S62950-1

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
HEALTH FACILITIES AND
SERVICES REVIEW BOARD

REPORT OF PROCEEDINGS had at the hearing of the above-entitled matter, taken at the Bloomington-Normal Marriott Hotel & Conference Center, 201 Broadway Street, Normal, Illinois, on August 14, 2013, at the hour of 9:00 a.m.

BOARD MEMBERS PRESENT:

MS. KATHY OLSON, Chairperson;
MR. PHILIP BRADLEY;
DR. JAMES BURDEN;
SENATOR DEANNA DEMUZIO;
JUSTICE ALAN GREIMAN;
MR. DAVID PENN;
MR. RICHARD SEWELL.

ALSO PRESENT:

MR. FRANK URSO, General Counsel;
MS. ALEXIS KENDRICK, Board Staff;
MS. COURTNEY AVERY, Administrator;
MR. DAVID CARVALHO, IDPH Ex-Officio;
MR. BILL DART, IDPH Staff;

MR. MATT HAMMOUDEH, IDHS Ex-Officio;
MR. MIKE JONES, IDHFS Ex-Officio;
MR. MICHAEL CONSTANTINO, IDPH Staff;
MR. GEORGE ROATE, IDPH Staff;
MR. NELSON AGBODO, Health Systems Data Manager;
MS. CLAIRE BURMAN, Rules Coordinator; and
MS. CATHERINE CLARKE, Board Staff.

I N D E X

CHAIRPERSON OLSON: Good morning everybody. It is 9:00 o'clock promptly, so we will get started. I'll call this meeting to order.

Can we have a roll call, please?

MR. ROATE: Mr. Bradley.

MEMBER BRADLEY: Here.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: Here.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Here.

MR. ROATE: Justice Greiman.

MEMBER GREIMAN: Here.

MR. ROATE: Mr. Hayes is absent.

Ms. Olson.

CHAIRPERSON OLSON: Here.

MR. ROATE: Mr. Penn.

MEMBER PENN: Here.

MR. ROATE: Mr. Sewell.

MEMBER SEWELL: Here.

MR. ROATE: Seven members present.

CHAIRPERSON OLSON: Thank you.

I'm told we have one person for public participation. If that person could come

forward.

MS. KENDRICK: Edwin Cook?

MR. SHEETS: Dr. Cook is going to testify at the table with us.

MS. KENDRICK: All right. No public participation.

CHAIRPERSON OLSON: Okay. There is no public participation.

May I have a motion to go into executive session for applications pending administrative hearing?

MEMBER PENN: So move.

MEMBER GREIMAN: Second.

CHAIRPERSON OLSON: Voice vote, please? All in favor?

MR. URSO: Excuse me, Madam Chair. You have to say "pursuant to 2(C)(1), (5), and (11) of the Open Meetings Act."

CHAIRPERSON OLSON: Pursuant to --

MR. URSO: Pursuant to Section 2(C)(1), 2(C)(5), and 2(C)(11) of the Open Meetings Act.

CHAIRPERSON OLSON: Pursuant to Section (2)(C)(1), 2(C)(5), and 2(C)(11).

All in favor?

(The ayes were thereupon heard.)

CHAIRPERSON OLSON: Opposed?

We are now in Executive Session at 9:05. We will let you know when we're done. This could be lengthy, so make yourselves comfortable.

(Whereupon at 9:05 a.m., the Board adjourned into executive session, after which the following proceedings were had in public session commencing at 11:22 a.m.)

CHAIRPERSON OLSON: We're back in open session.

Compliance Issues, Settlement Agreements, and Final Orders.

Frank?

MR. URSO: I'm requesting a motion to approve a final order on Orland Park Surgery Center, Docket No. 13-03.

CHAIRPERSON OLSON: Can I have a

motion to approve --
MEMBER SEWELL: So move.
CHAIRPERSON OLSON: Second?
MEMBER PENN: Second.
CHAIRPERSON OLSON: Is that a roll call or voice? Let's have a roll call vote.
MR. ROATE: Yes, ma'am. I'm sorry?
CHAIRPERSON OLSON: It was motion made by Richard Sewell, seconded by David Penn.
MR. ROATE: Motion made by Mr. Sewell, seconded by Mr. Penn.
Mr. Bradley.
MEMBER BRADLEY: Yes.
MR. ROATE: Dr. Burden.
MEMBER BURDEN: Yes.
MR. ROATE: Senator Demuzio.
MEMBER DEMUZIO: Yes.
MR. ROATE: Justice Greiman.
MEMBER GREIMAN: Yes.
MR. ROATE: Ms. Olson.
CHAIRPERSON OLSON: Yes.
MR. ROATE: Mr. Penn.
MEMBER PENN: Yes.

MR. ROATE: Mr. Sewell.
MEMBER SEWELL: Yes.
MR. ROATE: That's seven votes in the affirmative.
CHAIRPERSON OLSON: Motion passes. Frank?
MR. URSO: I'm also requesting approval of a Final Order on Vanguard Health Systems, Weiss Memorial Hospital, and MacNeal Hospital, Docket Nos. HFPB 07-28 and 07-29.
CHAIRPERSON OLSON: May I have a motion?
MEMBER PENN: So move.
MEMBER SEWELL: Second.
CHAIRPERSON OLSON: Roll call?
MR. ROATE: Motion made by Mr. Penn, seconded by Mr. Sewell.
Mr. Bradley.
MEMBER BRADLEY: Yes.
MR. ROATE: Dr. Burden.
MEMBER BURDEN: Yes.
MR. ROATE: Senator Demuzio.
MEMBER DEMUZIO: Yes.
MR. ROATE: Justice Greiman.

MEMBER GREIMAN: Yes.
MR. ROATE: Ms. Olson.
CHAIRPERSON OLSON: Yes.
MR. ROATE: Mr. Penn.
MEMBER PENN: Yes.
MR. ROATE: Mr. Sewell.
MEMBER SEWELL: Yes.
MR. ROATE: Seven votes in the affirmative.
CHAIRPERSON OLSON: The motion passes.
MR. URSO: The final request I have is a motion to approve a memo to close the file based upon the Attorney General's information about a fine being uncollectible for Michael Reese Hospital, which is Docket No. HFSRB 09-06.
CHAIRPERSON OLSON: May I have a motion?
MEMBER PENN: So move.
MEMBER GREIMAN: Second.
CHAIRPERSON OLSON: Roll call, please?
MR. ROATE: Motion made by

Mr. Penn, seconded by Justice Greiman.

Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Yes.

MR. ROATE: Justice Greiman.

MEMBER GREIMAN: Yes.

MR. ROATE: Ms. Olson.

CHAIRPERSON OLSON: Yes.

MR. ROATE: Mr. Penn.

MEMBER PENN: Yes.

MR. ROATE: Mr. Sewell.

MEMBER SEWELL: Yes.

MR. ROATE: Seven votes in the affirmative.

CHAIRPERSON OLSON: Motion passes.

MR. URSO: We have several referrals to legal counsel.

I'm requesting the Board's approval to refer the following matters to legal counsel for review and filing any notices of noncompliance, which may include sanctions

detailed and specified in the Board's act and rules, and those cases are 11-121, Lisle Center for Pain Management and the second one being Fullerton Kimball Medical & Surgery Center, 12-045. Those are two separate referrals to legal counsel.

CHAIRPERSON OLSON: May I have a motion to refer these to legal counsel, please?

MEMBER GREIMAN: So move.

MEMBER PENN: Second.

MR. ROATE: Motion made by Justice Greiman, seconded by Mr. Penn.

Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Yes.

MR. ROATE: Justice Greiman.

MEMBER GREIMAN: Yes.

MR. ROATE: Ms. Olson.

CHAIRPERSON OLSON: Yes.

MR. ROATE: Mr. Penn.

MEMBER PENN: Yes.
MR. ROATE: Mr. Sewell.
MEMBER SEWELL: Yes.
MR. ROATE: Seven votes in the affirmative.
CHAIRPERSON OLSON: Motion passes.
Applications Subsequent to Intent to Deny. I'm told that 12-089, Riverside Medical, and 12-096, Silver Cross, have both been served.
So we will call 12-102, DaVita West Side Dialysis, Chicago. If the applicant can please come to the table.
Mr. Constantino, may I have the State Board Staff Report, please?
MR. CONSTANTINO: Thank you, Madam Chairwoman.
The applicants are proposing to establish a 12-station ESRD facility in approximately 6,700 gross square feet of leased space in Chicago, Illinois.
The modified cost of the project is approximately $2.7 million. The anticipated completion date is September 30th, 2014.

On May 14, 2013, the State Board issued an Intent to Deny for this project. The applicant submitted additional material on July 11th to address the concerns of the State Board.

As part of that submittal, the applicants modified the project and reduced the cost of the project by approximately $75,000. This reduction in cost removed the negative finding related to the 1120 criteria in the original State Board Staff Report.

Thank you, Madam Chairwoman.

CHAIRPERSON OLSON: Thank you, Mike.

Would the people at the table introduce themselves and be sworn in?

MS. DAVIS: Penny Davis, Division Vice President with DaVita.

MR. SHEETS: Chuck Sheets, attorney from Polsinelli representing the applicant.

DR. COOK: Dr. Edwin Cook, nephrologist.

MR. URSO: The Board members can't hear you.

DR. COOK: Dr. Edwin Cook, nephrologist.

(The witnesses were thereupon duly sworn.)

CHAIRPERSON OLSON: Comments for the Board?

MS. DAVIS: Thank you.

Good morning. I'm Penny Davis, the Division Vice President for DaVita in Chicago. With me today is, as we mentioned, our Co-Medical Director at this facility, Dr. Edwin Cook, and our legal counsel, Chuck Sheets.

As you know, we are here after receiving an intent to deny by a vote of four to four at the May meeting. I'd like to begin by addressing the concerns of the four Board members who voted no in May. As you may recall, the no votes all used excess capacity as the reason for casting a negative vote.

The two main findings in the Staff Report noted by the Board in our last appearance are due to underutilization of existing facilities within 30 minutes.

While some of these facilities are operating below 80 percent, average utilization among operational facilities is 77 percent.

In the last quarter alone, the utilization in the service area grew by 119 patients, which is 2 percent. It's no surprise that there is currently a need for 15 stations in the City of Chicago, as the total census of in-center ESRD patients in the region grew by 1,386 patients since 2008, and that number comes from the US ESRD data that we recently received.

Most of this growth is concentrated on the South and West sides of the City, which will directly benefit from this proposed facility. As a responsible health care provider, we have to be preparing for future need, just as your own need estimates do.

I want to mention something that's different around need numbers related to dialysis versus hospitals and nursing homes.

Hospitals and nursing homes are population based; and so as the population

grows or a decline in population happens, we actually see bed need go up or down.

With dialysis it's based on the patients and the increased disease within the population.

Despite the clear need for additional stations in the City of Chicago, if you compare the 2011 facility data for suburban Chicago (HSA 7) to the City of Chicago, you can see that the lower income parts of metro Chicago have reduced access to dialysis care.

While patient numbers between these HSAs are virtually the same, with Chicago having slightly more, 4,685 patients as of December 31st versus 4,674 patients in the near suburbs, the suburban patients have much better access to treatment with 990 stations for Chicago residents and 1,065 for suburban Cook and DuPage counties.

Based on the data gathered by the Board for 2011, of the patients treated in the City of Chicago for 2011, 21 percent were Hispanic and 67 percent were people of African American or nonwhite.

When it comes to health care services access limitations, the city of Chicago is unlike any other city in the state of Illinois. Given the access issues, we believe that this facility is absolutely necessary.

This is particularly true for the patients of Drs. Cook and Hollandsworth, who are planned medical directors for the West Side facility. These doctors operate a chronic kidney disease clinic at Cook County Health System's Provident Hospital.

Provident Hospital is responsible for providing a wide array of health care services to low-income residents of the County, including pre-ESRD care. Once a patient has kidney failure, though, these patients must receive a transplant or start dialysis.

Based on their income levels and the fact that most of these patients don't have insurance, they are not candidates for transplant.

Drs. Cook and Hollandsworth work with their patients for years during their early stages of CKD, and their patients have

entrusted them with the management of their care.

When it becomes time to transition to dialysis, it is much easier on the patient to continue to work with their same physician.

While some facilities near the proposed site have capacity for new patients, no single existing facility in the area can accommodate all their patients. Thus, the patients would be spread throughout the planning area at different dialysis facilities where Dr. Cook and Dr. Hollandsworth do not round.

One of the current facilities that they do round at that is nearby is our Emerald Facility. There also are medical directors there. That facility is currently at 85 percent.

I want to make mention of the fact that because of the type of practice that Drs. Cook and Hollandsworth have, they treat, like many nephrologists don't, patients who are uninsured. They take all colors. They go to Provident. They run their clinic there.

They are probably the most generous

doctors that I know of in terms of taking care of people who have no other access.

To ask them to go to one more facility after they currently round at five dialysis centers, they go to three hospitals, and they also do their clinic at Provident would be, I think, a strain on the physicians and the care that they provide.

If the facility is not approved, most of these patients will be forced to find a new physician, making their transition to dialysis more difficult.

Please remember that patients on dialysis have an average of three to five additional comorbidities. That means that they have three to five other diseases, they are on eight to ten other medications, and are very complex patients.

To complicate the transition further, because many of these patients have no insurance, their options for a new physician are limited because not all physicians will take care of patients regardless of their ability to pay, as Drs. Cook and Hollandsworth

do.

If these patients want to remain being treated by Drs. Cook and Hollandsworth, this facility would be their only option.

We want to point out that two of the facilities that are listed as not meeting the capacity numbers are Rush and Cook County.

The Rush facility on their own treats pediatric patients, and the Cook County facility is being used more and more for their acute patients and not for chronic dialysis.

As stated earlier, with the 2 percent increase in the number of patients treated in the last quarter alone and the Board's inventory identifying a need for 15 dialysis stations in the City of Chicago, we implore you and suggest that these stations be placed in a community that truly needs them.

If the Board has any questions after Dr. Cook speaks, we'd be happy to answer them.

CHAIRPERSON OLSON: Thank you.

Dr. Cook?

DR. COOK: Hello.

MR. CARVALHO: Could I determine

whether I have a conflict here?

Dr. Cook, you work at Provident?

DR. COOK: Yes, I do.

MR. CARVALHO: Are you financially involved in this application?

DR. COOK: No.

MR. CARVALHO: Well, I'll still step out. Provident is part of the Cook County Health System.

CHAIRPERSON OLSON: Let the record reflect that Mr. Carvalho is leaving.

(Whereupon, Mr. Carvalho left the room.)

DR. COOK: Good morning. My name is Dr. Edwin Cook.

I have been a practicing nephrologist in the Chicago area for over 30 years, and I am here in support of the DaVita proposal to establish West Side dialysis and will be the medical director of this facility with my partner, Dr. Donald Hollandsworth, if the project is approved.

In over 30 years of practice, I have seen the number of cases of end stage renal

disease skyrocket. From 1980 to 2010, the number of reported ESRD cases in the United States has increased nearly tenfold from over 60,000 to about 600,000, in 2010.

This increase is due in large part to the obesity epidemic our country is facing. One of the results of higher obesity rates is the increasing prevalence of diabetes and hypertension in the general public, two of the leading causes of chronic kidney disease and end stage renal disease.

In fact, diabetes accounts for 44 percent of all new cases of kidney failure, and hypertension causes approximately 25,000 new cases of kidney failure annually.

As the number of individuals with diabetes and hypertension continues to rise, the incidence and prevalence of kidney failure will increase for the foreseeable future. Given these increases, we must ensure adequate access to dialysis care.

Once patients reach end stage renal disease, there are basically two options, transplant or dialysis. Although almost all

ESRD patients receive insurance coverage, many do not have coverage during the earlier stages of chronic kidney disease.

This is particularly prevalent at the clinic we serve at Cook County's Provident Hospital, and this is one of the reasons I and my colleague, Dr. Hollandsworth, decided to run a clinic at Cook County's Provident Hospital.

Over the years we've developed great relationships with these patients, many of whom come from all over the city of Chicago to obtain free or reduced cost care.

In order to ensure we continue to treat these patients, we try to send them to facilities where we round. None of the facilities in the area can accommodate a substantial number of our patients; and as a result, we would be unable to round at each facility to continue treating all our patients once they initiate dialysis.

Although one of these facilities, John H. Stroger Hospital of Cook County, appears to have sufficient capacity, it can no longer

accommodate many chronic patients because it has to use most of its stations for inpatients.

This, coupled with the high utilization at other facilities where I round, would require me to no longer see most of my patients, unless the Board approves this facility.

The West Side facility will directly benefit my patients in the surrounding community, and I respectfully ask the Board to approve this project.

Thank you for your time.

CHAIRPERSON OLSON: Thank you, Doctor.

Questions from the Board?

MEMBER SEWELL: I'm trying to understand the access difficulties.

It sounds like one big part of it is that there's a poor population who is more likely to be Medicaid covered, and the other aspect of it sounds like a race and ethnicity kind of issue.

Now, how does that play out in terms of

the access of these patients to some of these underutilized facilities?

MS. DAVIS: First of all, in terms of race, African-American and Hispanic patients are much more likely to have the diabetes, have the hypertension, which causes the end stage renal disease.

We know that approximately 60 percent of our patients across the country -- and that includes all the rural areas in the country -- are African-American or Hispanic.

They also have an access issue from the point of view that undocumented patients, for instance, can go to the County or to Provident and see Dr. Cook.

When they go on dialysis, they get -- actually, the state of Illinois has emergency Medicaid. Not all facilities will do what we do, which is to help that person get through their emergency Medicaid application and get them onto Medicaid.

In addition, the County patients, all of that care that they get -- uninsured patients get before they are eligible for Medicare is

done at no cost. Medicare doesn't kick in when you hit ESRD until 90 days.

So what we're able to do, we take those patients from day one. Dr. Cook takes those patients. If they're eligible to get on Medicare, great.

Generally, it takes us anywhere from three to five months to get a patient on Medicare and receiving payments, but it's a commitment that we have made to the community.

I will tell you the other facility that Dr. Cook works out of, Emerald, loses money. We lose money every year, but we keep those facilities open and have committed to keep those facilities open to serve the poor communities. Hopefully, our facilities in another market or another area will be profitable to help keep them open.

So the access issue is really about in those communities on the West and South Side, we're seeing phenomenal growth numbers; and it's because we continue to see higher rates of disease.

We recently participated last weekend in

Senator Maddy Hunter's event, Community Health Fair, as well as the 51st Street Health Fair because of the fact that we are able to identify patients with hypertension and, hopefully, get them referred into a system of care. We'd like see them prevent dialysis and prevent end stage renal disease, but it's not happening.

So the access issue is really about they have to take Medicars. They have to take buses. Some it's family members dropping them off, and they're doing that before and after work.

Most patients want a first shift, which means they start dialysis at 5:00 o'clock in the morning. So to have the number of stations available to them so that they can have a shift that they want to be on so that if they work, they can continue to work is important to us.

One of the things I want to mention -- and, you know, we've spoken before about DaVita's charity care. Our charity care has gone up every year over the last three years,

and that care is for those patients in the first 90 days that we don't ever get reimbursement for if they end up going on Medicare.

Recent MedPAC data that came out -- this is a for-profit company, but I will let you know that on an average, MedPAC's Medicare margin for dialysis providers is 2 to 3 percent.

When you look at the same margins for SNFs, for instance, SNFs are 22 to 24 percent. Home health is 15 percent. Long-term acute care is 10 percent. So the Medicare margin for a dialysis patient is very, very low.

We lose -- for every Medicaid treatment, we lose $77. Yet we continue to provide that care and those treatments because we see it as a commitment.

We also, you know, work to make sure that we get -- we want people to stay working. They're less depressed if they stay working. We're now trying to help patients find jobs so they can go back to work because they will be less depressed and they will stay healthier.

So, you know, it's an overall commitment to the holistic care of a patient and part of the community need that we want to build and continue to build facilities in these communities.

CHAIRMAN OLSON: Other questions? Dr. Burden?

MEMBER BURDEN: Thank you, Madam Chair.

As you know, when you were here in May, I voted for this project. So my questions are a little different.

Was the projection of 15 ESRD stations a computed need of 15 based on, as we discussed yesterday, a ten-year projection? Is that correct, Mike?

MR. CONSTANTINO: Yes.

MEMBER BURDEN: Would that mean that that need would be less or would you have to -- in the five-year projection we're now going to be talking about in the future, would that be more or less, if you know?

MR. CONSTANTINO: Well, it's an inventory you haven't approved yet.

MEMBER BURDEN: Pardon me?
MR. CONSTANTINO: It's an inventory you have yet to approve that I discussed with you yesterday.
MEMBER BURDEN: Yes.
You can't answer that?
MR. CONSTANTINO: No, I can't.
MEMBER BURDEN: Thank you.
Just for the record, Doctor, I notice Dr. Hollandsworth was here back in May.
DR. COOK: Right.
MEMBER BURDEN: He does claim to be part-time at Provident. That's not important in the big picture, but it's in the record.
What I wanted to ask also was: How close is Little Village to your location?
It's a very busy unit that DaVita runs, I see, over 100 percent.
MS. DAVIS: Yeah. That's at Western and Cermak.
MEMBER BURDEN: So it's south of you, then?
MS. DAVIS: Right, and that's running over 100 percent because we've now

added a seventh shift where we have an evening shift for patients who work -- or want to work because we were out of space, out of room.

MEMBER BURDEN: Thank you.

CHAIRPERSON OLSON: Other questions?

MEMBER BURDEN: I had one more question. Excuse me. It's an opportunity to ask.

I noticed that some time ago DaVita brought on HealthCare Partners as an additional support to the services you have at dialysis facilities. I was impressed when I read about that.

What do they do other than what you provide? I'm curious.

Their internists are primary care doctors or are you the health care provider that is part of the HealthCare Partners program at DaVita? Help me. I'm just curious about that.

MS. DAVIS: Sure.

The biggest reason that we acquired or partnered with HealthCare Partners was for

DaVita to learn more about integrated care.

The HealthCare Partners organization has been part of the pioneer ACOs, and they have been delivering care, especially in California, Arizona, and Florida, in a very integrated and cost-reducing method and at the same time improving quality.

They've actually taken on capitation, which is similar to what we do with the bundle. So the reason for the partnership was for them to teach us more about how to do integrated care. So we're learning from them all the time.

As we've developed integrated care products, we are working with ACOs to take on the whole risk on end-stage renal stage patients, to take on that life and to try and reduce costs and at the same time improve quality.

MEMBER BURDEN: In my time -- and I've been away for 13 years -- the nephrologists, of course, by definition -- and I knew a lot of them -- surely rendered this type of care on a per diem basis, but the

HealthCare Partners seemed like a bigger, more organized attempt to create a situation where the dialysis patient could really get more for his buck, more done at that time.

Is that what I'm hearing you say regarding HealthCare Partners?

MS. DAVIS: Yes.

MEMBER BURDEN: But they're really not here in our area to that degree as they are in the far western part of our country; is that correct?

MS. DAVIS: Yeah. We're actually hoping that HealthCare Partners will come into the Illinois market with us over the next three to five years.

MEMBER BURDEN: So that is right. They aren't really on board. It sounds like a good idea, and that's why I wanted to ask you.

Thank you.

MS. DAVIS: Yeah. We learn from them. We're in meetings with them all the time so that the dialysis is learning from them and they're learning from us. I think it's probably the best thing DaVita could have

ever done.

CHAIRPERSON OLSON: Any other questions or comments?

I'll entertain a motion to approve Project 12-102, DaVita West Side Dialysis to establish a 12-station ESRD in Chicago.

I would ask when you vote that you explain your yes or no vote.

Can I have a motion, please?

MEMBER BRADLEY: So move.

MEMBER SEWELL: Second.

CHAIRPERSON OLSON: Roll call, please?

MR. ROATE: Motion made by Mr. Bradley, seconded by Mr. Sewell.

Mr. Bradley.

MEMBER BRADLEY: I think this is a project that will indeed increase access to health care, particularly for lower-scale economic patients. So I vote yes.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: I vote yes in large part because I believe they are going to provide excellent medical care to a community

in dire need of such.

I'm also impressed, as I've requested information about the HealthCare Partners providing generalized medical care for these patients who have, in my experience, many medical problems besides chronic renal disease. So I vote yes.

MR. ROATE: Thank you.

Senator Demuzio.

MEMBER DEMUZIO: I vote yes due to the fact that you did go back after your denial, and you made the changes that were required of you to get a reduction of cost. So I go ahead and vote yes because of that.

MR. ROATE: Thank you.

Justice Greiman.

MEMBER GREIMAN: Yes. I vote yes, also, based on Member Bradley's observations as to the people who will be served by this facility.

MR. ROATE: Thank you.

Ms. Olson.

CHAIRPERSON OLSON: I also vote yes based on the observations of Mr. Bradley about

the underserved population that this facility will be serving.

MR. ROATE: Mr. Penn.

MEMBER PENN: I'm voting yes, again, from what Board Member Bradley presented.

MR. ROATE: Mr. Sewell.

MEMBER SEWELL: I vote yes.

I don't see a way in our health care system to overcome the payer mix and other issues that limit access by the population that this applicant plans to serve.

So in spite of the fact that we have a number of facilities that aren't at the occupancy level, I vote yes.

MR. ROATE: Thank you, sir.

That's seven votes in the affirmative.

CHAIRPERSON OLSON: The motion passes. Congratulations.

Other business, we have none.

Rules development, Claire do you want to tell us where we're at with that?

MS. BURMAN: Yes. Thank you.

Today we're looking at the proposed

Board responses to the public comment that we received during the 45-day public comment period.

The first day of the public comment period started on the day that these rules were published in the Illinois Register. We did conduct a public hearing. Several people attended, but only one chose to give testimony at that time.

During the written period, we received comments from eight different entities, including the person that provided oral testimony at the public hearing.

So this is a summary. I know it's rather a long summary, but there were a lot of issues raised. The point of the responses is to give JCAR the Board's response to all the issues that were raised in the public comment. So that is what this document represents.

CHAIRPERSON OLSON: Thank you, Claire. Thank you for all your hard work on this. This is a very extensive document.

Do any Board members have any questions or comments for Claire with regard to this

document?

MEMBER GREIMAN: What do you mean "JCAR"?

MS. BURMAN: JCAR. This is part of the JCAR process.

MEMBER GREIMAN: So we have to give it to JCAR; right?

MS. BURMAN: Yes.

CHAIRPERSON OLSON: Other questions or comments? We don't need action on that; right?

MS. BURMAN: We require an approval.

CHAIRPERSON OLSON: May I have a motion to approve the public comment document to be -- the responses to public comment document to be sent to JCAR? May I have a motion?

MEMBER DEMUZIO: Motion.

MEMBER BURDEN: Second.

CHAIRPERSON OLSON: Roll call, please?

MR. ROATE: Motion made by Senator Demuzio, seconded by Mr. Sewell.

Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Yes.

MR. ROATE: Justice Greiman.

MEMBER GREIMAN: Yes.

MR. ROATE: Ms. Olson.

CHAIRPERSON OLSON: Yes.

MR. ROATE: Mr. Penn.

MEMBER PENN: Yes.

MR. ROATE: Mr. Sewell.

MEMBER SEWELL: Yes.

MR. ROATE: Seven votes in the affirmative.

CHAIRPERSON OLSON: Motion passes.

Old Business, there's none.

New Business. The Financial Report was included in your packets.

Does anybody have any questions or comments on the Financial Report?

Office of Auditor General Entrance Conference. Courtney, can you fill us in on

that?

MS. AVERY: Sure.

CHAIRPERSON OLSON: We are adding to the New Business the Intergovernmental Agreement, which is being passed to you now. Take a quick look at it.

MS. AVERY: As you know, yesterday Mr. Ed Wittrock was with us. He's with the Office of the Auditor General.

You have in your packets what they were going to look at and some of the progress that's being made towards how the CON does his work.

Where the fines and settlements are fair, consistent, and apportioned to the degree of violation, I think that will be covered with our new statute change. So please review that.

Springfield Staff put together all the information that was needed and requested for the entrance meeting, and he was satisfied with that so far. So the process is going to take about a year.

Kathy sat in on the conference calls for

our entrance meeting and IDPH's Center for Comprehensive Planning.

David can give an update on what happened with that part, but the process is probably going to take about a year. Along the way they'll probably be requesting more information, Board clarification.

They extensively reviewed our Web site and found that a lot of information was included that they were looking for and were very pleased with it. So I think we will have a successful outcome, and I'll keep you posted once we get the findings from the performance audit.

MR. CARVALHO: Sometimes before we take a step back, it's sometimes hard to keep track of all the different audits that go on.

There's the regular cycle you're probably familiar with that the Auditor General reviews. He does a performance audit for different agencies. It's usually a two-year cycle, and so the Illinois Department of Public Health generally is having a performance audit by the Auditor General

that's underway.

The audits that Courtney is referring to are out of the ordinary audits. When the statute that Mike was describing so fondly a couple of hours ago was adopted, a provision was put in there.

Since the legislature knew that they were changing the process substantially and that they were creating a new entity, the Center for Comprehensive Health Planning, the legislature also put in a provision asking the Auditor General to do an audit of the CON process after it had been underway in the new way for a period of time.

I forget. It's triggered in the statute, but the time has passed. So that provision is triggered, and the Auditor General is doing that review of the CON process itself.

Those of you may recall there was a similar audit done, I think, around ten or twelve years ago where the Auditor General was looking at the process not simply to see whether T's are crossed and I's are dotted but

also from the perspective of what is the impact of this process on the health care system?

Is it a positive impact, a negative impact, or an indeterminate impact?

So that one is underway. Then, as I mentioned, in the same statute it also called for an audit of the Center for Comprehensive Health Planning.

That audit will, as you know, probably be a lot briefer because there is no Center for Comprehensive Health Planning yet. There was no funding to establish it until this current fiscal year began, but that audit is underway as well.

So there's three audits. You may hear from time to time about each of them, and two of them relate to the Department and one relates to the Board.

MEMBER SEWELL: So the Center for Comprehensive Health Planning is authorized, but there's no appropriation for it?

MR. CARVALHO: Yes. Until this year there was no appropriation for it. So it

was authorized in the legislation. It went into effect 2009; and in each subsequent budget year, there was no appropriation for it.

In this fiscal year, the one that began July 1, there was an appropriation to the Department to establish that center. So we've undertaken the steps that one would do starting with developing a job description for the director of the center.

If you recall from the statute, the director of the center is appointed by the Governor and subject to Senate confirmation.

So once we have a job description put together, there will be an advertisement for that position; and then the Governor will select someone. He or she will commence with making the center operational.

CHAIRPERSON OLSON: To clarify, when you say there was an appropriation in this year's budget, just so everybody understands, the appropriation comes out of our budget.

I believe that money has already changed

hands.

MR. CARVALHO: No. Let me clarify that a little.

The appropriation comes out of the Health Facilities Planning Fund. That is the fund populated by fees and fines that you collect; but in the world of the legislature, those aren't your dollars. You just happen to have created the apparatus that populates the fund.

The legislature can appropriate them to any purpose that's consistent with the statute. So one of the things that the legislature chose to do this year was to appropriate about $900,000 of it to the Department of Public Health to establish the Center for Comprehensive Health Planning, which is created by the Health Facilities Planning Act and, therefore, in view of the legislature -- and a general amendment to the Governor's proposed budget as well.

In view of the legislature, that's an appropriate expenditure of the funds in that fund since it serves the purpose of the Act.

It happens to be activity by the Center for Comprehensive Health Planning and not activity performed by the Board, but it is still activity contemplated by the Act.

The dollars don't change hands in any sense. They are in the fund in the bank account of the State, and they remain in the fund in the bank account of the State until they are spent pursuant to that appropriation.

But no monies from that appropriation have been spent because the first activity will be to hire the director of the center, and that hasn't occurred yet.

MEMBER SEWELL: Does the center have a board or an advisory board, or is that us?

MR. CARVALHO: No.

In the original Task Force Report, they contemplated the center; and in the original legislation, there were proposals to create a new board that would be in effect supervisors of the center.

The legislation hasn't actually passed. They decided instead to put the center as a

unit within the Illinois Department of Public Health.

So the employment and expenditure and all other sorts of activities, those will be in the chain of command at the Illinois Department of Public Health.

However, the center will create a Comprehensive Health Plan, and that plan will be submitted to the State Board of Health, also a preexisting board, and the State Board of Health will have the responsibility for accepting or rejecting or modifying the plan created by the center.

MEMBER SEWELL: This is my last thing.

CHAIRPERSON OLSON: Go ahead.

MEMBER SEWELL: I don't know if other Board members are even interested in this, but I do think that we have an interest in the Center for Comprehensive Health Planning because one of the things that we don't appear to have is a plan.

And our Certificate of Need decisions now are made based upon rules, but they don't

really take the system in any specific direction to either improve access or quality or contain costs or some of the other objectives that really are sort of behind a Certificate of Need.

You know, I'd like to gauge the interest of Board members in trying to influence how this center develops, how it's staffed, and what it does within the context of the legislation because I would be willing to work with other Board members on that and give unsolicited advice to the Director of the Illinois Department of Public Health about how we use this opportunity.

MEMBER BURDEN: In my humble opinion --

CHAIRPERSON OLSON: Turn your microphone on.

MEMBER BURDEN: -- I would defer to anyone else who wishes to comment.

I couldn't help but be impressed by Mr. Sewell's approach, and I concur, although I'm not sure I could be of much help since, as a physician, I feel pretty lonely in this

group.

I don't know if there's a real medical approach to much of what I hear. It's all political.

However, I do appreciate his comment, and I do think -- in view of the fact that our people that work for us so arduously and at great length and are, in my judgment, severely underpaid, I'd like to see at least some input on how these funds are spent.

I do agree and have always felt that we are a blind Board. There's no going-forward planning.

Am I understanding, David, that -- is it '09 that the original center was voted upon and created?

And now we're four years later, and all we've got is a plan maybe to have a full-time person who is going to try to put this together. It sounds like it's moving, like a lot of things in the state of Illinois, extremely slowly.

Is there a chance that we could influence the development of this Board in a

way that's more appropriate, or are we expecting too much from our position as members of this Board?

MR. CARVALHO: Let me back up.

There are other provisions of the statute that I didn't describe that maybe you need to know about as you contemplate Mr. Sewell's suggestion.

The idea behind the center was actually the other way around, which was the center would reduce this plan, which would then be available and integrated into your process so that that element that you just described as being missing would be there.

But the thought that the legislature had was to establish this in a separate and independent entity since you would be hearing -- in effect, it was kind of like you are the adjudicators. You are the traffic cops of the people coming in and saying "I want a yes" or the opponent to say "I want a no" and that currently you have information about inventories in your rules, but you don't have a context into which to put that, an

overall plan.

For example -- the best example -- you may recall a few years ago someone wanted to produce a center related to cancer care, and the reality is the only thing your Staff had information about in terms of cancer care is cancer care that occurs at a hospital, an ASTC, an ESRD, or a nursing home because those are the only things that you have.

So people were coming in to testify about, "Well, this isn't necessary because there's all this other cancer care going on out there."

But to your staff that's invisible. Since you don't permit it, you don't get permits to do it, and you don't keep inventories of it, it doesn't exist for you.

The same thing comes up with the various proposals to shut down residential facilities of the State.

The State says, "Well, these services are going to be provided in these other ways," and your Staff can do nothing but say, "Well, that's what the applicant says, but we have no

inventories of that. We don't regulate it," et cetera.

So there's no statutory provision for feedback the other way; but I think once the center is up and running, there's certainly no impediment, but there wasn't an intention to separate the processes.

CHAIRPERSON OLSON: I understand that. I also know that you said it's not the Board's money, which I understand.

If we're in the middle of a performance audit, if I'm sitting in the chair for the performance auditor and this Board is giving over initially $900,000 a year, eventually over $1 million a year, I don't think we've done our due diligence if we're not at least seeing some kind of budget, some kind of sustainability study.

The numbers that I see show that the thing is going to be broke in a few years, and I don't think it's unreasonable for us to ask.

Maybe we do that by putting together a committee with Mr. Sewell to kind of monitor the activity because you're right. We've seen

nothing to date, and $900,000 is going to be --

MR. CARVALHO: With all due respect -- and the two legislators on your Board I think understand what I'm saying -- you have given -- the Board -- the government center nothing. It wasn't your money to give.

It's in a fund of the State. The legislature could have appropriated it to anything, anything consistent with the Act.

That Act that created you also creates the center. So in the view of the legislature, using that fund for a center is consistent with the Act. They didn't need your permission. You aren't doing it. They're doing it.

CHAIRPERSON OLSON: With all due respect, I understand that, but I don't think it's unreasonable for us to ask to see a budget and some kind of sustainability study and to at least have information about what kind of activity is happening. I think that's all that Richard is asking for.

I don't want to take too much more time,

but if we could have him work on --

MEMBER DEMUZIO: David, is the Affordable Care Act going to be a major part of the center's role in trying to disperse the information and be part of the Affordable Care Act?

MR. CARVALHO: That's a very good question.

If the center had been created four years ago, one of those lamentable things about it not having been funded is I do think it would have been very relevant to the State's planning the implementation of the Affordable Care Act because, as you've heard them say yesterday, the Affordable Care Act does not contemplate the health care system tomorrow looking exactly like today just moving forward.

So anticipating workforce needs and changes in delivery system is exactly what the center was contemplated to be in the thick of; but because it was not funded, it did not exist.

Therefore, the State has cobbled

together other ways of dealing with that, way more committees than one could imagine. Matt and I are both on some of those. So yes, it will play a central role.

I don't want to minimize what the Chair said. The use of the fund for the purpose of supporting the center at the time it was initiated last spring in the Governor's budget was not -- Courtney knows this, but all the Board members should know this, too -- was not viewed as a long-term sustainable way to fund it because, exactly as the Chair indicated, if you look at the projected expenses of this Board and the projected expenses of the center and the projected revenues in the fund, the fund cannot support all those activities in the future.

So the legislature next year and the Governor next year, when they put the budget together, will have to look at the fund and see whether the fund can sustain both activities or whether some alternative -- and the conversations have always been in terms of an alternative revenue source for the center.

The Board has always had -- the legislature has always devoted the dollars in the fund to this Board first, but the impetus to finally get off the dime -- and, again, Alexis and Courtney know -- Senator Garrett for a long time has been seeking some funding to get the center created, but there was never a source identified.

So to get it going this year, it was identified it is not sustainable. Everybody who put it together this year knew it was not sustainable.

The decision was made to get it going, get it up and running, perhaps even help improve its value, but then try to figure out a way to sustain it going forward.

MEMBER DEMUZIO: There is no revenue stream identified? This is just a onetime see what happens?

MR. CARVALHO: Yes.

It always had been a deficiency in the statute that no revenue source was identified.

Again, our two former legislators know that this isn't the first time the legislature

has created something without an identifiable source. Half of our audit is probably going to say these 12 statutes were not implemented because there wasn't a revenue source.

CHAIRPERSON OLSON: Isn't that why we're in the mess we're in in the state of Illinois?

We keep creating programs that we cannot support. So I would submit the Board wants a more active role in at least monitoring the activities of the center.

Are we in agreement on that?

MEMBER BRADLEY: No.

This is the responsibility of the Director of the Department of Public Health. It's in his budget. The financial operations of this are not our responsibility, nor should they be our concern.

CHAIRPERSON OLSON: The way I understand it, it's not in his budget.

MR. CARVALHO: It's in our budget.

MS. AVERY: There was -- and I can't challenge you right now on it because I

don't have all the information.

There was an appropriation bill that allowed for the fund to administer this program that's going to be within the Department of Public Health. There was an appropriation bill that clearly said that's a line item. So I'm not understanding how it's not the funds from the Board.

My question was: Those other boards' commissions control their budgets. I'm not sure. So if that's the point, why doesn't this Board get to control the Health Planning Fund or have some input into it?

When the line items came out in the budget, we weren't even aware of the appropriation until it was in committee. You and I talked about it, and you weren't aware of it either. So as an ex-officio, you weren't able to advise the Board that it was coming.

So all the financial parts I'm not understanding. Does that increase the appropriation from the Planning Fund to IDPH to $2.8 million now?

All of that I haven't gotten a clear picture and understanding of.

MR. CARVALHO: I'll be happy --

MEMBER BRADLEY: The situation in the State is we do not have enough money to do all the things we want to do. The administration has chosen to recommend that some of the funds that are not fully utilized be swept from time to time.

The most dramatic example is probably the Road Fund. The Road Fund is collected for a certain purpose, but the legislature and the Governor have agreed that the Road Fund is going to be used in part for other purposes, and they sweep those funds out of there.

I think the understanding is at some point they have to renew them in the fund, but it's perfectly legitimate -- it happens all the time -- for the people who appropriate money to move funds out of some fund into another to fund another operation.

My understanding is that this has been used to give the director of the Department the ability to hire this person and get this

process started.

I don't think we've asked because I don't think we contemplated we were going to be involved.

MR. CARVALHO: I do agree with you, Mr. Bradley.

One thing I'd clarify or point out is this isn't a sweep. The fund is by statute dedicated to support activities of the Health Facilities Planning Act, not the Board, under the Act. The center is created under the Act.

So this isn't an instance where the Road Fund is being used to pay for health care. It's where a fund that says by its terms in the statute it is available for purposes -- as long as the legislature appropriates it, available for purposes under the Act, one of the things in the Act is the center.

So the way that it manifests in the budget is -- and we can get a copy of the budget line items and share them with everybody.

As you know, over the last several years, there's been a line item appropriation

to the Board because some of the activities of this function are directly under the Board, Courtney's salary, Frank's salary, some of the expenditures. I forget who pays the rent. Some of the expenditures are directly under the Board.

Under the Intergovernmental Agreement, some of the expenditures in support of this Board's function are at the Department. So there historically has been a line item appropriation to the Department. Those expenditures include Mike and George, the whole Staff, supplies, et cetera.

So for the last four years, there's been an appropriation, a single line item to the Board, a single line item to the Department.

The truth of the matter is if you look at the actual expenditures, both of those lines have been larger than what we've spent because we put in a cushion so that if an expenditure was going to be a Board expenditure, there was room. If there was a Department expenditure, there was room.

Let me give you an example that's not

the real one.

MEMBER SEWELL: Can I interrupt you? Because Mr. Bradley's comments are not relevant to what I was talking about.

There's no objection here to the legislative intent, which is to use the money collected from the fines, et cetera, to get this Office of Comprehensive Health Planning going.

But the flaw in the set of relationships is every time we go into executive session and decide whether we're going to fully collect a fine or whatever or partially, we're influencing how much money is in that fund.

Now, if all this control stuff is to be in the Department of Public Health and we don't have a role in it on the money side, they ought to be making those decisions because we could decide we're not going to fine anybody and there wouldn't be any money there. That's all I'm saying.

What I'm more concerned about than the money -- there's nothing wrong with that -- is what is the Office of Comprehensive Health

Planning going to do?

Is it going to enhance the economic discipline in the system?

There's sections of the Affordable Care Act that talk about the responsibility of delivery systems for improving population health.

With our relationship with the Illinois Department of Public Health, this Office of Comprehensive Health Planning is an opportunity to make that actually happen in Illinois.

So that's what I'm more concerned about than how the money flows and how much they get versus how much we get. I just want us to give some thought to this. I'd like for it to proceed quickly.

MEMBER BRADLEY: I do think that's a laudable goal, but I don't think it's the responsibility of this Board.

We have a very set process that we're supposed to implement and oversee. Those that are on this Board and care about the health care system certainly should let their

opinions be known to the people in charge, the director or whoever, not through the action of this Board but through you personally talking to them or meeting with them or volunteering to be on some kind of committee that is advising us, but it's not a Board responsibility.

CHAIRPERSON OLSON: I think we're going to move along. We'll come back and revisit that.

Office Relocation. Courtney?

MS. AVERY: Okay. Just a quick update. We are looking at office space at 67 West Washington Street. We pretty much have a floor plan, and there's going to be one or two other agencies that will join. So we're waiting on the status of those two agencies and how the floor will be configured and what other programs will go in there.

I sent an e-mail to CMS yesterday and today for an update to get some idea of how much this is going to cost so you can approve it or not. They don't have that yet.

So we're waiting on those other two

agencies to figure out so we'll know what our costs are per square foot for this space at 67 West Washington.

CHAIRPERSON OLSON: Moving on to Item D, Graduate Public Service Internship Program, Courtney?

MS. AVERY: That is called in short the GPSI program from the University of Illinois at Springfield.

Working with the Department, we've come to a consensus of agreement on how to flip the cost of that. So Nelson, myself, Mike, Bill Dart, and Mohammed, who is part of the hybrid for the CON -- and Mohammed does a lot of the population data -- we're trying to figure out how we will pay for this position and the supervision and the duties and responsibilities.

So we had a change this morning. That's why I didn't distribute the plan for it. So as soon as we get it finalized, I'll e-mail it to you and ask for comments and feedback on it.

CHAIRPERSON OLSON: Thank you.

Approval of Inventory of Health Care Facilities and Services and Need Determinations.

Mike Constantino, please?

MR. CONSTANTINO: Yes.

We're asking the Board to approve our new inventory for hospitals, long-term care, and other services such as ESRD, et cetera. We would like to have a vote on that today. I will make a couple comments about the inventory.

This is, once again, for five years instead of the ten years we've been looking at. Courtney and Alexis were able to get that change in the statute, and I don't know when that was.

Was that a year ago or two years ago?

MS. KENDRICK: Last year.

MR. CONSTANTINO: Last year.

So one of the good things Courtney and Alexis did was get this done. It will have a dramatic effect on the numbers.

We had estimated for 2018, state of Illinois, there will be 14 million people in

the state. That's going to be reduced by 1.2 million in 2015. There is a dramatic effect on these bed need numbers.

I also want to note that for ESRD, the utilization numbers are increasing. What you heard here today from DaVita is correct. Those numbers are increasing.

CHAIRPERSON OLSON: Thank you, Mike. Thanks to Courtney and Alexis for the hard work on this.

Could I have a motion to approve the new inventory, the new five-year inventory?

MEMBER DEMUZIO: Motion.

MEMBER PENN: So move.

MEMBER SEWELL: Seconded.

MR. ROATE: Motion made by Senator Demuzio and Mr. Penn, seconded by Mr. Sewell.

Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Yes.

MR. ROATE: Justice Greiman.

MEMBER GREIMAN: Yes.
MR. ROATE: Ms. Olson.
CHAIRPERSON OLSON: Yes.
MR. ROATE: Mr. Penn.
MEMBER PENN: Yes.
MR. ROATE: Mr. Sewell.
MEMBER SEWELL: Yes.
MR. ROATE: That's seven votes in the affirmative.
CHAIRPERSON OLSON: Motion passes, and the new inventory is adopted going forward.
Approval of Public Participation Guidelines.
MS. AVERY: For clarification, when we sent out the guidelines with the changes last meeting, there were two errors. We sent you the wrong version, and we did not take a vote on it.
We have a motion for approval and a vote to approve it. So you have the updated one with just minor changes to it, and we need a motion to approve it.
So it's essentially the same one. We

just sent the wrong version. The version you have now, it shows what those changes are that are in a lighter font in gray and underlined.

MEMBER DEMUZIO: Motion.

MEMBER SEWELL: Second.

CHAIRPERSON OLSON: It's been moved and seconded to approve the Public Participation Guidelines.

Roll call vote.

MR. ROATE: Motion made by Senator Demuzio, seconded by Mr. Sewell.

Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Yes.

MR. ROATE: Justice Greiman.

MEMBER GREIMAN: Yes.

MR. ROATE: Ms. Olson.

CHAIRPERSON OLSON: Yes.

MEMBER PENN: Mr. Penn.

MEMBER PENN: Yes.

MR. ROATE: Mr. Sewell.

MEMBER SEWELL: Yes.

MR. ROATE: Seven votes in the affirmative.

CHAIRPERSON OLSON: Motion passes, and the new participation guidelines are in effect.

Intergovernmental Agreement. Courtney?

MS. AVERY: Again, the Interagency Agreement, I sent you all a draft. I'm sorry that you got it today.

The changes ideally would have been in red, but they're underlined and formatted where you can see what the changes are. It was mostly moving around some things, and one of the major ones was the statement "Until such time that the Chicago office is relocated with a separate and distinct location no later than February 2014."

What I'm asking is that you allow me to have signature and negotiation authority with the Department to sign off on this so we can get it moving.

We technically are way behind because this should have been done in June, and next

year we'll make sure that we get it out sooner.

I also just made a distinction from the Board to HFSRB. There's not a lot of change in the content.

I also added a part with the governmental relations now that we have a person on staff that does our monitoring and compliance and things with the State legislature -- I'm sorry, lobby -- not lobby. Scratch lobby -- negotiations with the State legislature, that I just added that the Department will assist the Board in doing so.

So what I'm asking for today is that you grant me the authority to sign off on it and to negotiate with the Department.

CHAIRPERSON OLSON: Comments or discussions on Courtney's request?

Can we have a motion to allow Courtney negotiation and signature power on the Intergovernmental Agreement?

MEMBER DEMUZIO: Motion.

MEMBER SEWELL: Second.

MR. ROATE: Motion made by Senator

Demuzio, seconded by Mr. Sewell.

Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Yes.

MR. ROATE: Justice Greiman.

MEMBER GREIMAN: Yes.

MR. ROATE: Ms. Olson.

CHAIRPERSON OLSON: Yes.

MR. ROATE: Mr. Penn.

MEMBER PENN: Yes.

MR. ROATE: Mr. Sewell.

MEMBER SEWELL: Yes.

MR. ROATE: Seven votes in the affirmative.

CHAIRPERSON OLSON: Motion passes.

That concludes new business for today.

I would entertain a motion -- our next meeting will be September 24, 2013, in Springfield Illinois.

I will entertain a motion to adjourn.

MR. URSO: Kathy, do we have a

location for Springfield?

CHAIRPERSON OLSON: The location in Springfield is the State House Inn.

Do I have a motion and a second to adjourn?

May I have a voice vote to adjourn? All in favor say aye.

(The ayes were thereupon heard.)

Opposed?

Motion passes. We are adjourned until September 24th.

(Which were all of the proceedings had in the above-entitled matter, concluding at 12:30 p.m.)

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

I, Jean S. Busse, Certified Shorthand Reporter No. 84-1860, Registered Professional Reporter, do hereby certify that I reported in shorthand the proceedings had in the above-entitled matter and that the foregoing is a true, correct and complete transcript of my shorthand notes so taken as aforesaid.

IN TESTIMONY WHEREOF I have hereunto set my hand and affixed my notarial seal this 28th day of August, 2013.

Jean S. Busse

JEAN S. BUSSE, CSR, RPR