fee would be.

I think -- I still think we are very reasonable keeping an initial application fee of 5,000. We looked at other states. I think we are in line there.

Our thresholds are higher than any surrounding state in the Midwest.

We're looking at all those things to try to normalize or level the playing field in the entire area.

MEMBER HARDY-WALLER: John, I was going to ask. This is Antoinette Hardy-Waller.

I was just going to ask, what do you think primarily was driving the reduction in revenue,

particularly the net over the last four to five years?

MR. KNIERY: We had an anomaly here last year, so we had a record year. We had a large number of projects filed. I think we always see that it ebbs and flows enclosed.

I think coming out of COVID, I think there's no norm quite yet, and I think we are just now starting to see it, so I think there's a pent up demand and we saw that, and now there's higher interest rates and things like that, we are seeing things are leveling out and people are being more selective in projects they do.

Everything is cyclical. I do believe it can come back. We are just in one of those times that projects are not as high volume as they had been.

MEMBER HARDY-WALLER: Do you think that where we are in terms of revenue as sort of leveling out and the norm will be over time for the most part?

MR. KNIERY: No. I think we're low. I think we're low, and it's good that we have the funds that when things are high, that we put the money away and it works itself out.

CHAIRWOMAN SAVAGE: I would think as the economy continues to improve that it's going to get better for us, and hospitals are going to take more risks as we go along.

MEMBER KATZ: It's David Katz.

It's got to be highly correlated with the interest rates. I mean, it's not a whole lot more complicated than that.

How big of a problem is

it -- that $4 million, how big a problem is that? Is that -- is there reserves?

MR. KNIERY: We have -- so we have a cash balance in our fund of 4.7 at the end of last fiscal year. It's a little less than that now, but it's still healthy and so we should be able to weather a couple of years.

MEMBER KATZ: Thank you.

CHAIRWOMAN SAVAGE: Okay. We are going to move on to Kenton Tilford. He is going to talk about the 2023 annual hospital questionnaire profiles and do a website demo quickly.

MR. TILFORD: Thanks so much. So we finally figured out -- we finally finished the hospital profiles for 2023. I have an example of it on the board behind you. It's a little bit of a new design and that's the

statewide summary.

I have got a couple of bullet points as far as changes from last year that I wanted to go over.

Some of the trends, there's the trend towards outpatient surgeries from inpatient, outpatient surgeries, up 11 percent, inpatient, 5.4 percent. Outpatient's revenue is up 19 percent, as opposed to 9 percent for inpatient revenue.

Charity care declined from last year, which seems like something that we should look at.

The CON occupancy rate is 59.1. It was 59.3 in 2022. And as far as the charity care goes in 2022, charity care was 1.75 percent of net revenue. In 2023, it's 1.3 percent.

Also another trend, average inpatient and outpatient surgery

time has declined. 3 hours for inpatient, 1.7 for outpatient.

And also I just want to ask to the board members and anyone else, if anyone has anything that they want us to be looking at in particular, you can always feel free to reach out to me. I can give you whatever we have.

I think that's about it. We can send the profiles out to the board via email after this, but with that being said, we can go to the website now.

MR. KNIERY: While you get that set up, we need a vote to -- we do need a quick vote to approve the profiles that Kenton is proposing.

CHAIRWOMAN SAVAGE: I have a motion to approve the hospital questionnaire profiles. I have a second.

Second by Gary Kaatz. And

all in favor say aye.

(A chorus of ayes.)

CHAIRWOMAN SAVAGE: And any nays.

(No response.)

CHAIRWOMAN SAVAGE: No nays, so that passes.

And for Renee, that means all board members voted aye.

All right. So go forth with your demonstration.

MR. TILFORD: Just fixing my technical difficulties here.

MR. KNIERY: This is John Kniery. While they are still pulling this up, I just want to point out, Kenton and Shari, that Kenton, mostly Kenton came up with a full draft rewrite of our website, but the entire staff has been working very diligent on it, and I think it will be much easier to navigate and search which will hopefully make things a little bit

better. So thank you both. Thank you.

MR. TILFORD: Thanks, John.

Here is the home page, so if you notice, the awful brown is not there anymore. So we got like we have a new feature called a Project Search that the guys at Do It suggested.

So when you use the search function in our website, it usually does not work very well. It just like brings up a bunch of old documents that might -- may or may not be related.

But now you can go to the project search and type in the project name and it will send you right to that project.

You can still do the normal search on the website if you are trying to find old documents, but I think that makes the key thing that people do here a lot easier

to find.

We have got -- the main thing with that is just the new design, so I think it looks a lot better. The stakeholders are all going to have a nicer experience.

We got a nice little staff page here, and go to announcements, it's largely the same content, but hopefully a little bit easier for everyone to find.

CON applications, just click on these links here, download the application forms.

In the future we would like to be able to make the process entirely online, so we are not like downloading a PDF and not having people send it back and all that good stuff.

As far as the data goes, this will be a lot better in the future. Right now it's just kind

of everything we have is up there, but the great thing that Do It helped me with was a filter system for this, so if you just want to see ASTC data, you just hit that and it will pop up from each year.

In the future I would like to do more to be able to see year over year data better, but I think it's a good start.

CHAIRWOMAN SAVAGE: I like it. Easy to use it looks like.

MR. TILFORD: Yeah. And Do It made sure it was accessible on mobile too, so it looks pretty nice there too.

Does anyone have any questions about it?

Thanks so much.

CHAIRWOMAN SAVAGE: Okay. May I have a motion to go into executive session pursuant to Session 120/211 of the Open Meetings Act to discuss probable

or imminent legal action?

MEMBER HARDY-WALLER: So moved.

MEMBER KATZ: Second.

CHAIRWOMAN SAVAGE: That would be Ms. Hardy-Waller and then Mr. Katz -- what's his name? David Katz, not Gary, so David Katz is second.

Now, all those in favor of said motion, say aye.

(A chorus of ayes.)

CHAIRWOMAN SAVAGE: All those opposing the motion to move into executive session, say nay.

(No response.)

CHAIRWOMAN SAVAGE: Okay. The ayes have it.

So everybody online with the exception, of course, of Renee, shall need to log off.

(Whereupon, executive session was had and transcribed under separate cover.)

(The following proceedings were held in regular session after executive session.)

CHAIRWOMAN SAVAGE: We're in regular session.

So now may I have a motion to approve these settlement agreements and final orders for Centers for Health Ambulatory Surgery Center, LLC, Swedish American Hospital and Endeavor Health and Northwest Community Foot and Ankle, LLC.

MEMBER KATZ: So moved. David Katz.

MEMBER TANKSLEY: Audrey Tanksley. Second.

CHAIRWOMAN SAVAGE: Splendid.

George, could you call the

roll.

MR. ROATE: Thank you, Madam Chair.

Mr. Budde?

SPEAKER: Yes.

MR. ROATE: Thank you.

Mr. Fox? David Fox. Thank you.

David Katz.

MEMBER KATZ: Yes.

MR. ROATE: Gary Kaatz?

MEMBER KAATZ: Yes.

MR. ROATE: Dr. Tanksley?

MEMBER TANKSLEY: Yes.

MR. ROATE: Ms. Hardy-Waller?

Chairman Savage?

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: That's seven votes in the affirmative.

CHAIRWOMAN SAVAGE: Okay. The settlement agreements and final orders are approved.

So now we have referrals to

legal counsel for Ascension Healthcare, Retina Surgery Care, AdventHealth, HSHS and Premier Cardiac.

So now may I have a motion to approve the referral of these matters listed in Item 12C of the agenda to the legal counsel for review and appropriate compliance action?

MEMBER KATZ: So moved again. David Katz.

MEMBER BUDDE: This is Rex Budde. I second.

CHAIRWOMAN SAVAGE: Splendid. All those in favor say aye.

(A chorus of ayes.)

And any nays?

(No response.)

CHAIRWOMAN SAVAGE: No.

The ayes have it.

All right. So let's see. Our next meeting, everyone put on

your calendar, December 10th. It will be exciting. Yes.

UNIDENTIFIED SPEAKER: Antoinette and I cannot make that meeting, so you might want to consider an alternative date.

CHAIRWOMAN SAVAGE: Okay. So we will look at that. We will get back to everyone because January also has to be rescheduled, so maybe it will all work out.

He's working on it right away. All right.

Now wishing everyone a very Happy Halloween and a Happy Thanksgiving, and now may I have that all important motion to adjourn?

MEMBER HARDY-WALLER: So moved.

MEMBER BUDDE: Second.

CHAIRWOMAN SAVAGE: And all in favor of this say aye.

(A chorus of ayes.)

CHAIRWOMAN SAVAGE: I hear no nays, so that motion has passed and we thank you, Renee, for coming on at the last minute. Thank you.

(Which were all the proceedings had at the above-entitled cause at 5:35 p.m.)

STATE OF ILLINOIS )
) SS:
COUNTY OF KANE )

I, Renee E. Brass, Certified Shorthand Reporter of the State of Illinois, CSR No. 084-004119, do hereby certify that I caused to be reported in shorthand and thereafter transcribed the foregoing transcript of proceedings. I further certify that the foregoing is a true and complete transcript of my shorthand notes so taken as aforesaid, and further, that I am not counsel for nor in any way related to any of the parties to this action, nor am I in any way interested in the outcome thereof.

IN TESTIMONY WHEREOF, I have hereunto set my hand this 13th day of November 2024.

Renee E Brass

CSR No. 084-004119-Expiration Date: 5.31.2025

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