
Transcript of Open Session

Date: June 30, 2020

Case: State of Illinois Health Facilities and Services Review Board

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1 ILLINOIS DEPARTMENT OF PUBLIC HEALTH
2 HEALTH FACILITIES AND SERVICES REVIEW BOARD
3

4 OPEN SESSION - MEETING
5

6 Bolingbrook, Illinois 60490

7 Tuesday, June 30, 2020

8 10:00 a.m.
9
10

11 BOARD MEMBERS PRESENT:

12 DEBRA SAVAGE, Chairwoman

13 GARY KAATZ

14 BOARD MEMBERS PRESENT VIRTUALLY:

15 DEANNA DEMUZIO

16 SANDRA MARTELL

17 LINDA RAY MURRAY

18 KENT SLATER
19
20
21

22 Job No. 257113B

23 Pages: 1 - 207

24 Reported by: Paula Quetsch, CSR, RPR

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1 ALSO PRESENT:

2 COURTNEY AVERY, Administrator

3 MICHAEL CONSTANTINO, IDPH Staff

4 ANN GUILD, Compliance Manager

5 GEORGE ROATE, IDPH Staff

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1 P R O C E E D I N G S

2 CHAIRWOMAN SAVAGE: Calling our meeting to
3 order. George, can you do a roll call, please.

4 MR. ROATE: Thank you, Madam Chair.
5 Gary Kaatz.

6 MEMBER KAATZ: Here.

7 MR. ROATE: Dr. Martell.

8 MEMBER MARTELL: Yes, present.

9 MR. ROATE: Dr. Murray.

10 MEMBER MURRAY: Here.

11 MR. ROATE: Mr. Slater.

12 CHAIRWOMAN SAVAGE: Are you there, Kent?

13 MS. AVERY: Mr. Slater?

14 MEMBER SLATER: Yes.

15 MR. ROATE: Thank you.

16 Ms. Savage.

17 CHAIRWOMAN SAVAGE: Present.

18 MR. ROATE: There are five in attendance.

19 CHAIRWOMAN SAVAGE: Thank you.

20 Now may I have a motion to go into closed
21 session pursuant to Section 2(c)(1), 2(c)(5),

22 2(c)(11), and 2(c)(21) of the Open Meetings Act.

23 MEMBER KAATZ: So moved.

24 CHAIRWOMAN SAVAGE: A second.

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1 MEMBER MURRAY: Second.

2 (At 10:08 a.m. the Board adjourned into
3 executive session. Open session proceedings
4 resumed at 10:38 a.m. as follows:)

5 CHAIRWOMAN SAVAGE: Calling the meeting
6 back to order. Good morning. These are
7 definitely unusual times due to this ongoing
8 COVID-19 pandemic. We have several of our Board
9 members remote in addition to two of us here, plus
10 the State Board staff. We appreciate everyone's
11 understanding, patience, and flexibility as we go
12 through this meeting today in this hybrid mode.

13 This meeting had been constructed this way
14 for personal safety of our members, our applicants,
15 the public, and those of us here. Physical
16 distancing is in place here. Our applicant and
17 our public participation specific to that
18 applicant will be appearing before the Board at
19 prearranged times.

20 I would like to thank Governor Pritzker
21 and his staff, Dr. Ezike and all of the IDPH and
22 the local health departments around the state, as
23 well as all local government leadership for their
24 hard ongoing work during this pandemic, and a

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1 very, very special thank you to all of our healthcare
2 teams and all healthcare facilities and first
3 responders around the state. We are very grateful
4 for your service.

5 Now, may I have a motion to approve the
6 June 30th, 2020, meeting agenda.

7 MEMBER KAATZ: So moved.

8 CHAIRWOMAN SAVAGE: May I have a second.
9 May I have a second for that motion.

10 MS. AVERY: Mr. Slater, will you please be
11 the second?

12 MEMBER SLATER: I'm sorry?

13 MS. AVERY: Will you second the motion to
14 approve the June 30th meeting agenda?

15 CHAIRWOMAN SAVAGE: May I have a second
16 motion to approve the June 30th, 2020, meeting
17 agenda? That would be for Sandra, Kent,
18 Dr. Murray, Senator Demuzio.

19 MS. AVERY: Senator, are you available?

20 Can everyone hear us?

21 MEMBER MARTELL: Yes.

22 MS. AVERY: Okay. We need a second on the
23 approval of the meeting agenda.

24 MEMBER MARTELL: I don't know if we've

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1 been unmuted yet.

2 MS. AVERY: You're unmuted.

3 CHAIRWOMAN SAVAGE: We hear you.

4 MEMBER MARTELL: Okay. Then I'll second.

5 MS. AVERY: That was Dr. Martell?

6 MEMBER MARTELL: Yes, Dr. Martell. We'll
7 say our name -- maybe for ease we'll say
8 Dr. Martell seconded the motion.

9 CHAIRWOMAN SAVAGE: All in favor say aye.
10 (Ayes heard.)

11 CHAIRWOMAN SAVAGE: May I have a motion to
12 approve the February 25th, 2020, transcript.

13 MEMBER MURRAY: Whoever is trying to talk
14 now, I can't hear them.

15 CHAIRWOMAN SAVAGE: Trying again, may I
16 have a motion to approve the February 25th, 2020,
17 transcript.

18 MEMBER MARTELL: This is Dr. Martell. I
19 so move for approval the February minutes.

20 CHAIRWOMAN SAVAGE: And may I have a second.

21 MEMBER MURRAY: This is Linda Murray, second.

22 CHAIRWOMAN SAVAGE: And all in fair say aye.
23 (Ayes heard.)

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1 CHAIRWOMAN SAVAGE: Okay. May I now have
2 a motion to approve the final orders on HFSRB 19-02.

3 MEMBER MURRAY: If this is -- you know,
4 you're the chair. You keep fading in and out.
5 About every third word I can hear. I'm not sure
6 where you are or what kind of mic you have.

7 CHAIRWOMAN SAVAGE: Can you see me,
8 Dr. Murray?

9 MEMBER MURRAY: I can hear you but when
10 you talk, it's about every third word comes
11 through.

12 MEMBER MARTELL: It's the same here.

13 CHAIRWOMAN SAVAGE: So may I have a motion
14 to approve final orders on HFSRB 19-02, Genesis
15 Medical Center in Silvis; HFSRB 19-04, Javon Bea
16 Hospital Rockton campus, and HFSRB 20-02 Palos Hills
17 Surgery Center.

18 MEMBER MARTELL: This is Dr. Martell. I
19 so move.

20 MEMBER MURRAY: This is Linda Murray, I
21 second.

22 CHAIRWOMAN SAVAGE: And all in favor say aye.
23 (Ayes heard.)

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1 CHAIRWOMAN SAVAGE: As listed on the
2 agenda, Paula will include those in the transcript
3 as opposed to reading them.

4 So on the agenda is --

5 MS. AVERY: Madam Chair, may I clarify?

6 CHAIRWOMAN SAVAGE: Of course.

7 MS. AVERY: So the items approved by the
8 Chairwoman as listed on the Tuesday, June 30th, 2020,
9 agenda, those are the items that the Chair is
10 referring to, and they're in alphabetical order A
11 through DD, and we will include those in the
12 transcript.

13 CHAIRWOMAN SAVAGE: Thank you.

14 (The following items were approved by the
15 Chairwoman:)

16 A. Alteration: #15-056 Transitional Care of
17 Lisle, Lisle 6.99% Increase in Project Costs;

18 B. Alteration: #16-002 Transitional Care of
19 Fox Valley, Fox Valley, 7% Increase in Project
20 Costs;

21 C. Alteration: #18-047 Ophthalmology Surgery
22 Center of Illinois, Itasca, 7% Increase in Project
23 Costs;

24 D. Alteration: #19-004 Smith Village, Chicago,

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1 Alteration of Project Funding Sources;

2 E. Permit Renewal: #17-035 Manor Court of
3 Rochelle, Rochelle, 6 Month Renewal (2nd Request);

4 F. Permit Renewal: #17-073 Illinois Back & Neck
5 Institute, Elmhurst, 5 Month Renewal (2nd Request);

6 G. Permit Renewal: #18-019 Dialysis Care Center
7 Evergreen Park, Evergreen Park, 12 Month Renewal;

8 H. Permit Renewal: #18-006 Fresenius Kidney
9 Care Madison County, Granite City, 12 Month Renewal;

10 I. Permit Renewal: #18-024 NorthShore
11 Pediatric Partners MOB, Wilmette, 6 Month Renewal;

12 J. Permit Renewal: #18-002 Retina Surgery
13 Center, Niles, 12 Month Renewal;

14 K. Permit Renewal: #18-018 North Suburban Pain
15 and Spine Center, Des Plaines, 6 Month Renewal;

16 L. Permit Renewal: #18-047 Ophthalmology Surgery
17 Center of Illinois, Itasca, 12 Month Renewal;

18 M. Permit Renewal: #19-025 Physician's
19 Surgical Center, O'Fallon, 9 Month Renewal;

20 N. Change of Ownership: #E-013-20 Advocate
21 BroMenn Medical Center;

22 O. Change of Ownership: #E-014-20 Advocate
23 Eureka Hospital;

24 P. Discontinuation: #E-012-20 Passavant Area

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1 Hospital, Discontinue 14-Bed AMI Category of Service;

2 Q. Extension of Financial Commitment: 18-014

3 Carle Surgicenter, Danville, 12-Month Extension;

4 R. Extension of Financial Commitment: 19-032

5 Greater Chicago Ctr. for Adv. Surgery, 12-Month

6 Extension;

7 S. Alteration: #18-025 University of Chicago

8 Medical Center MOB increase the permit amount by

9 6.99%;

10 T. Discontinuation: #E-027-20 Good Samaritan

11 Hospital, Mt. Vernon, Discontinue Open Heart Surgery;

12 U. Change of Ownership: #E-029-20 Hinsdale

13 Surgical Center (Real Estate Only);

14 V. Change of Ownership: #E-030-20 Central

15 Illinois Endoscopy Center (Real Estate Only);

16 W. HSHS St. Anthony Medical Center: Revise

17 2018 Surgical Data;

18 X. AMITA Health Hinsdale Hospital: Revise 2018

19 Cardiac Catheterization Data;

20 Y. AMITA Health Alexian Brothers Medical

21 Center: Revise 2018 Cardiac Catheterization Data;

22 Z. #20-014: Carle Foundation Hospital,

23 modernization project;

24 AA. #20-018: Edward-Elmhurst MOB Woodridge,

1 MOB project;

2 BB. #18-034: Edward Hospital, Relinquishment;

3 CC. #18-015: Edward Hospital, Relinquishment;

4 DD. #19-050: DaVita Freeport Dialysis, Permit
5 Alteration.

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1 CHAIRWOMAN SAVAGE: So on the agenda is
2 H-01, Project 19-031, the Advanced Surgical
3 Institute, Evergreen Park.

4 May I have a motion to approve
5 Project 19-031, Advanced Surgical Institute to
6 establish an ASTC.

7 (No response.)

8 MS. AVERY: Motion, please, Dr. Murray or
9 Dr. Martell.

10 MEMBER MARTELL: I'm going to be -- you
11 know, we hate to be difficult about this, but we
12 can barely hear the Chair.

13 MS. AVERY: Okay. So we're on Project
14 No. 19-031. The Chair has asked for a motion to
15 approve Project No. 19-031.

16 MEMBER MARTELL: 19-031?

17 CHAIRWOMAN SAVAGE: The Advanced Surgical
18 Institute.

19 MEMBER MARTELL: Got it. I so move.

20 CHAIRWOMAN SAVAGE: And may I have a second.

21 MEMBER MURRAY: Second. Dr. Murray, second.

22 CHAIRWOMAN SAVAGE: Is there anyone here
23 to represent the applicant?

24 MS. AVERY: You can come to the table.

1 And please let the record show that there
2 is no one registered for public participation.

3 MR. CONSTANTINO: Courtney, there is.

4 MS. AVERY: Oh, there is?

5 MR. CONSTANTINO: Yes.

6 MS. AVERY: Who?

7 MR. CONSTANTINO: Two individuals.

8 MS. AVERY: I apologize. We have
9 two individuals for public participation. Please
10 come to the table.

11 CHAIRWOMAN SAVAGE: And then please be
12 sworn in and identify yourselves, spelling your
13 name for our court reporter when you do so.

14 MS. AVERY: I apologize.

15 (Whereupon, the witnesses were thereupon
16 duly sworn.)

17 MS. AVERY: We will have a two-minute
18 speech.

19 DR. HANLON: Can all the Board members
20 hear me?

21 MS. AVERY: You have to speak really
22 loudly.

23 DR. HANLON: Can all the Board members
24 hear me?

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1 CHAIRWOMAN SAVAGE: Dr. Murray, if you're --

2 MEMBER MURRAY: I can barely hear him.

3 MS. AVERY: We'll do our best.

4 DR. HANLON: Okay. I will talk very loud.

5 Pardon me for that.

6 I am Dr. John Hanlon, president of
7 OSF Healthcare Little Company of Mary Medical
8 Center in Evergreen Park, Illinois. My remarks
9 are in opposition to the proposed establishment of
10 the freestanding two-room ambulatory surgery
11 treatment center with a nonhospital-based
12 freestanding cardiac cath laboratory as described
13 in the permit application. My concerns are similar
14 to those expressed by the Review Board members at
15 your December meeting where the project was
16 deferred.

17 I concur with the State Board staff report
18 that approval will result in an incremental
19 oversupply and contribute to the current excess
20 capacity in the market for both cardiac
21 catheterization labs and nonhospital-based
22 ambulatory surgery procedure rooms. If approved,
23 the project will fragment the delivery of
24 cardiovascular services in the market and contribute

1 to excess capacity and further underutilization of
2 existing services. Currently there are no
3 barriers to patient access for catheterization
4 services based on Review Board criteria.

5 As part of their justification for the
6 ASTC in their original application in December,
7 applicant stated they would have diverted over
8 1300 of the 1600 cardiovascular procedures they
9 performed in hospitals in the previous year to
10 their new center, or 83 percent of their cases.
11 In the present application they state they will
12 divert only 584 cases from the hospitals where
13 they perform cardiac procedures as shown in their
14 executive summary.

15 There is no explanation for why they would
16 now divert fewer cases, which is baffling since
17 now they are specifically requesting that this
18 facility be a cardiac cath facility.

19 OSF Little Company of Mary has two cath labs
20 with a 2018 utilization of over 700 procedures.
21 This time around the applicant proposes to divert
22 206 procedures from Little Company to their
23 physician-owned facility. This is about 30 percent
24 of our 2018 utilization. Even based on their

1 sharply revised figures, our resulting cath lab
2 utilization would decrease to 500 cases --

3 MR. ROATE: Two minutes.

4 DR. HANLON: -- barely enough to support a
5 single laboratory, much less our two labs.

6 May I be granted one more minute?

7 CHAIRWOMAN SAVAGE: Okay. One more minute.

8 DR. HANLON: Thank you.

9 In conclusion, based on these facts which
10 substantiate the State Board staff report, if this
11 project is approved, Little Company of Mary will
12 be greatly impacted.

13 Presently access to cardiovascular services
14 is not constrained, and, in fact, there is excess
15 market capacity in the service area generally and
16 at our facility in particular. The diversion of
17 cardiac patients from the cath lab at our hospital
18 will adversely affect our ability to keep our cath
19 lab skilled and our ability to provide optimal care
20 for the underserved population in our area.

21 During the COVID crisis, Little Company of
22 Mary has proved to be a lifeline to a population
23 in Chicago that is medically at high risk, and we
24 have treated over 1,000 inpatients with confirmed

1 or suspected COVID. We are also a cardiac lifeline
2 for those same patients, but this project would
3 put that service at risk.

4 I respectfully request that this permit be
5 denied. Thank you.

6 MR. QUERCIAGROSSA: My name is
7 AJ Querciagrossa. I am the chief executive officer
8 for the metro region of OSF Healthcare and OSF Little
9 Company of Mary, Evergreen Park. My remarks are
10 in opposition of the proposed establishment of a
11 freestanding two-room ambulatory surgery treatment
12 center containing a freestanding cardiac cath lab
13 as described in Permit Application 19-031.

14 My concerns are similar to Dr. Hanlon and
15 the Review Board. My comments today will pertain
16 to the overarching market considerations starting
17 with the project definition.

18 In my judgment the Board's focus or
19 deliberation should be on the applicant's request
20 to develop a freestanding nonhospital-based
21 cardiac cath laboratory which will be housed in
22 this ASTC. The Board's cardiac catheterization
23 review criteria should apply. There is no
24 demonstrable need for additional capacity in our

1 market.

2 Cardiac catheterization need. The Health
3 Service Area 7 has 68 cardiac catheterization
4 laboratories with an associated 48,468 procedures.
5 Based on Review Board utilization guideline, there
6 is a potential calculated excess of 41 cardiac
7 catheterization laboratories and 60 percent excess
8 procedural capacity in this planned area. There
9 is no need for an additional cardiac catheterization
10 laboratory. There is no barrier to access.

11 ASTC room need. The Health Service
12 Area 7 has 52 ambulatory surgery treatment centers
13 with 167 rooms and over 152,000 surgeries. Based
14 on Review Board utilization guideline, there is a
15 potential calculated excess of 78 operating rooms.
16 There is no need for additional capacity or barrier
17 to access.

18 Given substantial underutilization of both
19 cardiac cath labs and ASTC rooms in Plan Area 7,
20 there is no barrier to access. There is no
21 demonstrable need to additional capacity with
22 Board approval of this project.

23 MR. ROATE: Two minutes.

24 MR. QUERCIA GROSSA: In conclusion, based

1 on these facts that further substantiate the State
2 Board's report, the market has excess capacity.
3 Hence, no demonstrable need or barrier to access.
4 Our hospital continues to serve the community and
5 those medically at-risk populations, which include
6 the underinsured and those that have no access to
7 healthcare.

8 MR. CONSTANTINO: Two minutes.

9 MR. QUERCIAGROSSA: Cardiac services at
10 Little Company of Mary are essential, and the
11 proposed project puts our services at risk.

12 I appreciate your consideration.

13 CHAIRWOMAN SAVAGE: Thank you.

14 MS. AVERY: Is there anyone else in the
15 room or on the Webex that would like to provide
16 comment on this project?

17 (No response.)

18 MS. AVERY: Hearing none, the applicants
19 can come to the table and be sworn.

20 There are, again, wipes on the table you
21 can use to clean the microphones.

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1 CHAIRWOMAN SAVAGE: Please identify
2 yourselves and be sworn in.

3 MR. NIEHAUS: Bryan Niehaus.

4 DR. AL-KHALED: Dr. Nouri Al-Khaled.

5 DR. SPEAR: Dr. William Spear.

6 DR. ZAIDI: Dr. Ali Zaidi.

7 (Whereupon, four witnesses were thereupon
8 duly sworn.)

9 CHAIRWOMAN SAVAGE: Please proceed with
10 your statement to the Board -- oh, I'm sorry;
11 Mike, please present your State Board staff report.

12 MR. CONSTANTINO: Thank you, Madam Chair.
13 The applicant is asking the State Board to approve
14 the establishment of an ASTC performing cardiac
15 catheterization surgical services only. The cost
16 of the project is approximately \$5.5 million.

17 This project was deferred from the
18 December 2019 State Board meeting. No public
19 hearing was requested. Letters of support and
20 opposition were submitted and are included at the
21 conclusion of the State Board report along with
22 the transcript from the December 2019 report. The
23 expected completion date is August 31st, 2021.

24 I need to make a couple of comments about

1 this application.

2 The first comment I would like to emphasize
3 to the Board, the applicants do have sufficient
4 referrals to establish this cardiac cath ASTC.
5 They do have sufficient referrals. That was an
6 oversight on my part and that was a mistake.

7 The second comment I would like to make is
8 the applicant and this Board staff have a difference
9 of opinion regarding the unnecessary duplication
10 of service. That rule requires an application
11 proposing to establish cardiac cath services must
12 indicate if it will reduce the volume of existing
13 facilities below 200 catheters in the HSA 7 planning
14 area. That is not the case. That will not happen.

15 The second part of that criteria states
16 the applicant proposing this establishment must
17 contact all of the facilities which are in the
18 HSA 7 cardiac cath planning area and asking for
19 the impact the proposed service will have on their
20 facility.

21 We received one letter from Little Company
22 of Mary Hospital. However, their utilization will
23 not drop below 200 cardiac catheters per lab, which is
24 in their case 400 procedures.

1 I believe when I looked at the requirement
2 that it will have an impact on OSF Little Company
3 of Mary Hospital.

4 Thank you.

5 CHAIRWOMAN SAVAGE: Thank you, Mike. Now,
6 please proceed with your statement to the Board.

7 MR. NIEHAUS: Thank you. Good morning. I
8 hope everybody on the Webex can hear us, but we'll
9 do our best to speak loudly and clearly.

10 Thank you, Board staff, for the report.
11 Thank you, Mike, for the comments about the
12 discussion we had about the rules. Although there
13 are three findings by the Board staff, we do feel
14 that overall the report is a positive one.

15 All three findings are related to whether
16 this project is needed based on other services
17 that are already present within the market.
18 Otherwise, we've met all the criteria put forth by
19 the Board.

20 The only noted opposition is from OSF Little
21 Company of Mary Medical Center. The other service
22 providers do not oppose this project, and we have
23 noted support from area physicians. What we hope
24 to convey today in this project is a new service

1 option for patients in the market without having
2 an undue impact on OSF Little Company of Mary or
3 any other provider.

4 No other option exists for the applicant's
5 patients to obtain cardiac diagnostic and
6 interventional services in an ambulatory surgical
7 setting today. The only other ASTC offering
8 cardiac surgeries is not approved for cardiac cath
9 and is designed to have one operating room
10 fulfilling only the needs of that practice's
11 patient panel. That is not why they are not
12 opposing this project either.

13 This Board, CMS, and the industry at large
14 recognized the value in offering cardiovascular
15 care in the ASTC setting. Most importantly, the
16 physicians that provide the care believe it is an
17 option their patients deserve.

18 I'll turn it over to them now, but please,
19 if there's any questions from the Board members
20 about the technical requirements of the rule, I'd
21 be happy to address them in question and answer.

22 DR. AL-KHALED: Good morning, Board members.
23 I hope you can hear me today, and I really thank
24 you for having us in spite of all that's going on.

1 As presented this morning, we are here
2 asking for your approval for a single-specialty
3 cardiovascular surgery center. We're offering
4 interventional cardiology procedures including
5 cardiac catheterization, coronary intervention,
6 and pacemakers. We think this project is very
7 vital and very important to our community and to
8 the citizens in our community, and I will elaborate
9 on this for two main reasons.

10 Despite all what's been said and what's
11 heard until now, there's a main fact that happened
12 in the last two years that the Center for Medicare
13 and Medicaid Services has accepted and approved
14 multiple CPT codes for outpatient cardiac procedures
15 to be done in an ambulatory surgical center. The
16 main reason they approved that is cost, and that's
17 the first thing I'm going to talk about.

18 Currently the procedures Medicare
19 allowable for us to deliver in our community and
20 future ambulatory surgical center will be 25 up to
21 70 percent cheaper than what is delivered in the
22 hospital, the same exact procedure. The reason is
23 because there is something that Medicare pays to
24 the hospital called facility fee, and these facility

1 fees vary according to the kind of hospital that
2 the procedure is delivered in even at the level
3 and the differences between hospitals. So Medicare
4 came in saying if we are delivering the same high
5 quality of care to our patients, there are procedures
6 that could be done in an ambulatory surgical
7 setting for a lot less cost than what we would be
8 paying in hospitals paying them the facility fee.

9 I'll give a simple examination of a cardiac
10 catheterization. A cardiac catheterization
11 Medicare allowable today in an ambulatory surgical
12 center that we are asking for pays about \$1,340.
13 It pays more than double in the hospital. Medicare
14 would be responsible for paying the hospital an extra
15 \$1,620. That's Medicare allowable for the procedure,
16 which means 20 percent will trickle down to our
17 citizens, and that will cost them an extra \$325.

18 Medicare, another example, have allowed us
19 in an ambulatory surgical center to do pacemakers.
20 They will pay around \$7,000 for the pacemaker.
21 The hospital cost is double that or a little bit
22 more than double. It will cost an extra \$7,987,
23 which means 20 percent also trickle to our citizens
24 and to our patients where they will be responsible

1 for the difference of \$1,597.

2 These are only two examples of the CPT codes
3 that have been approved by Medicare to be done in
4 ambulatory surgical centers. That said, I want to
5 move to the second one which has to do with our
6 current scenario and our current circumstances.
7 My second point is access.

8 Our patients deserve to have ambulatory
9 access for a simple reason. COVID-19 is a perfect
10 example of what happened in all institutions on
11 the south side and around us. We and our patients
12 who are not infected with COVID were hostages to
13 COVID. Why? Because our hospitals turned into
14 COVID units. Our hospitals were loaded with COVID
15 patients. Elective procedures got delayed, and
16 above all that very importantly that our sick
17 patients were so afraid of going to hospitals that
18 had pandemic patients.

19 Though all the numbers are counting COVID
20 cases, the death from COVID cases, but very soon
21 we're going to be seeing death from patients who
22 got delayed because of patients who were afraid of
23 going to the hospital or the hospital could not
24 offer our patients elective procedures because we

1 were overwhelmed with this disease. I am hoping
2 we will not see another pandemic, but in the last
3 20 years we have seen something smaller that put
4 the hospital resources under significant strain
5 such as the Swine flu, West Nile, Ebola, and
6 currently every year during the normal flu season,
7 the H1N1 season, our hospitals go under quite a
8 bit of strain. And I think our patients deserve
9 to have another system that could help them where
10 they are, and it could help them and help the
11 whole healthcare system in the country.

12 I truly appreciate your time today. I
13 would appreciate to look at this with sincere
14 consideration, and if there's any questions or any
15 doubts about any of the criteria before you vote,
16 please give us the chance to defend it.

17 Thank you.

18 DR. SPEAR: Good morning. Thank you
19 everybody for being here today -- I'm sorry; there's
20 some feedback from the cameras. My name is
21 Dr. William Spear. I'm a cardiac electrophysiologist
22 and my comments today are to address specifically
23 the opposition by OSF Little Company of Mary
24 Medical Center.

1 As you know, this project has one source of
2 opposition, and that's OSF Little Company of Mary.
3 Their opposition in writing and today is framed to
4 discredit the need for this project centered
5 around the interests of their facility only.

6 A few data points that I want you to
7 consider before making your decision. First of
8 all, our group, we're estimating that we're going
9 to do 1,738 cardiac catheterization procedures as
10 a practice in 2021 when the center would open. We
11 also anticipate that 584 procedures or one-third
12 of our volume would be done in the surgical center.

13 We estimate that we will move 206 procedures
14 from Little Company of Mary to the surgical center
15 in the first year of operation. This is 11 percent
16 of our total volume. We still project to perform
17 407 cases at Little Company of Mary, which is
18 23 percent our volume and an increase from the
19 most recent 12 months.

20 This one is a big one. Nobody has
21 mentioned to this point the closure of a major
22 hospital called MetroSouth Hospital which closed
23 in 2019. So all the numbers we're looking at are
24 2018 numbers, but MetroSouth, when it closed, it

1 closed three cardiac catheterization labs which
2 did 1250 annual cardiac catheterization
3 procedures, and it was only 15 minutes away from
4 Little Company Mary Hospital. A large portion of
5 these patients are now receiving their care at
6 Little Company, and they're not reflected in the
7 State data or the opposition's data. Despite the
8 enormous impact of this closure on the community and
9 the project, this was not mentioned.

10 And the largest impact that our center
11 would impose would be actually on Advocate Christ
12 Medical Center in which we would move 312 procedures,
13 and they are not in opposition to this project.
14 Likewise, Palos Hospital, which is one of our
15 partner hospitals, does not oppose this project,
16 either.

17 So I hope this helps reframe the project
18 for you to consider the benefits to the community
19 against an impact to one hospital. Ultimately,
20 denying the project does not protect Little
21 Company of Mary or any other single hospital, as
22 any patient procedure that could be moved to our
23 surgical center can also be moved to any other
24 area hospital.

1 Denying this project only hurts patients
2 in the community that have to pay more with less
3 options. Our patients deserve the same options
4 for their cardiology care as for other specialties
5 with similar surgical centers. We are asking for
6 your assistance in serving our patients, and we
7 respectfully ask for your vote when this comes to
8 a vote.

9 Thank you very much.

10 DR. ZAIDI: Good morning. My name is
11 Dr. Ali Zaidi. We represent a cardiology group
12 with 11 practicing physicians that has been
13 delivering cardiac care for the last three decades
14 in the southwest suburbs. Our practice is primarily
15 based at Christ Hospital, Palos Hospital, and
16 OSF Little Company of Mary Medical Center.

17 Our experience and quality of care has been
18 recognized by the hospitals in which we practice
19 with directorship positions in each hospital in
20 order to help direct and deliver the best cardiac
21 care to the community. This includes the head of
22 the cardiovascular assurance community at Christ,
23 director of atrial fibrillation program at Christ,
24 director of echocardiograph group at Palos,

1 cardiovascular executive committee member at
2 Palos, and director of cardiology at Little
3 Company of Mary Hospital.

4 I would like to emphasize that we are
5 supportive and involved in our area hospitals and
6 that we will continue to perform cases and direct
7 care for the community with our hospital partners.
8 However, we are also supportive of our patients in
9 the community. This project is about their needs.

10 There is no other option for us to offer
11 surgery center access and rates to our cardiology
12 patients today. Any new facility is at financial
13 risk but it is our risk. Despite the recent
14 challenges from COVID-19, we are willing to take
15 this risk to offer services we believe the
16 community requires and deserves. The economic
17 ramifications of this pandemic will hit healthcare
18 spanning for years to come, and this is a real
19 opportunity to reduce costs further without any
20 compromise of patient care.

21 We are not looking to replace hospitals.
22 It is exactly the opposite. We are trying to
23 bring our community options that others in this
24 country have for their cardiac care. The data

1 shows our project is not a threat to area provider
2 success, and we will continue to be a partner to
3 them despite their opposition.

4 We do believe our patients deserve more,
5 not less than what the healthcare community can
6 offer today. We ask for your support. Thank you.

7 CHAIRWOMAN SAVAGE: Thank you.

8 Does anyone have any questions for our
9 members here?

10 MEMBER KAATZ: Madam Chair, can I?

11 CHAIRWOMAN SAVAGE: Absolutely.

12 MEMBER KAATZ: Nice presentations. Just a
13 couple questions. Most of them are fair; one or
14 two may not be. I understand that so play with me
15 on that.

16 Are you going to take -- are you going to
17 have any limits on people who have Medicaid or
18 cannot afford care?

19 DR. AL-KHALED: Our group consultants in
20 cardiology and electrophysiology is going to have
21 16 providers. Our group was established around
22 35 years ago, and from the date established until
23 today we serve our community regardless of the
24 insurance schedule. We have Medicare; we have

1 Medicaid; we have private insurance; we have HMOs.

2 So the answer is yes, we take care of
3 Medicare; we take care of Medical Advantage plans,
4 too, in our office, and we deliver at the same
5 level and the same care to every private or
6 regular insurance company.

7 MEMBER KAATZ: Are you going to have limits
8 on the number of Medicaid patients?

9 DR. AL-KHALED: There's no limits in our
10 books. Though, there is one insurance that's
11 called Meridian which is a branch of Medicaid,
12 which we are part of the Advocate Physician
13 Partners, and there's a cap to it, but we never
14 reach that cap. We're always open for them, but I
15 really don't know the exact number. But we will
16 not limit deliberately any access to any of our
17 patients when they come to us.

18 MEMBER KAATZ: Madam Chair, can I continue
19 with a couple of other questions?

20 CHAIRWOMAN SAVAGE: Yes.

21 MEMBER KAATZ: Can I continue, please,
22 Electrophys, are you going to be doing ablations;
23 are you going to be doing -- where are you going
24 to put a limit on what you can do in an ambulatory

1 setting versus a hospital setting?

2 DR. SPEAR: Our intention is to start out
3 with routine pacemakers, defibrillators, and those
4 types of electrophysiology procedures and keep the
5 ablations as inpatient in the hospitals.

6 Now, as ablation evolves, as you know, it
7 used to be an eight-hour procedure in the hospital
8 with surgical back up; now it's a two- to three-
9 hour procedure and sometimes safe to discharge,
10 sometimes.

11 So I don't think we're there yet where we
12 could do cardiac ablations in an outpatient surgical
13 center. I would still feel more comfortable in
14 the hospital. Two, three, five years from now
15 that may change as technology changes, and it may
16 proceed to that if it's approved by the State and
17 the Federal government to do that, then we may
18 evolve. But the intention off the bat is strictly
19 simple pacemakers, defibrillators, battery changes,
20 and so forth.

21 MEMBER KAATZ: Any limits on what you're
22 going to be doing with regard to interventional
23 procedures?

24 DR. AL-KHALED: All complex intervention

1 procedures will be done in the hospital. So the
2 objective is to do the -- and that's, by the way,
3 a Medicare criteria, too. It's a Class A lesion,
4 meaning the lesion is expected to do well at a
5 much lower risk. So we are not going to be doing
6 anything in the range of atherectomy or laser. We
7 will be doing just simple straightforward stenting,
8 and this position will be made as we do the
9 angiogram. If the patient is a candidate, he will
10 get the stent. If we think the patient by any
11 means presents any kind of a risk, then the
12 patient will be dealt with in the hospital.

13 So yes, there is a limitation. That
14 limitation is well studied and evaluated.

15 MEMBER KAATZ: Do you have the support of
16 your cardiothoracic surgeons? I'm nervous about
17 what happens when you get a sick patient that's in
18 an ambulatory cath lab, and you have to send them
19 to a surgeon right away. Where are they and what
20 kind of plans do you have?

21 DR. AL-KHALED: I can give you an analogy
22 what happened over the last 25 years. Over the
23 last 25 years the acute myocardial infarction and
24 coronary intervention had moved from tertiary care

1 centers to regular centers. OSF Little Company of
2 Mary is a perfect example. We have serviced this
3 hospital since 1985 until now. OSF Little Company
4 of Mary does not have an open heart program, and
5 we do angioplasty and coronary intervention since
6 the year 2000. Patients are within 3 to 4,
7 5 minutes in case we have a problem patients move
8 to Christ Hospital which has the heart surgical
9 center.

10 Our location of our anticipated ambulatory
11 surgical center is 1.1 miles only away on the same
12 street as Advocate Christ Medical Center. In our
13 application we have gotten a letter of support
14 from the hospital. Christ is willing to take our
15 patients in case something happened to any of them
16 during the procedure immediately to Christ Hospital
17 and we have that letter.

18 MR. NIEHAUS: Just to correct the
19 statement, it wasn't a letter of support; it was a
20 transfer agreement that Christ executed with us.

21 DR. AL-KHALED: Correct. So we are ready
22 to do this. Currently our -- that's one analogy.
23 So we've done it with the hospital; we can do it
24 with the ASTC.

1 The second thing is we are not intending
2 to do anything that we consider high risk, but
3 you're right, sometimes even a simple case can
4 turn into a disaster, and we will be ready for it
5 by doing that.

6 You know, currently we do stress testing
7 in our office which is going to be next to this
8 building, and if we have an abnormal stress test
9 or some patients come in with chest pain to the
10 office, we move those patients immediately to either
11 Christ Hospital or to Little Company of Mary.

12 So we have a precedence of being able to
13 mobilize our patients very quickly, and we have a
14 receiving physician or entity right where the
15 patient is going to arrive. And this scenario has
16 arisen many times, and we have taken care of it,
17 so it should be the same path, the same technique.

18 MEMBER KAATZ: Thank you.

19 CHAIRWOMAN SAVAGE: Other questions?

20 MEMBER MARTELL: Yes. This is Dr. Martell.

21 I would like -- could Mike provide some
22 additional -- I know that he referenced this
23 earlier in the staff report that there was a
24 change in the volume calculation. If he could go

1 through that again, it was difficult to hear him,
2 and I want to make sure that I understand that.

3 MR. CONSTANTINO: Yes, Dr. Martell. What
4 I was trying to explain, in your staff report at
5 the end of page 3 I had a finding regarding the
6 establishment of cardiac cath, whether or not they
7 have sufficient referrals to support the
8 establishment. I made a mistake. They do have
9 sufficient referrals to support the establishment
10 of the cardiac cath. What I disagreed with Bryan
11 on was how the unnecessary duplication of service
12 was interpreted.

13 It's my opinion that the way the rule reads
14 requires that the applicant proposing to establish
15 cardiac cath services must indicate if it will
16 reduce the volume of existing facilities below
17 200 caths per lab per year, and all of the
18 hospitals we identified in HSA 7, they will not be
19 reduced below 200 caths a year per lab.

20 The second part of that criteria asked that
21 the applicant contact all of the hospitals within
22 HSA 7 who have cardiac cath services and ask them
23 the impact the proposed project will have on the
24 proposed facility. We only received one letter,

1 and that was from OSF Little Company of Mary.

2 MEMBER MARTELL: Thank you for that
3 clarification.

4 CHAIRWOMAN SAVAGE: Do we have any other
5 questions?

6 (No response.)

7 CHAIRWOMAN SAVAGE: Okay. I do have a
8 question.

9 So you state in your application for permit
10 that there are no viable options for your cardiac
11 cath patients. Yet OSF Little Company of Mary
12 Medical Center states that they can handle the
13 vast majority of cardiovascular cases as they are
14 at 25 percent of capacity.

15 Can you please explain further to the
16 State Board why you feel there are no viable
17 options for these patients?

18 MR. NIEHAUS: I think we all acknowledge
19 that there's hospitals that can provide these
20 procedures and have some capacity to accept the
21 cases. The cases are being done in the area
22 hospitals today. There's not a challenge in
23 getting a patient cardiac catheterization; the
24 challenge is being able to offer them the

1 ambulatory surgical setting that is different by
2 nature from the hospital setting and has all the
3 associated impacts and benefits to the community
4 the physicians outlined today.

5 Does that answer the question?

6 CHAIRWOMAN SAVAGE: It does.

7 MEMBER MARTELL: I have another question.

8 CHAIRWOMAN SAVAGE: Go ahead.

9 MEMBER MARTELL: It's for the staff members.

10 I know that in October of 2019 we approved another
11 ASC, and the volumes have not been reported. Do
12 we have anything? I mean, we know that we went
13 into a shutdown pretty quickly within almost the
14 first quarter. Is there any update on the one that
15 was approved in October to help us understand what
16 their volumes have been like?

17 MR. CONSTANTINO: We don't have anything
18 to date. We're still in the process of collecting
19 that data.

20 MEMBER MARTELL: And am I correct in
21 understanding that they were approved and would be
22 providing cardiac procedures, as well?

23 MR. CONSTANTINO: They will be, yes.

24 MEMBER MARTELL: Thank you.

1 CHAIRWOMAN SAVAGE: And then I do have a
2 question. You had mentioned that you have an
3 agreement, a transfer agreement with Christ; is
4 that correct?

5 MR. NIEHAUS: That is correct. It's in
6 our application.

7 CHAIRWOMAN SAVAGE: Thank you.
8 Any other questions?

9 (No response.)

10 CHAIRWOMAN SAVAGE: Okay. George, will
11 you please call the roll.

12 MR. ROATE: Thank you, Madam Chair.

13 Motion made by Dr. Martell, seconded by
14 Dr. Murray.

15 Senator Demuzio.

16 (No response.)

17 MR. ROATE: Senator Demuzio.

18 MS. AVERY: She's on the phone. Come back
19 to her.

20 MR. ROATE: Okay. Mr. Kaatz.

21 MEMBER KAATZ: I'm opposed to the project.

22 MR. ROATE: Thank you.

23 Dr. Martell.

24 MEMBER MARTELL: Based on the staff report

1 and the testimony heard today, I continue with my
2 decision to intend to deny.

3 MR. ROATE: Thank you.

4 Dr. Murray, you're muted, ma'am.

5 MEMBER MURRAY: I'm sorry; I forgot I was
6 muted. I vote to deny based on the staff report
7 and today's testimony.

8 MR. ROATE: Thank you.

9 Mr. Slater.

10 MEMBER SLATER: I vote to deny based on
11 the testimony of the opponents, State Board
12 report, and the clear excess capacity in the given
13 service area.

14 MR. ROATE: Thank you.

15 Chairwoman Savage.

16 CHAIRWOMAN SAVAGE: I vote to deny based
17 on the State Board report and the corrections, as
18 well as the opposition.

19 MR. ROATE: Thank you.

20 Coming back to Senator Demuzio.

21 (No response.)

22 MR. ROATE: Shall we consider her absent?

23 CHAIRWOMAN SAVAGE: Absent, yes.

24 MR. ROATE: That's 5 votes in the

1 negative, 1 vote absent.

2 CHAIRWOMAN SAVAGE: So the application for
3 permit is denied.

4 MS. AVERY: And I'll be sending you
5 something --

6 MR. CONSTANTINO: Courtney, that was as an
7 intent to deny. It wasn't denied. It was
8 deferred from the --

9 CHAIRWOMAN SAVAGE: May I make a correction?

10 MS. AVERY: I'm sorry; let the record
11 reflect that this was an intent to deny, and we'll
12 follow up with you. I apologize.

13 CHAIRWOMAN SAVAGE: My apologies.

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1 CHAIRWOMAN SAVAGE: I would like to introduce
2 our other Board member. He is our newest member,
3 Gary Kaatz, who is from the Rockford area.

4 Gary, if you'd like to tell us a little
5 bit about yourself.

6 MEMBER KAATZ: Thank you. I'm honored to
7 be part of this group. I've submitted my share of
8 certificates of need and have had very, very
9 challenging and productive experiences with the
10 staff in particular and the Board over -- going
11 back to the Pam Taylor, actually. I know you're
12 shocked because I don't look that old.

13 I'm originally from a small town in western
14 Pennsylvania and came out to go to graduate school
15 in Chicago, spent most of my career at what is now
16 Rush University Medical Center --

17 MEMBER MARTELL: Apologies, but we can't
18 hear anything he said. Does he have a microphone?

19 MEMBER KAATZ: Can you hear me now?

20 MEMBER MARTELL: Yes.

21 MEMBER KAATZ: I am honored to be part of
22 the Board, and I have great respect for the staff
23 and the functions and the goals, the mission of
24 the Planning Board, so I'm really honored to be

1 part of it.

2 I am from a small town in western
3 Pennsylvania, came out to Chicago to go to
4 graduate school. I spent most of my career at
5 what is now Rush University Medical Center in the
6 city, and for the last 15 years I have been the
7 CEO of Rockford Health System.

8 CHAIRWOMAN SAVAGE: Thank you so much. So
9 next on our agenda is H-02, Project 19-059, Quad
10 Cities Rehabilitation Institute Moline.

11 May I have a motion to approve
12 Project 19-159, Quad Cities Rehabilitation
13 Institute to establish a 40-bed comprehensive
14 physical rehabilitation hospital.

15 MEMBER MURRAY: This is Dr. Murray. I
16 so move.

17 CHAIRWOMAN SAVAGE: May I have a second.

18 MEMBER MARTELL: Dr. Martell, I so second.

19 CHAIRWOMAN SAVAGE: Is there anyone
20 present online to represent the applicant?

21 AUDIENCE MEMBER: Yes, there are.

22 MS. AVERY: Madam Chair, I will note for
23 the record that we did not have anyone preregistered
24 for public participation.

1 Is there anyone on Webex on the virtual
2 platform that would like to give any remarks
3 regarding Application 19-059?

4 (No response.)

5 MS. AVERY: Hearing none, we will proceed.
6 But I ask as you're speaking, even when you speak
7 the first time, whenever you're speaking please
8 state your name for the court reporter. Thank
9 you. And if you have any written testimonies,
10 please email them to myself, courtney.avery@IL.gov.
11 That will be helpful for the court reporter, also,
12 and you'll be sworn in virtually by the court
13 reporter.

14 CHAIRWOMAN SAVAGE: Okay. So who is our
15 first person to talk?

16 MR. SILBERMAN: This is Mark Silberman.
17 And do you want us to all acknowledge and be sworn
18 in before we begin --

19 CHAIRWOMAN SAVAGE: That would be helpful.

20 MR. SILBERMAN: -- or do we do it
21 individually?

22 CHAIRWOMAN SAVAGE: No, together would be
23 helpful.

24 MR. SILBERMAN: Then I would acknowledge

1 for the record that our speakers today will be
2 myself, Mark Silberman, Dr. Toyosi, T-o-y-o-s-i,
3 Olutade, O-l-u-t-a-d-e; Troy DeDecker,
4 D-e-D-e-c-k-e-r; Marty Chafin, C-h-a-f-i-n, and
5 Mr. Morado, Juan Morado, and we will all now
6 address the swearing in.

7 (Whereupon, the witnesses were thereupon
8 duly sworn.)

9 CHAIRWOMAN SAVAGE: Thank you.

10 Mike, please proceed with the State Board
11 staff report.

12 MR. CONSTANTINO: Thank you, Madam Chair.

13 The applicants are proposing to establish
14 a 40-bed freestanding comprehensive physical
15 rehabilitation hospital in Moline, Illinois, at a
16 cost of approximately \$33.8 million. The expected
17 completion date is May 2nd, 2022.

18 We received a number of support letters,
19 no opposition letters, and no public hearing has
20 been requested.

21 Thank you, Madam Chair.

22 CHAIRWOMAN SAVAGE: Thank you. Okay.

23 Mr. Silberman, Juan Morado, and others go forth.

24 MR. SILBERMAN: Yes, thank you. I will

1 begin. I'm just going to manage my technological
2 capabilities and put this up on the screen.

3 Thank you. For the record, this is Mark
4 Silberman, and I would like to thank the Board for
5 the opportunity to appear before you today, and I
6 would like to thank the Board staff for its
7 assistance throughout this project that can only
8 be described as an overwhelmingly positive staff
9 report.

10 It's always very encouraging when we can
11 bring forth a project that reflects the widespread
12 acknowledgement of the needs of the community and
13 overwhelming support. And the support is not just
14 from politicians and from healthcare professionals
15 and members of the public; the support that we
16 were able to document is also in the form of letters
17 of referral from local physicians sufficient to
18 justify the scope and the size of the project that
19 we are proposing.

20 When you add to the fact that this is a
21 project that has had absolutely no opposition, no
22 request for a public hearing, no letters of any
23 opposition, hopefully that will help you understand
24 why this is a project we are so excited to appear

1 before you today to have you review, consider, and
2 hopefully to approve.

3 So as I mentioned before, I have with me
4 today Dr. Toyosi Olutade. He is the chief medical
5 officer for UnityPoint Health Trinity; also Troy
6 DeDecker, who is the president of the central
7 region for Encompass Health; Marty Chafin, who is
8 the president of Chafin Consulting Group, and
9 lastly, my colleague, my partner, my friend
10 Juan Morado from Benesch Law.

11 What we are going to do is to focus our
12 presentation on three big things, how this project
13 will both advance access to necessary healthcare
14 and further the ability of UnityPoint to both
15 modernize its facility but also to better serve
16 the community that it is dedicated to.

17 Second, we're going to focus on the services
18 that Encompass provides, both the range of conditions
19 and types of patients that it serves but also the
20 philosophy that it brings towards providing inpatient
21 rehabilitation understanding that our expected
22 population for this proposed project is over
23 73 percent Medicare and Medicaid.

24 And lastly, since today's project reflects

1 replacing an aging 22-bed in-hospital unit with a
2 brand-new state-of-the-art stand-alone 40-bed
3 rehabilitation hospital which is dedicated to
4 providing comprehensive rehabilitation services,
5 what we're going to do is focus on the 18 beds
6 that we are proposing to add to this service area
7 and the need for those beds by offering an
8 explanation of the significant gap in care that
9 exists and the methodologies available that justify
10 adding those additional 18 beds to this community.

11 And, finally, Juan Morado is going to walk
12 through the limited findings that we have in the
13 staff report and explain why we are confident
14 that this is a project which is really well designed
15 to provide necessary access to quality care to a
16 community that right now is facing an unnecessary
17 obstacle to being able to obtain healthcare.

18 So with that our speakers will advance
19 through the PowerPoint, but as I understand it,
20 you all have available copies or PDFs of the same
21 presentation. So one thing I did want to
22 acknowledge for the record is that all of the
23 information contained in the PowerPoint is
24 information that is either within our certificate

1 of need that we filed or within the staff report
2 that your staff presented.

3 And with that I'll hand things off to
4 Dr. Olutade.

5 DR. OLUTADE: Thank you, Mark.

6 Good morning. Thank you for having us here.
7 I am a board-certified internist practicing for
8 over 10 years. I'm currently the chief medical
9 officer of UnityPoint Health Trinity since the
10 month of May, but prior to that I served as a
11 medical director for the hospitalist program for
12 over five years, and as a team we do care for more
13 than 55 percent of the patients at UnityPoint
14 Health Clinic.

15 Now, this care at UnityPoint Health
16 Trinity -- I'm really proud to be associated with
17 this hospital system. They've been providing care
18 for over 100 years to the community and are very
19 well trusted. In the care of our patients, it's
20 usually with other specialists' support like
21 orthopedics, cardiology, neurosurgery, trauma.

22 For my own personal introduction to
23 Trinity, I couldn't be happier. After a patient
24 of mine had a stroke, the process of recovery

1 included rehab and intensive rehab, and the
2 dedication of the staff there, it was really good
3 to see how this patient of mine was able to
4 recover as much function as she did and was able
5 to get back to sewing, which was one of her
6 hobbies.

7 Over the past couple of years we've had
8 increased numbers of rehab, and while the care has
9 been excellent there, we know that it's outdated.
10 We need additional space for more intensive and
11 rigorous rehab of patients. Right now what a lot
12 of my colleagues and myself do as a workaround --

13 (Interrupted audio.)

14 CHAIRWOMAN SAVAGE: Doctor, if you could --
15 you're having some breaking up, so if you can
16 start back just a couple minutes before that,
17 she's having a very hard time hearing you.

18 MS. AVERY: Mike Mitchell, will you please
19 mute everyone's microphone, and please do not
20 unmute your mics. Mike Mitchell will control that
21 because we're getting a lot of background noise,
22 also. Thank you.

23 DR. OLUTADE: Thank you. No problem.

24 I would just share the workaround that a

1 lot of the providers currently at UnityPoint
2 Health Trinity have to come up with for their
3 patients who are in need of active rehab but when
4 there's insufficient space on the rehab unit.
5 Either they're kept on the medical floors for a
6 little longer on low-dose therapy, or they're
7 discharged to our partners on low-dose therapy, as
8 well. And this gap ends up adversely impacting
9 the patient's ability to fully recover and get
10 back to their families.

11 This is one of the things that -- why I got
12 excited about this plan to engage Encompass with
13 its rich history and proven record of delivering
14 high-quality rehab, intense rehab for patients in
15 partnership with a medical facility to take care
16 of patients who need this much needed care but are
17 not getting it sufficiently.

18 With that I'll hand over to Troy.

19 MR. DeDECKER: Thank you very much, Doctor.

20 My name is Troy DeDecker, and I'm the
21 central region president for Encompass Health and
22 as a physical therapist with greater than 20 years
23 experience in providing care at leading hospitals,
24 the last seven years with Encompass Health.

1 Encompass Health prides itself by partnering
2 with strong community hospitals like UnityPoint
3 Health Trinity to provide the highest level of
4 inpatient rehabilitation care as we do across the
5 country. Our focus is to provide the high dose of
6 therapy that the physician talked about to allow
7 our patients to recover and return home to live
8 their lives.

9 The slide before you shows our patient
10 mix, but I think what is important is some of the
11 stories behind the mix, so I want to give you a
12 few examples:

13 A 32-year-old mother that was involved in
14 a car accident that resulted in a brain injury with
15 a broken pelvis. Her primary goal was to recover so
16 that she could return home and care for her children,
17 and the high dose of therapy that she received in
18 our rehab hospital allowed her to do that;

19 A 60-year-old father that suffered a
20 devastating stroke. He needed our high-dose
21 rehabilitation to allow him to return home but,
22 more importantly, to walk his daughter down the
23 aisle late last year;

24 Or more recently, a 52-year-old school

1 teacher that was stricken with COVID. He spent
2 17 days on a ventilator and suffered significant
3 cognitive deficits and physically debilitated. He
4 spent 14 days in our high-dose rehab environment
5 which did allow him to return home.

6 And with that I would like to pass it
7 to Marty.

8 MS. CHAFIN: Thank you, Troy.

9 I'm Marty Chafin of Chafin Consulting
10 Group. You've heard Dr. Olutade and Troy DeDecker
11 talk about the individual patients and their needs
12 and how they'll benefit from the patient rehab.
13 I'm going to step back from that and talk from a
14 community standpoint, if you will. However,
15 before I jump into those slides, let me make some
16 comments.

17 The first is I'm going to walk you through
18 quantitatively how it closed the identified gap in
19 care. I'd like you to please interrupt me as
20 needed with any questions, but we will talk about
21 different tables and charts throughout.

22 The second point is just very briefly by
23 way of background, this marks my 33rd year in
24 healthcare. I have been in the healthcare industry

1 since graduating from Georgia Tech. Most of my
2 experience is on the consulting side working in a
3 number of states as well as internationally. I
4 also worked for several years for the provider
5 side in an integrated healthcare system that had
6 an array of services, including the rehab services
7 we're talking about today.

8 In front of you is Slide 4. This is the
9 geographic area we are talking about that is at
10 issue today, the need for HSA 10 to have additional
11 beds. HSA 10 is comprised of three counties, Rock
12 Island, Mercer, and Henry County. The population
13 in that county is around 200,000. More importantly,
14 within that population is a large and growing
15 65-and-over population. In fact, the population
16 within that three-county service area will
17 increase almost 10 percent between 2019 and 2024.

18 The relevance of that is that the primary
19 user of inpatient rehab services is the Medicare
20 population. So we have an increase in population
21 which is driving the bed need that we'll discuss
22 later.

23 You can't think about HSA 10 without
24 recognizing that it is part of the larger Quad

1 Cities area. If you think of a 17-mile radius
2 around the proposed facility which is based on the
3 Board's rule of the 17-mile geographic service
4 area, the population doubles to nearly 400,000.
5 Again, that population has a large elderly or age
6 65-and-older population.

7 On Slide 4 you also see Table 6. That is
8 straight from the staff report, and this is the
9 first time that I can quantify for you that there
10 is a significant gap of care. Dr. Olutade talked
11 about that, that they have to have a workaround
12 because there are too few beds. This is when we
13 start putting numbers to that.

14 Looking at the 17-mile geographic service
15 area, there's 22 beds existing that the beds that
16 we hope to --

17 (Audio connection lost.)

18 CHAIRWOMAN SAVAGE: We lost you.

19 MR. SILBERMAN: Juan is going to mute
20 himself and try to -- I will address this as best
21 as I can, but I can assure you I don't have nearly
22 the skills that Marty has.

23 But if you take a look at Slide 5, there
24 are three bases by which we are addressing the

1 documented need for this proposed project. And I
2 promise I'll stop -- for the record, this is
3 Mark Silberman.

4 There is the documented physician referrals,
5 and that is something I mentioned earlier. When
6 you look at the number of referrals that we've been
7 able to identify for this project, those referrals
8 which were presented by local physicians who can
9 reflect the need that they see for their patients
10 boots on the ground, those referrals justified the
11 occupancy of 54 beds at 85 percent, which is the
12 Board's percentage of occupancy for expansion.

13 Now, we are not seeking 54 beds; we're
14 only seeking 40. But the perceived need and it is
15 a predicted need that is reflected in the referral
16 letters that we submitted to the Board, does show
17 a need of that level.

18 The other issue is the idea of the lower
19 utilization that historically you will see with
20 regards to IRF services, and that is what was
21 reflected in the gap here that we had in Slide 4.

22 And then lastly, we'll address the
23 limitations that are resulting from the existing
24 22-bed unit. Overwhelmingly the notion is that

1 there are technological advances that result from
2 the construction of a new facility, the large gym,
3 the more dedicated patient rooms, individualized
4 rooms instead of a majority of semiprivate rooms.
5 So to that end what we have here -- and I will let
6 Marty jump in as soon as we get her back.

7 MR. MORADO: She should be online.

8 MR. SILBERMAN: Marty, are you online?

9 MS. CHAFIN: I am. I apologize.

10 MR. SILBERMAN: God bless. Let me go back
11 one slide, and we now see what that really sounded
12 like from an artist.

13 MS. CHAFIN: Thank you and I apologize
14 for that.

15 The gap in here was just identified in
16 terms of beds per population, and that is HSA 10
17 has less than half of the number of beds that the
18 statewide average is. That was the prior slide.
19 The question then becomes how many beds is enough
20 to meet that gap in care and close the gap in care.

21 We answer that in two ways. One is through
22 the documented physician referrals. Mark may have
23 just mentioned that. I'll talk about that briefly.
24 And that is a need for 54 beds, and it is based on

1 what the physicians, boots on the ground, if you
2 will, are indicating that they will be referring
3 to the new facility.

4 The second way that we can quantify the
5 beds needed to address that gap in care that,
6 again, you saw the beds per 1,000 population, less
7 than half of the statewide rate, is to look at the
8 historically low utilization of IRF services and
9 use the same approach that we later saw used in
10 the Libertyville application. I presented that to
11 you in February, and that application was approved
12 based on the same methodology.

13 Finally, the third basis for need is not
14 quantifiable but is no less important, and that is
15 the limitations of the existing 22-bed unit.
16 Dr. Olutade mentioned that previously. Next slide,
17 please.

18 Here you see physicians that are seeing
19 patients in the HSA and their intent to refer a
20 significant number of patients to the new facility,
21 the addition of the 18 beds plus the 22. So that
22 we all understand the map in front of you, HSA 10
23 counties are in blue, Rock Island, Mercer, and
24 Henry. The 17-mile radius that the Board's rule

1 references in terms of geographic service area is
2 what you see in red, the red circle. You'll also
3 note in green UnityPoint Hospital.

4 The physicians have written letters and have
5 attested to the fact that they see a significant
6 number of patients that need rehab, and because of
7 that they intend to refer over 1,182 patients to
8 the proposed facility, and that equates to a
9 54-bed need with 85 percent occupancy. The vast
10 majority of their referrals, 85 percent are from
11 the three-county HSA 10.

12 That's why we're proposing the beds, to
13 fill that gap in care. The physicians are saying
14 they need 54. We know we've got to close the gap
15 in care. The map shows you where the patients are
16 residing. The darker colors that you see mean
17 more patients reside in that zip code. So this
18 supports from the boots on the ground, if you
19 will, a 54-bed need, meaning that's how many beds
20 will close that gap in care that I referenced
21 previously.

22 Next slide.

23 The second way that we can first, quantify
24 the gap in care and second, address the gap in

1 care -- this may seem familiar to what we did in
2 the Libertyville application -- is to not look at
3 beds per population -- as we already did; we
4 reference that in the staff report -- but to look
5 at what's really happening in terms of discharges.

6 Slide 7 shows when you look at the Illinois
7 average, which is the red line, 11 discharges per
8 1,000 Medicare beneficiaries, and you compare that
9 to the Rock Island discharges per 1,000, there is
10 a significant gap in care, and it has worsened
11 over time. That gap has been growing.

12 If you added 2018 data to this chart, Rock
13 Island would be even lower, 4 discharges per 1,000
14 compared to the statewide average of 11. So
15 Illinois is more than double acceptability to beds
16 in terms of discharges to Rock Island. It is more
17 than three times in Henry County, discharges of
18 3 per 1,000 Medicare beneficiaries. Mercer has so
19 few discharges that in 2009 and then in the last
20 two years you can't even quantify the discharge
21 rate out. But illustratively this again is the
22 gap in care. We talked about beds per 1,000, and
23 now it's actually discharge per 1,000.

24 The question again is how do we fill that

1 gap. Slide 8 addresses that for you. Again, same
2 methodology. It begins with, as Dr. Olutade talked
3 about, patients that need and would benefit from
4 inpatient rehab. For HSA 10 there are 7,294 rehab
5 appropriate discharges. That is based on identifying
6 patients that we expect would not only need rehab
7 but would benefit from it.

8 The three factors then that were considered,
9 one is the target discharge rate, what is a
10 reasonable percentage of those patients we expect
11 would actually be admitted to inpatient rehab.
12 8 percent is what you see here. That is based on
13 Encompass' experience in the central US. The
14 second factor is an in-migration factor. I
15 mentioned briefly the greater Quad Cities area.
16 You saw the four hospitals in that Quad Cities
17 area. The reality is there's a 35 percent
18 in-migration factor that is occurring for the
19 existing 22-bed rehab unit and the rehab
20 appropriate patients, and we expect that to
21 continue for the new facility.

22 Finally, the factor that is considered is
23 the average length of stay, the statewide average
24 of approximately 14 days.

1 When you factor those in mathematically,
2 you get a bed need of 41. This is a conservative
3 forecast because this does not account for the
4 aging in place. As I mentioned before, it's about
5 an 11 percent increase in population aged 65 and
6 older who is the primary user.

7 The question then becomes what if you
8 don't close the gap. Slide 9 shows you this. The
9 patients have few choices. Absent approval of
10 this project, the closest Illinois-based providers
11 are almost two hours away. Residents would have
12 to drive to Rockford that's over 100 miles, two
13 hours one way, or Peoria almost 100 miles and an
14 hour and a half away. The negative impact of that
15 is not only to the patient in terms of being
16 distant from the patient's community physician,
17 primary care and cardiologist, but also the
18 distance from the family members that need to be a
19 part of this daily care of this patient's recovery.

20 The next slide, I will wrap it up with
21 this. We talked about two ways that you can
22 quantify the need to close that gap. The third
23 need circled back to where it started. Dr. Olutade
24 talked about the limitations of the 22-bed hospital,

1 that it needs to be expanded. What you see in
2 front of you on Slide 10 is actually from the
3 staff report. There are structural limitations
4 that need to be a more modern facility. We agree
5 with that and expect to expand it by increasing beds.

6 Approval of this project is a win/win/win
7 for this community. Number one, it addresses the
8 gap in care by adding to the existing beds. We've
9 quantified that gap in care; the physicians say
10 there is a need for 54 beds based on the patients
11 they treat and expect to refer. The quantitative
12 approach that I've used here that was approved in
13 Libertyville shows the need for 40 more.

14 The second win is that Rock Island needs
15 the ability -- and you'll hear about that in the
16 next presentation -- they need the ability to use
17 that space that is vacated as a flex space as they
18 increase their number of private rooms.

19 The third win is that this project will
20 positively impact the Illinois Quad Cities economy
21 both short-term and long-term.

22 With that I'll turn it over to Juan Morado.

23 MR. MORADO: Thank you, Marty, Board members
24 for your attention and time so far. Allow me the

1 opportunity to summarize our presentation for you
2 by touching on three points and addressing the
3 staff report findings.

4 First, this project is the right size for
5 this community. All the need methodologies support
6 approval of this project, and we're going to
7 discuss the investment in the community.

8 The project is the right size. That's why
9 the project is for 40 beds, not 22 and not 100.
10 As the Board notes and staff, as well, the 100-bed
11 rule is not historically based on any particular
12 research or policy. And while we understand and
13 respect that it is the rule, we appreciate the
14 Board's willingness over the years to use your
15 discretion to approve right-size projects that can
16 provide needed services to a community.

17 Today you heard from Marty Chafin, premier
18 health planner, who educated us all on the
19 statistical justification for this project. We
20 are all in agreement that there is a need for
21 these services in the planning area, and the
22 existing hospital unit is physically limited as
23 noted in your staff report.

24 Under every need methodology there is

1 ample justification for you to approve this 40-bed
2 facility. The referrals justify it. You previously
3 accepted an alternative need methodology for two
4 similar projects in Andersonville and Libertyville
5 and found that methodology sufficient to approve
6 those projects.

7 Using rehabilitation inpatient codes and
8 discharge data for patients who have received the
9 high-dose inpatient care that Troy DeDecker and
10 Dr. Olutade discussed reflects a need for even
11 more beds than we're seeking in this application.
12 We are seeking a 40-bed facility because it's the
13 right size at this time. However, it's important
14 to note that our construction designers build our
15 facilities in a manner that would accommodate
16 future growth, and it allows us to come back to
17 the Board to add additional capacity to meet the
18 needs of the community.

19 Your staff report correctly notes that we
20 have met the criteria associated with project need
21 as there are no other services within 10 miles. You
22 only need to take a look at the slide that's on
23 your screen now to see that the two closest units
24 are 89 and 118 miles away. There's simply not

1 sufficient access for rehab beds in the region.

2 This project represents a \$33 million
3 investment in the Quad Cities region and specifically
4 in Rock Island, Illinois. We expect significant
5 economic growth from this project, including
6 hundreds of temporary construction jobs, 150 new
7 jobs at the hospital itself, and naturally
8 significant long-term economic growth within the
9 region.

10 We think it's telling that there's been an
11 overwhelming number of support letters from
12 physicians, business and political leaders, and
13 absolutely no opposition. We hope we have
14 provided you with ample documentation of the need
15 for this service in the HSA and the evidence to
16 give you comfort to use your discretion to approve
17 this project, fulfill your mission, and provide
18 access to necessary care for this community.

19 We thank you for your consideration, and
20 we'd be happy to answer any questions.

21 CHAIRWOMAN SAVAGE: Do any of the members
22 have any questions at this moment?

23 Gary.

24 MEMBER KAATZ: Thank you, Madam Chairwoman.

1 I have a couple questions and a comment and a
2 request, if I may.

3 How many physiatrists will be practicing
4 at the new hospital?

5 MR. DeDECKER: So typically we usually
6 staff a 40-bed hospital with between two to
7 three physiatrists.

8 MEMBER KAATZ: And will you have an
9 internist whose primary responsibility is making
10 rounds there?

11 MR. DeDECKER: I don't think I heard the
12 entire question, but I think the question was will
13 we have an internist at the hospital.

14 MEMBER KAATZ: Correct, making rounds.

15 MR. DeDECKER: Yes, we will.

16 MEMBER KAATZ: And are you going to have
17 patients eat together, or are you going to have
18 patients eat in their rooms?

19 MR. DeDECKER: So that really depends a lot
20 on the individual patient needs. In our hospitals
21 we have environments where patients would prefer
22 to eat in a room and have their families come and
23 visit them in their room, but we also have patients
24 that have challenges with swallowing, and they

1 actually are in therapeutic feeding groups where a
2 speech therapist is assisting the patient, and at
3 times patients do commingle in a dining room area
4 to have their meals together. It is not something
5 that is mandated by us. Some of it depends on the
6 individual needs of those patients or the wants of
7 the patients and/or families.

8 MEMBER KAATZ: Thanks. Are you going to
9 have a swimming pool, a therapeutic swimming pool?

10 MR. DeDECKER: I can't hear; I'm sorry.

11 MEMBER KAATZ: Included in your proposal I
12 didn't see, is there going to be a therapeutic
13 swimming pool?

14 MR. DeDECKER: No.

15 MEMBER KAATZ: My comments now are watch
16 the outpatient space, because as you grow, I think
17 you're going to be surprised by being limited by
18 outpatient space, and I hope that you have the
19 ability to physically sequester some additional
20 space because when you come back here three or
21 four years from now and you want to go from 40 to
22 60, you'll be prepared for that.

23 And my last request is if there is an
24 organization that represents the physically

1 challenged in your community, could you please
2 include them so that the height of your drinking
3 fountains, and your sinks, and your other things
4 that relate to activities of daily living are
5 incorporated through their eyes.

6 Thank you.

7 MEMBER MARTELL: This is Dr. Martell and I
8 have a follow-up kind of a question because I know
9 that there's another project on the docket for
10 today that's kind of in relation to this, and part
11 of the rationale on the other one was not only the
12 aging facility but the staffing.

13 Can you give me any sense of why you think
14 your staffing model at this will be different than
15 your ability to recruit and retain staff at this
16 facility?

17 MR. DeDECKER: I'm not quite sure I
18 understand the question.

19 MR. SILBERMAN: Troy, how will the
20 stand-alone facility be able to -- and Encompass
21 address some of the staffing challenges at the
22 IRF facility?

23 MR. DeDECKER: Oh, sure. I think I can speak
24 to on the acute care side when you think about

1 UnityPoint Trinity and staffing from a nursing
2 perspective in an acute care hospital, clearly
3 there's a nursing shortage and nursing demand at
4 all of our hospitals, and there is a special
5 clinical expertise to being an ICU nurse, or an
6 emergency department nurse, surgical nurse, and
7 even a rehab nurse. And it can be a challenge for
8 acute care hospitals and for the nursing staff to
9 be expected to float between the individual nursing
10 units that require really a different skill set.

11 And at our hospitals we really advocate in
12 developing our nurses and make them all certified
13 inpatient rehabilitation nurses. So typically
14 what happens is it's a draw, and we're able to get
15 the staff that we are able to develop their
16 confidence to care for the unique patient needs
17 that we treat.

18 MEMBER MARTELL: Thank you.

19 CHAIRWOMAN SAVAGE: And I have a question.
20 When you say that there was sort of a -- 35 percent
21 of your patients coming from out of the region, do
22 you know why these patients were not utilizing
23 already the 22-bed unit at a higher degree?

24 MR. SILBERMAN: Marty, do you want to

1 address the challenges that the IRF faced?

2 MS. CHAFIN: I could not understand the
3 question. Could you repeat that?

4 CHAIRWOMAN SAVAGE: Yes. Do you know the
5 reason why the patients -- the 35 percent of the
6 patients that are in-migration, why they were not
7 already using the 22-bed unit, the IRF that's
8 scheduled in the next round on the agenda?

9 MS. CHAFIN: Can you repeat that?

10 MR. SILBERMAN: Marty, I'll frame the
11 question, set up the answer, and let you fill in
12 with --

13 MS. CHAFIN: I just couldn't hear it.

14 MR. SILBERMAN: No worries. The question
15 was why were the patients who we had in-migrating
16 not utilizing the 22-bed IRF. And I think the
17 first part of it, Madam Chair, is that the IRF --
18 the 22 beds were set up mostly in nonprivate
19 rooms, which both creates issues from a healthcare
20 delivery perspective but also from a patient
21 preference perspective. And the 40-bed facility,
22 if I'm correct, they are all individual rooms;
23 they are designed to both accommodate geriatric
24 patients, to accommodate food service in room,

1 family visiting, therapy in space.

2 So I think one of the challenges both
3 became the limitations for the 22-bed facility to
4 grow and meet current needs, but also I do believe
5 that the benefits come from the dedicated facility
6 both from a staffing and also an environment
7 perspective really do help.

8 Marty, if you can still address that from
9 a health planning perspective, I think that may be
10 helpful.

11 MS. CHAFIN: Sure. The 35 percent
12 in-migration factor is reflective of patients that
13 are coming into the unit; it's just that there are
14 so few beds. So that 35 percent is what is coming
15 into this 22-bed program. That was why I used
16 that factor. Does that address your question?

17 CHAIRWOMAN SAVAGE: It does. Thank you.

18 MR. DeDECKER: May I make a comment to
19 that effect?

20 CHAIRWOMAN SAVAGE: Of course.

21 MR. DeDECKER: I think the other thing,
22 you know, obviously UnityPoint Trinity Hospital
23 was built before the way rehabilitation has been
24 practiced today and really the way medicine is

1 currently practiced today. And I would think just
2 from a practical capacity standpoint, even though
3 they're licensed for 22 beds, when you consider
4 either gender, or individual patient infections,
5 or a geriatric type of patients really a practical
6 capacity on a 20-bed unit is probably closer to
7 14 to 16 beds just because there are many patient
8 conditions that don't allow you to commingle
9 patients as we had historically.

10 CHAIRWOMAN SAVAGE: Thank you. Anyone
11 else have any other questions?

12 (No response.)

13 CHAIRWOMAN SAVAGE: Okay. George, will
14 you please call the roll.

15 MR. ROATE: Thank you, Madam Chair.

16 Motion made by Dr. Murray, seconded by
17 Dr. Martell.

18 Senator Demuzio.

19 (No response.)

20 MR. ROATE: Gary Kaatz.

21 MEMBER KAATZ: I vote yes.

22 MR. ROATE: Thank you.

23 Dr. Martell.

24 MEMBER MARTELL: I vote yes in support of

1 the application based on the testimony and additional
2 formula provided regarding needs assessment.

3 MR. ROATE: Thank you.

4 Dr. Murray.

5 MEMBER MURRAY: -- the testimony.

6 MR. ROATE: Could you repeat, ma'am? We
7 just got the last half of your comment.

8 CHAIRWOMAN SAVAGE: Repeat that, Linda.

9 MS. AVERY: Dr. Murray, can you hear us?

10 MEMBER MURRAY: Yes; I'm sorry. This is
11 Dr. Murray. I vote yes based on the staff report
12 and clarifications and the testimony.

13 MR. ROATE: Thank you.

14 Mr. Slater.

15 MEMBER SLATER: I vote yes based on the
16 testimony.

17 MR. ROATE: Thank you.

18 Chairwoman Savage.

19 CHAIRWOMAN SAVAGE: I vote yes based on
20 the State Board staff report and the testimony.

21 MR. ROATE: Thank you.

22 That's 5 votes in the affirmative.

23 CHAIRWOMAN SAVAGE: Thank you. That
24 application for permit is approved.

1 MR. SILBERMAN: Thank you very much.

2 MS. AVERY: For clarification, on
3 Project E-010-20, are those the same applicants?
4 If not, then we'll have to swear those persons in.

5 MR. SILBERMAN: That is the same
6 applicants, and we are prepared for the Board to
7 address the exemption request to discontinue.

8 MS. AVERY: Thank you.

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1 CHAIRWOMAN SAVAGE: Okay. So next on the
2 agenda is C-01, E-010-20, Trinity Medical Center -
3 Rock Island.

4 May I have a motion to approve E-010-20,
5 Trinity Medical Center to discontinue a 22-bed
6 comprehensive physical rehabilitation category of
7 service.

8 MEMBER KAATZ: So moved.

9 MEMBER MARTELL: I so move. This is
10 Dr. Martell.

11 CHAIRWOMAN SAVAGE: Okay. Gary will be
12 the first and Dr. Martell the second.

13 Is there any presentation that the
14 applicants would like to make or people here to
15 talk about that?

16 MR. MORADO: I think the only thing we
17 wanted to say, members of the Board, is that you've
18 heard already about the 22-bed unit that's going
19 to be discontinued because of the new facility,
20 and we would mention that that discontinuation
21 will not occur until the new facility is complete
22 and open. So there will be no gap, no additional
23 gap in care while the facility is being constructed.

24 CHAIRWOMAN SAVAGE: Thank you. Mike,

1 would you please present the State Board report.

2 MR. CONSTANTINO: Thank you, Madam Chair.

3 The applicants are asking the State Board
4 approve the discontinuation of a 22-bed comprehensive
5 physical rehab category of service at Trinity
6 Medical Center - Rock Island.

7 There is no cost to this project. The
8 applicants are requesting that this category of
9 service remain in operation until such time as the
10 Quad Cities Rehab Institute has been licensed by
11 the Department of Public Health. The applicants
12 have submitted all the requirements of the State
13 Board.

14 Thank you, Madam Chair.

15 CHAIRWOMAN SAVAGE: Thank you.

16 Do any of the Board members have any
17 questions?

18 (No response.)

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

21 MR. ROATE: Thank you, Madam Chair.

22 Motion made by Mr. Kaatz, seconded by Dr. Martell.

23 Mr. Kaatz.

24 MEMBER KAATZ: I vote yes based on the

1 testimony as well as how it integrates with the
2 request of H-02.

3 MR. ROATE: Thank you.

4 Dr. Martell.

5 MEMBER MARTELL: I vote yes based on the
6 staff report and the testimony heard today.

7 MR. ROATE: Thank you.

8 Dr. Murray.

9 MEMBER MURRAY: I vote yes based on the
10 staff report and today's testimony.

11 MR. ROATE: Thank you.

12 Mr. Slater.

13 (No response.)

14 MR. ROATE: Mr. Slater.

15 CHAIRWOMAN SAVAGE: I think he fell off.

16 MS. AVERY: We lost -- well, one second.

17 MEMBER MURRAY: I can see him. He was
18 trying to talk. He was on mute.

19 MEMBER SLATER: I vote yes -- can you hear
20 me? -- based on the staff report.

21 MR. ROATE: Thank you.

22 Chairwoman Savage.

23 CHAIRWOMAN SAVAGE: I vote yes based on
24 the State Board staff report and the testimony.

1 MR. ROATE: Thank you.

2 That's 5 votes in the affirmative.

3 CHAIRWOMAN SAVAGE: The application for
4 exemption is approved. Thank you.

5 MR. SILBERMAN: Thank you, Madam Chair, and
6 thank you for your continuing your service throughout
7 all of this craziness.

8 CHAIRWOMAN SAVAGE: Thank you.

9 MS. AVERY: So we're back on schedule. We
10 had this call scheduled from 11:20 to 12:20. We
11 will take a break and return back at 1:20.

12 (Recess taken, 12:14 p.m. to 1:28 p.m.)

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1 CHAIRWOMAN SAVAGE: Okay. We are calling
2 our meeting back to order. So next on our agenda
3 is Project 8-03 -- Project 20-011, Northwestern
4 Memorial Hospital in Chicago.

5 May I have a motion to approve
6 Project 20-011, Northwestern Memorial Hospital for a
7 modernization/expansion in Chicago.

8 MEMBER MARTELL: I so move.

9 CHAIRWOMAN SAVAGE: May I have a second.

10 MEMBER KAATZ: I'll second that.

11 CHAIRWOMAN SAVAGE: Okay. Is there anyone
12 here to represent the applicant? Yes.

13 MS. AVERY: Madam Chair, before we start,
14 there should be at least six people virtually that
15 want to give testimony and public participation.

16 CHAIRWOMAN SAVAGE: Is that the case,
17 Mr. Mitchell?

18 MR. MITCHELL: I couldn't hear that.

19 MS. AVERY: The public participation for
20 Project No. 20-011.

21 MR. MITCHELL: I have Anne Igoe and
22 Greg Will who are in opposition to the project.

23 MS. IGOE: This is Anne Igoe. There
24 should be four of us that are registered.

1 MR. MITCHELL: I'm not seeing Marcus Buell
2 or Kim Smith on my list. If they didn't sign in
3 with their names, I can't identify them.

4 MS. IGOE: Got it. I know they're signed
5 in, but I think they're over the phone, so it
6 would be their phone numbers that would identify
7 them.

8 MR. MITCHELL: I don't see phone numbers.
9 So if they didn't enter their names, I won't be
10 able to get them connected to testify.

11 CHAIRWOMAN SAVAGE: So for the public
12 participation, does one of you one to start.

13 MS. IGOE: Marcus was going to be the
14 first to testify. Mike, are you saying -- if I
15 gave you Marcus' phone number, would you be able
16 to unmute him?

17 MR. MITCHELL: No. All I can see -- if he
18 didn't put his name in, all I can see is call in
19 user for the number. I can't identify and I
20 can't -- I mean, I don't know which one is him. I
21 can't see any details on it, so I don't know which
22 one he is.

23 MS. AVERY: Can he -- Anne, can he
24 identify himself by raising his hand? Or anyone

1 that is on for public participation for Project
2 No. 20-011 chime in now, say which user you are.
3 If not, we will have to skip over you, but we need
4 to get started.

5 MS. IGOE: So there's like a hand raising
6 option? I apologize.

7 MS. AVERY: Or they can speak into the mic
8 and let Mike Mitchell know that they're ready to
9 start their testimony.

10 CHAIRWOMAN SAVAGE: Those who are looking
11 to testify, if you go to -- hover on your screen,
12 and you'll see a little bubble --

13 MS. AVERY: They're on the phone.

14 CHAIRWOMAN SAVAGE: Oh, you're on the
15 phone. Never mind.

16 MS. IGOE: I have a person who is saying
17 he is not logged in through the computer. The
18 other option is I can just three-way him, and then
19 it will be on your line. Is that okay?

20 MS. AVERY: Yes. You all figure that out,
21 and we'll start with the proponent from
22 Northwestern. We'll start with that while you
23 work out the other stuff.

24 MR. MITCHELL: Well, I have two proponents

1 Lee Francis and Bernice Mills-Thomas.

2 MS. AVERY: Let's start with one of the
3 two of them.

4 MR. MITCHELL: Okay. I will unmute them
5 in just a second here. Hang on.

6 MS. AVERY: Thank you.

7 CHAIRWOMAN SAVAGE: We thank everyone for
8 your patience, flexibility, and understanding.

9 DR. FRANCIS: Lee Francis here. Can you
10 hear me, Mr. Mitchell?

11 MR. MITCHELL: Yes, I have unmuted both
12 Bernice Mills-Thomas and Lee Francis. You should
13 both be able to speak now.

14 DR. FRANCIS: Thank you.
15 Bernice, do you want to go first?

16 MS. MILLS-THOMAS: Sure. Can you hear me?

17 MR. MITCHELL: Yes, we're hearing you.

18 MS. MILLS-THOMAS: Great. Sure. Can I
19 go now?

20 MS. AVERY: Yes, please start.

21 MS. MILLS-THOMAS: Thank you so much to
22 the Illinois Health Facilities Board for allowing
23 me the time to speak in support of Northwestern
24 Medicine.

1 Good afternoon. I'm Bernice Mills-Thomas,
2 as he just said. I'm the CEO of Near North Service
3 Corporation, a Federally qualified community health
4 center in the City of Chicago. The partnership
5 between Near North and Northwestern Medicine goes
6 back over more than 40 years, and over that time
7 we have cared for thousands of patients together,
8 offering the best primary care in Chicago at Near
9 North and aligning those patients with the best
10 specialty care here in Chicago through Northwestern
11 Medicine.

12 Working together we have served patients
13 from all of Chicago, north, south, and west. We
14 have collaborated on diabetes prevention, breast
15 cancer prevention, and colon cancer prevention
16 modules. Northwestern Medicine physicians see
17 patients at Near North sites for specialty services
18 like psychiatry, cardiology, and ophthalmology.

19 We also collaborated on the launch of the
20 Denny Clinic within the Lawson House YMCA, and
21 that's an on-site clinic designed to serve one of
22 Chicago's largest single-room occupancy facilities.

23 I believe strongly that collaborative
24 relationships in providing healthcare services

1 makes communities stronger. Unfortunately, there
2 are many barriers to that care that prevent families
3 in Chicago from receiving quality healthcare.
4 However, our longstanding relationship with
5 Northwestern Memorial strengthens Near North's
6 efforts to improve the health of Chicago residents.
7 For many years we have been building a powerful
8 network to improve healthcare services for Chicago
9 families.

10 Additionally, Northwestern Medicine has
11 provided millions of dollars in funds over the
12 years to support the operations of Near North. I
13 know that expansion of Northwestern Medicine's
14 services like the project before you today means
15 more access for our patients at Near North.

16 Again, I'd like to thank you for allowing
17 me to have this time to speak to you today.

18 Thank you.

19 CHAIRWOMAN SAVAGE: The next proponent,
20 please.

21 DR. FRANCIS: Hello and thank you to the
22 Illinois Health Facilities Board for the opportunity
23 today. I am Lee Francis. I'm the CEO of Erie
24 Family Health Centers, and Erie is a primary care

1 medical home to over 82,000 patients at 13 service
2 locations in Chicago, Evanston, Skokie, and
3 Waukegan. We formally collaborate with Northwestern
4 Medicine to provide access to specialty diagnostic
5 and inpatient services regardless of insurance
6 status and regardless of the ability to pay.

7 In 2019 Erie made a total of 31,734 referrals
8 to Northwestern Medicine. Half of these were for
9 screening and diagnostic studies such as mammograms
10 and other scans, and half were for specialists and
11 specialty care. About 50 percent were uninsured,
12 and most of the other 50 percent were low income
13 and on Medicaid and/or on Medicaid plans. Through
14 our collaboration with Northwestern Medicine these
15 services are provided without charge in the vast
16 majority of cases. In addition, Erie delivers about
17 1300 babies annually at Northwestern Prentice
18 Women's Hospital.

19 Here are just two examples from my own
20 practice as a physician at Erie.

21 Ms. R.D. received the full range of breast
22 cancer diagnosis and treatment, including screening
23 and diagnostic mammograms, biopsies, genetic
24 evaluation, and treatment, including complete

1 reconstructive surgery. She is low income and
2 does not qualify for insurance. The services are
3 without charge.

4 Mr. O.B. survived COVID-19. After
5 three weeks in Northwestern's COVID ICU, he is now
6 home and hopes to return to his family business as
7 a locksmith in Chicago. He was uninsured and the
8 services were provided free of charge.

9 Through a combination of hospital and
10 community-based programs over decades Northwestern
11 reaches our patients regardless of their insurance
12 status or their ability to pay, and their
13 expansions, whether in Chicago, Lake County, or
14 elsewhere, do directly benefit our patients.

15 Thank you for your time and for hearing
16 our testimony.

17 CHAIRWOMAN SAVAGE: Thank you.

18 Now if we can have the opponents speak.

19 (Audio reverberation.)

20 MS. AVERY: Anne, that's not going to work
21 because we're getting feedback.

22 MEMBER MURRAY: I'm sorry; we can't hear a
23 thing because we're getting echos.

24 CHAIRWOMAN SAVAGE: It's echoing, yes.

1 MS. AVERY: Mike, go ahead and mute her.
2 That's not going to work.

3 Okay. Can someone else go, Anne, while
4 you figure out how to get that person in to
5 provide testimony?

6 MR. MITCHELL: Is Greg Will available?

7 MR. WILL: I'm here. Can you hear me?

8 MR. MITCHELL: Yes.

9 MR. WILL: Okay. There appears to be
10 no echo?

11 CHAIRWOMAN SAVAGE: No, but please talk a
12 little bit louder.

13 MR. WILL: So I will -- I'll proceed.

14 My name is Greg Will. I am the research
15 director at SEIU Healthcare Illinois. My
16 colleagues will give testimony about some of their
17 experiences working with Northwestern physicians
18 at the hospital. I'll be speaking about what in
19 our view is key context to the Northwestern
20 Memorial Hospital's expansion application which to
21 us would require conditions --

22 CHAIRWOMAN SAVAGE: Sir, excuse me. Sir,
23 if you could talk a little bit louder; we cannot
24 hear you well.

1 MS. AVERY: Will -- go ahead and mute his
2 microphone, Mike -- oh, Will, can you hear us?

3 MR. WILL: Yeah, I can.

4 MS. AVERY: You're going to have to speak
5 louder. We're having a challenge on this end hearing
6 you. We need you to get closer to your mic.

7 MR. WILL: Okay. Is this better?

8 CHAIRWOMAN SAVAGE: Talk a little more.

9 MR. WILL: Is this better?

10 CHAIRWOMAN SAVAGE: For now, yes.

11 Thank you.

12 MR. WILL: Yeah, apologies for that and
13 I'm sorry it took a second for me to hear what you
14 were saying and fix it.

15 So I'm giving what we view is the key context
16 for Northwestern application's excluding lower
17 income communities nearby to Northwestern Memorial.
18 In the past couple of years Northwestern has grown
19 by building and acquiring in affluent suburban areas.
20 Bloomingdale is a good example of this.

21 Northwestern has now more than 600 patient
22 care sites. Zero of those are located in the
23 medically underserved communities on Chicago's
24 south and west sides, zero.

1 As I'm sure you're well aware, life
2 expectancy in some of those areas, 68 in Chatham,
3 70 Englewood, lack of access, as well as social
4 determents. As I'm sure you're aware, as well,
5 Northwestern Memorial Hospital has been under
6 investigation by IDPH for overusing emergency
7 department bypass in recent years. It was on
8 bypass more than 3,000 hours last year, 30 percent
9 of the time in 2018 and 2019. Studies suggest
10 putting the emergency department on diversion
11 personally harms African-American patients. While
12 Northwestern Memorial Hospital says it serves --

13 MR. ROATE: Two minutes.

14 MR. WILL: As you know, your needing to
15 sign these applications during a pandemic is
16 disproportionally affecting communities --

17 MR. ROATE: Two minutes.

18 MR. WILL: There's really no resource
19 question here. Northwestern Medicine's most
20 recent financials show \$12 billion in assets,
21 347 million net income over expenses, and a
22 \$6.2 billion investment portfolio. Northwestern
23 Medicine could expand access to care into
24 Chicago's lower income communities of color. It

1 could make investment decisions on that basis and
2 chooses not to.

3 Thank you.

4 CHAIRWOMAN SAVAGE: Next.

5 MR. MITCHELL: Okay. Anne Igoe should be
6 reconnected now. Anne, are you there?

7 MS. IGOE: Thank you. I'm here. Can you
8 folks hear me?

9 CHAIRWOMAN SAVAGE: Yes. Thank you.

10 MS. IGOE: Thank you, Health Facilities
11 Review Board, for taking the opportunity to hear
12 from us today. My name is Anne Igoe, and I'm the
13 health systems director and vice president for
14 SEIU Healthcare which represents 1200 workers at
15 Northwestern Memorial Hospital. As a critical
16 stakeholder, we are concerned about Northwestern
17 Medicine's plan to spend over \$100 million on
18 two new construction projects, specifically around
19 Projects 20-011.

20 As my colleague Greg stated earlier,
21 Northwestern has received multiple warnings from
22 IDPH about abusing emergency department bypass.
23 We are in support of Northwestern's decision to
24 expand its ICU capacity at Northwestern, but it's

1 crucial to point out that the two main factors
2 behind Northwestern's high bypass rates have
3 nothing to do with lack of beds or space; it has
4 to do with staffing, and it shows Northwestern's
5 seriously misplaced priorities when it comes to
6 how the healthcare system chooses to invest and
7 not to invest in black and brown workers, which
8 are primarily our members at Northwestern Memorial
9 Hospital. Our housekeepers, our scrub techs, our
10 emergency room techs are primarily African-American
11 and primarily women.

12 Northwestern is quick to invest in
13 facilities in communities where most people have
14 good private healthcare coverage and especially
15 middle class income and are primarily white.
16 Northwestern is slow to invest in adequate wages
17 black and brown workforce and even slower to open
18 medical facilities in black and brown communities
19 where too many lives are lost each year because of
20 lack of access to healthcare.

21 As the Union that represents Northwestern
22 workers and specifically the housekeepers who do
23 their best to keep the beds in the emergency room
24 and throughout the hospital clean and quickly

1 turned around, we are painfully aware of
2 Northwestern's interest towards staffing. Even in
3 the face of the pandemic Northwestern has continued
4 to maintain a barebones skeletal staff and
5 supplement with temporary workers, and that has
6 been a longstanding pattern. Northwestern has
7 been consistently understaffed in the housekeeping
8 department and has failed to fill vacant positions
9 in a timely fashion. Over the past year vacancies
10 in the housekeeping department have been upwards
11 of 20 to 25 percent of the department, placing the
12 burden on employees.

13 MR. ROATE: Two minutes.

14 MS. IGOE: For over 100,000 hours of unfilled
15 shifts, only 50,000 of were filled by temporary
16 workers --

17 MR. ROATE: Two minutes.

18 MS. IGOE: -- or overtime hours. That
19 meant that half of those shifts just did not get
20 filled.

21 Northwestern is understaffed because even
22 though the health system has billions in assets
23 and is a nonprofit with a publically stated
24 commitment to provide high-quality healthcare to

1 those who need it, it pays such low wages that it
2 cannot attract or retain a full staff. Starting
3 wages in the housekeeping department just increased
4 a month ago to 15.25, a mere \$1.25 over what
5 minimum wage will be tomorrow.

6 Northwestern's refusal to pay housekeepers
7 a living wage means that it's not enough for staff
8 to turn beds over quickly enough to avoid emergency
9 room bypass, and we unfortunately have every
10 reason to believe that Northwestern management
11 will not adequately staff the beds it wants to
12 add. Until Northwestern commits to adequately and
13 safely staff the ICU beds and properly fill all
14 vacancies, Northwestern will continue to struggle
15 with capacity and be forced to turn away ambulances
16 30 percent of the time, a rate higher than --

17 MR. MITCHELL: Wrap up your testimony,
18 please.

19 MS. IGOE: Okay.

20 We are calling on Northwestern to commit
21 to treating more Medicaid patients as they seek
22 support in the ICU expansion. Currently,
23 Northwestern Medicine only has --

24 MS. AVERY: Ma'am, we have to end it.

1 You're over the two minutes.

2 MS. IGOE: -- on Medicaid at their
3 flagship hospital --

4 MS. AVERY: Mike Mitchell, end her, please.

5 MS. IGOE: -- 20 percent compared to the
6 University of Chicago --

7 MS. AVERY: Anne, you have to conclude
8 your comments. Thank you.

9 MR. MITCHELL: Okay. I have Kimberly
10 Smith now connected.

11 Ms. Smith, are you there?

12 MS. SMITH: Yes.

13 MS. AVERY: Ms. Smith, please be aware
14 that you only have two minutes, and then we will
15 cut your mic.

16 MS. SMITH: Can you hear me?

17 MR. MITCHELL: You need to speak up.

18 MS. SMITH: Can you hear me now?

19 MS. AVERY: Barely.

20 CHAIRWOMAN SAVAGE: A little bit louder,
21 please.

22 MS. SMITH: Can you hear me better now?

23 MS. AVERY: Yes.

24 CHAIRWOMAN SAVAGE: Yes.

1 MS. SMITH: Sorry about that. So my name
2 is Kimberly Smith, and I'm here to speak on behalf
3 of SEIU -- as an employee of Northwestern, as well
4 as a member of SEIU.

5 We're here today because Northwestern has
6 seriously misplaced priorities. Northwestern has
7 millions and millions dollars, but they won't pay
8 us livable wages. So if Northwestern wants to go
9 on bypass, then that's their issue, but we're
10 trying to help them by saying that they would do
11 this by paying us livable wages, as they can
12 easily afford to do so. And this is something
13 with their assets they can do and ensure that it's
14 a safe environment for ourselves as well as our
15 patients.

16 You would like to think that instead of
17 wanting to have a new facility in a largely white
18 and well-off suburb where people have good health
19 insurance that they would open facilities in black
20 and brown communities on the west and south sides
21 where people are dying because of the lack of
22 healthcare. Bloomingdale already has a lot of
23 healthcare facilities, but communities like
24 Chatham, South Shore, and Englewood, they really

1 need more help here. Northwestern is acting as if
2 they are (audio interruption) people that need
3 money. They can come in and they don't care about
4 that that they have to travel. When people can't
5 get to Northwestern because of the lack of
6 healthcare, that's the reason we're asking that
7 they build up in these communities.

8 Northwestern doesn't need every penny that
9 they can get. We are asking that they go out and
10 take the billions in assets that they have and
11 count those pennies and do what they're supposed
12 to do which is right and live up to their
13 responsibilities to provide care for people who
14 really need it.

15 Thank you.

16 CHAIRWOMAN SAVAGE: Thank you. Next.

17 MR. MITCHELL: Is Marcus Buell available?

18 (Audio distortion.)

19 CHAIRWOMAN SAVAGE: Marcus?

20 (Audio distortion.)

21 CHAIRWOMAN SAVAGE: We can't hear you well.

22 MS. AVERY: Asim, you have your mic live.

23 (Audio distortion.)

24 MS. AVERY: Mike Mitchell, mute him, please.

1 Mitch, can you mute everyone?

2 Okay. Mitch, the next speaker, please.

3 Thank you.

4 MR. MITCHELL: That is all the online
5 commenting testimony that I have listed here.

6 MS. AVERY: Okay. We'll go with the
7 speakers.

8 CHAIRWOMAN SAVAGE: All right. So we had
9 our motion. So now if our applicants could
10 identify themselves for our court reporter and
11 then be sworn in, please. And we do have the
12 wipes and everything for in between you.

13 MS. CREAMER: Julie Creamer, president of
14 Northwestern Memorial Hospital, C-r-e-a-m-e-r.
15 Thank you.

16 Ms. ORTH: Bridget Orth, O-r-t-h.

17 MR. CHRISTIE: Rob Christie,
18 C-h-r-i-s-t-i-e, senior vice president of external
19 affairs, Northwestern Medicine.

20 MS. MURPHY: Lynn Murphy, director of
21 planning and construction.

22 MR. CALLAHAN: Dan Callahan, project
23 manager, Northwestern Medicine.

24 (Whereupon, five witnesses were thereupon

1 duly sworn.)

2 CHAIRWOMAN SAVAGE: Okay. Mike, please
3 present the State Board staff report.

4 MR. CONSTANTINO: Thank you, Madam Chair.

5 The applicants are asking the State Board
6 to approve the modernization and an increase in
7 the number of ICU beds by 24 for a total of 139 ICU
8 beds and an additional 38 medical surgical beds
9 for a total of 558 medical surgical beds.

10 The cost of the project is approximately
11 77.6 million, and the anticipated completion date
12 is December 31st, 2022.

13 Public hearing was held on June 15, 2020,
14 and that information, transcript, and public comment
15 is included in your packet of information. No
16 support or opposition letters were received by the
17 State Board staff.

18 Thank you, Madam Chair.

19 CHAIRWOMAN SAVAGE: Thank you. If you'd
20 like to proceed with your presentation now.

21 MS. CREAMER: Good afternoon. I'm Julie
22 Creamer, president of Northwestern Memorial
23 Hospital, and I also would like to thank all of
24 you. We know how challenging it is to do things

1 electronically with mute buttons and the like, so
2 thank you all for all of these arrangements. It
3 feels very safe and comfortable here.

4 MS. AVERY: Pull it close and speak as
5 loud as you can because it has to reach that
6 speaker.

7 MS. CREAMER: So by way of background,
8 I've been a nurse in Illinois for 40 years, and
9 I've been at Northwestern Memorial for 35 years of
10 my career.

11 MEMBER MURRAY: This presentation is hard
12 to hear.

13 MS. AVERY: Pull it close.

14 CHAIRWOMAN SAVAGE: Literally on top of it.

15 MS. AVERY: You can put a paper towel over
16 it if you need to.

17 MS. CREAMER: No, I'm okay. We can wipe
18 off in between.

19 MS. AVERY: Okay.

20 MS. CREAMER: I've been at Northwestern
21 for 35 years of my career in a variety of
22 positions starting out as an ICU nurse and a
23 surgical nurse, and I've had the privilege of
24 serving as the president for coming up almost on

1 five years.

2 I'm here before you today representing an
3 incredible group of doctors, nurses, and staff.
4 Every day they put forth our patients for its
5 mission, and the work they have done in the last
6 four months has been absolutely spectacular.

7 We start every day at the hospital with a
8 morning huddle. I meet with all of our medical
9 directors, department directors, and vice
10 presidents to talk about the past 24 hours and to
11 look ahead, are we prepared to take excellent care
12 of our patients for the next 24 hours. People are
13 encouraged to bring up problems if they have them,
14 and we work together as a team to solve them.

15 As I was first in my role in these huddles
16 and later validating it with data, I noticed that
17 we had patients waiting long times in the emergency
18 department, recovery room, putting in external
19 transfers, and we were going on diversion at a rate
20 that was unacceptable. This is only four years --
21 so this was five years ago. That was four years
22 after our last project was approved to add capacity
23 to the hospital.

24 Since the opening of Feinberg Galter 20 years

1 ago, the demand for inpatient care at NMH has
2 continued to increase significantly. This proposed
3 project is our fourth time before you asking for
4 more beds. We've taken many steps to accommodate
5 this volume. I know many of you are in healthcare.
6 Process improvement projects, decreased length of
7 stay, decreased readmissions, getting people out
8 earlier, providing transportation home, all of
9 those things have made a difference but it's not
10 enough. The simple fact is that we took care of
11 almost 11,000 more ICU and med/surg inpatients
12 last year than in 1999.

13 In the almost five years that I have been
14 president we're taking care of 180 more patients
15 every day, and we have added 1300 patient-related
16 FTEs to our staff. We've worked with the
17 Northwestern University McCormick School of
18 Engineering to help us better understand our
19 bottlenecks and our capacity constraints, and what
20 we've learned is that in any given area of the
21 hospital, if we run above 85 percent occupancy,
22 the wait times for beds increase exponentially.
23 It looks like a hockey stick.

24 As stated in our CON application, while

1 our ambulance diversion rates were high in 2017 and
2 2018, we have worked very collaboratively with the
3 IDPH, and we've significantly decreased that
4 diversion rate. I'm very proud to tell you in the
5 last year it has been 3.9 percent.

6 The way we've done this is by putting
7 staffing in place to take care of patients waiting
8 in the ED and the recovery room, and although this
9 is a safe solution, it's not the best patient
10 experience. Anybody who has been in an ED or
11 recovery room, you would like to get to your bed
12 as soon as possible.

13 During the past four months of our COVID
14 period, our overall bed occupancy was much more
15 than usual. We stopped all our elective surgeries;
16 we've made room for our COVID patients, and during
17 this time we actually eliminated wait times in the
18 ED and in the recovery room for beds, and so it
19 gave me a lot of confidence that having more beds
20 will absolutely help.

21 The additional bed capacity that we are
22 seeking is going to improve healthcare for the
23 residents of the City of Chicago, Cook County, and
24 surrounding counties, and this will help us to

1 build our tertiary, our very high-end acuity
2 programs, particularly cardiac care, we have a lot
3 of bottlenecks there. The American Heart Association
4 reported earlier this year that an American dies
5 every 37 seconds from cardiovascular disease. In
6 2019/2020 our cardiovascular program at Northwestern
7 was ranked in the top 10 in the United States, and
8 this is a reflection of the leading edge care that
9 we provide to all at Northwestern.

10 According to the Centers for Medicare and
11 Medicaid Services, Northwestern Memorial Hospital
12 is the only hospital in the U.S. to achieve
13 exceptional high-quality outcomes at the lowest
14 possible costs, and this is in two big public
15 health risks, heart failure and heart attack.

16 We have good news in Illinois. According
17 to IDPH data, from 2000 to 2018 Cook County
18 mortality rates for deaths due to diseases of the
19 heart actually decreased from 30 percent to
20 24.8 percent, and we feel that we've been a real
21 contributor and want to continue our work to
22 decrease this mortality rate. As one of the largest
23 providers of inpatient services in Chicago, we
24 believe we're well positioned to do this, and the

1 increase in bed capacity will allow for it.

2 You've heard earlier from some of our
3 partners additional beds serve the entire Chicago
4 community. For over 40 years we have had these
5 strong and successful relationships with the
6 two Federally qualified health centers that you
7 heard from earlier. They have 28 locations
8 throughout many disadvantaged communities in
9 Chicago, and through this excellent relationship
10 with Near North and Erie Family Health we serve as
11 the primary referral hospital for subspecialty
12 care and diagnostic needs for thousands of
13 patients that they care for each year. We were
14 also able to supply our FQHC partners with PPE and
15 serve their patients in need of COVID testing.

16 By serving all of Chicago through these
17 local FQHC facilities, our Medicaid admissions at
18 NMH jumped to the sixth highest in the state last
19 year reaching 8,975 Medicaid patients. We provided
20 over 49,000 Medicaid inpatient days. Those
21 Medicaid numbers exceed all hospitals in Chicago
22 except for AMITA Presence Saint Mary of Nazareth.
23 NMH is recognized by the State as a high-Medicaid
24 hospital, and in addition, NMH is the largest

1 provider of charity care in Illinois second only
2 to Cook County Health and Hospital System.

3 During the pandemic approximately 45 percent
4 of the 1300 COVID patients who were treated as
5 inpatients at NMH reside in the neighborhoods
6 identified by the Chicago initiative to improve
7 health and reduce violence in the underserved
8 communities across Chicago.

9 And our commitment to serve all of Chicago
10 continues. We are currently in discussion with the
11 City of Chicago to acquire several parcels of land
12 in one of Mayor Lightfoot's INVEST South/West
13 communities to develop a 75,000-square-foot building
14 that could house things such as immediate care,
15 primary and specialty care, along with community
16 and retail space. We had our first meeting with
17 the City's Department of Planning and Development
18 on June 19th, and we hope to have more formal news
19 on this project in the coming weeks.

20 The COVID-19 pandemic has demonstrated
21 once again the need for continued investment in
22 healthcare infrastructure and flexible capacity.
23 Thanks to the flattening of the curve in Illinois
24 our COVID volume has come down from our high of

1 185 patients in our hospital, a third of those in
2 the ICU, most of them on ventilators, and I'm
3 happy to tell you today we have 44 patients.

4 But we do expect to always have some level
5 of COVID patients with us. This virus is not
6 going anywhere. It's a new disease. We know the
7 initial presentation is difficult, and there are
8 other emerging neurologic and cardiovascular
9 implications of this disease. This new patient
10 population puts an additional strain on beds that
11 was not anticipated at the time of our
12 CON application, making this project even more
13 vital to serve our community.

14 Thank you.

15 MS. ORTH: We would like to thank the
16 State staff for their guidance and review of our
17 project. We are pleased to have an almost all
18 positive State staff report. Out of the 16 review
19 criteria evaluated, we received only one negative
20 that I would like to address now.

21 The one negative that we received relates
22 to the State size criteria. Both the ICU unit and
23 med/surg unit are larger than the State standard
24 primarily due to the fact that we are constructing

1 these units in an existing business occupancy
2 floor plate. As with our project 10 years ago
3 that converted the 9th, 10th, and 13th floors of
4 this building from physician offices to beds, the
5 structural grid and large floor plate creates
6 excess space in the core and forces redundancy
7 such as additional nursing units, supply closets,
8 et cetera. The proposed units are based on the
9 previously approved CON project for the 9th, 10th,
10 and 13th floors. Additionally, the med/surg unit
11 includes 12 observation beds for which there is no
12 State size standard and therefore was not included
13 in the State's calculation of necessary square
14 footage for the med/surg unit.

15 Lynn Murphy can address additional
16 questions on this issue, or we're happy to take
17 any questions the Board may have.

18 CHAIRWOMAN SAVAGE: Okay. Do any of our
19 Board members have any questions?

20 MEMBER KAATZ: I do.

21 MEMBER MURRAY: Yes, I have a question.

22 MEMBER KAATZ: I'll defer.

23 MEMBER MURRAY: So when you've done
24 projections on these ICUs and capacity, I know you

1 expanded your ICUs during our last surge of
2 COVID-19, but how -- given the possibility that we
3 could be in a COVID state off and on for the next
4 two to five years, how does that impact your
5 projections on this expansion? Also, will this
6 construction reduce the number of beds even
7 temporarily?

8 MS. ORTH: I can answer that. The
9 construction will not reduce the beds because
10 there were physician practices that were on these
11 floors in the business occupancy of the Feinberg
12 Galter Pavilion.

13 MEMBER MURRAY: I'm sorry; you kept going
14 in and out. So you're saying that the
15 construction will not even temporarily reduce
16 ICU beds; is that correct?

17 MS. ORTH: That is correct.

18 MEMBER MURRAY: And then in terms of
19 future capacity, which I know is extremely hard to
20 predict, but there is a real possibility that we
21 could be having COVID patients for a number of
22 years, as some sort of studies state. What has
23 been your thinking about that?

24 MS. CREAMER: It's a great question. We've

1 been thinking a lot about that. This project will
2 absolutely help us. And the way that we were able
3 to flex up to 170 ICU beds during the COVID surge
4 was by converting surgical beds, and medical beds,
5 and even some observation beds to ICU beds. We
6 have the benefit of being able to convert to
7 negative air flow in many of our rooms, which was
8 important for the ICU, and we have plans in place,
9 every hospital in the state has plans in place to
10 be able to surge up at least 20 percent if we need
11 to do that. We all have existing emergency
12 management plans that can be activated if needed.

13 The other good thing about COVID, even
14 though the patients come, you have a little bit of
15 time. When we first opened our command center,
16 within a week we had 57 COVID patients; in two weeks
17 we had 122. So it gave us enough time, and we
18 have solid plans in place and triggers for knowing
19 when we would need to again do things like cancel
20 postponable surgeries and the like to accommodate
21 COVID.

22 It's a really important question.

23 Thank you.

24 MEMBER MARTELL: I also have a question,

1 Madam Chair.

2 CHAIRWOMAN SAVAGE: Yes, Dr. Martell.

3 MEMBER MARTELL: Given that we've had people
4 testify about their concerns regarding staffing at
5 these particular facilities, can you explain how
6 you, you know, with the expansion propose to maintain
7 the staffing levels that are needed to keep these
8 really functional staffed beds?

9 MS. CREAMER: Absolutely. Having the beds
10 without staffing doesn't put us anywhere.

11 You know, we've had very good success in
12 filling open positions. In fact, I just looked at
13 our vacancy rate where we are today. In EBS today
14 we have 17 open positions out of 490; that's a
15 3 1/2 percent vacancy. Patient escort, 1 open out
16 of 55, that's a 1.8 percent vacancy.

17 The two places where we're having a little
18 trouble is our OR scrub techs, right now we have
19 33 open positions, and our pharmacy techs. So
20 with our most recent work with the union we were
21 able to change the wages, and I think that we'll
22 be well on our way.

23 Of note, those two positions don't really
24 impact the bed problem that we talked about. And

1 since I have been the president I can tell you with
2 100 percent certainty we have never gone on diversion
3 because we didn't have enough housekeepers. We're
4 able to pull staff off of public areas and other
5 places. Patient care is our top priority. We
6 look at this every morning in the huddle, and it's
7 all hands on deck if we have a lot of call-ins or
8 other problems.

9 But staffing is critical. We have to have
10 the right people who know how to do their jobs well
11 to deliver on our patients' first mission, and as
12 a nurse who worked in the ICU I know how important
13 that is.

14 Thank you.

15 CHAIRWOMAN SAVAGE: Gary.

16 MEMBER MARTELL: And I have another question
17 regarding the square footage that seems higher than
18 the State standard. Can you -- anyone provide
19 additional detail on why that was determined to be
20 needed?

21 MS. MURPHY: I can answer that.

22 MS. AVERY: Really loud.

23 MS. MURPHY: This is Lynn Murphy. I'm
24 director of planning and construction. As Bridget

1 had explained at the beginning, one of the reasons
2 that our square footages are so much higher is
3 because of the floor plate that we are working
4 with. The way this floor is structured, it's
5 requiring us to have additional nurse stations,
6 supply closets, things like that in order to
7 provide the correct care. And we utilize obviously,
8 the exterior of the building for the windows for
9 the patient rooms, but it just is a very large floor
10 plate that requires some redundancy of services.

11 CHAIRWOMAN SAVAGE: Gary.

12 MEMBER KAATZ: A couple questions. I'm
13 Gary Kaatz.

14 First of all, with your current 115-bed
15 ICU complement, do you have subspecialization so
16 you have -- tell me about that, please.

17 MS. CREAMER: If you're familiar with
18 tertiary care centers, what we bring is
19 subspecialty care. And so we do have subspecialty
20 care in each of the ICUs, but we have very good
21 ability to flex to ICU as needed, and I think the
22 COVID time period was a great example of being
23 able to do that. We needed a lot of pulmonary
24 critical care medicine in the ICU, and so we were

1 able to staff up for those areas. So yes, we do
2 provide subspecialty care but we have flexibility.

3 MEMBER KAATZ: Are all of your 115 beds
4 now located next to each other or in the same unit?

5 MS. CREAMER: No, they're spread across
6 the Galter and Feinberg pavilions, but this is why
7 the connector is so important. So we have them
8 connected by a connector. So when we built the
9 other units, that's what we did and that's what we
10 would propose to do here, as well. So they're
11 contiguous but they're technically in two different
12 buildings. With a connector you would never know.

13 MEMBER KAATZ: So this new unit won't be
14 like miles away from this establishment?

15 MS. CREAMER: No. So we had a lot of
16 input from our physicians, our surgeons, and those
17 are very, very important points to make sure that
18 they're located in a place that makes sense.

19 MEMBER KAATZ: Roughly how many of your
20 ICU admissions are direct admits versus coming
21 through the ER just roughly?

22 MS. CREAMER: I don't know if I can -- if
23 I was just going to say off the top of my head --

24 MEMBER KAATZ: Yeah, yeah.

1 MS. CREAMER: -- probably 30 to 40 percent
2 ED and maybe the rest transfers, surgical cases.
3 It might be a little higher than that if I include
4 the surgical trauma that comes in through the ED.

5 MEMBER KAATZ: Thank you.

6 CHAIRWOMAN SAVAGE: And then with your
7 additional beds that you're proposing, will some
8 of those be isolation rooms?

9 MS. CREAMER: Yes. And Lynn will correct
10 me if I'm wrong but they will be. And the other
11 great thing that we learned about the Galter
12 pavilion, which is where these beds will be, that
13 whole building can be converted to negative air
14 flow. This was a lifesaver for us and our
15 patients.

16 And I'll just tell one quick story. Our
17 facilities people did amazing things changing
18 these rooms, and we got to go up and visit them on
19 the mechanical floor where they actually monitor
20 every room 24/7. If they worry about a room, they
21 have a device that they bring, and they slide it
22 under the door to do a diagnostic. So we're really,
23 really proud of the work done by that team.

24 CHAIRWOMAN SAVAGE: And then I see that

1 the hospital had a 3.5 percent annual increase in
2 med/surg patient days over a five-year period. Do
3 we have any idea why that would be?

4 MS. CREAMER: Well, I think our overall
5 volumes have just been increasing med/surg and
6 ICU. Is that your question?

7 CHAIRWOMAN SAVAGE: Right.

8 MS. CREAMER: To be honest with you, right
9 now we're getting to a place where we're not going
10 to be able to grow because of our capacity
11 constraints. We are doing a lot of work, for
12 example, with our surgeons on smoothing the surgical
13 schedule because if we can do more surgeries on
14 Friday and Saturday with short-length-of-stay
15 patients, we can take advantage of our bed day
16 drop that happens on the weekend. And this is why
17 when you look at the aggregate numbers over time,
18 between weekends and holidays it kind of takes
19 those 95 percent days down.

20 So we've had pretty good cooperation with
21 that. It's a culture change. Patients actually
22 like it, so we're going to continue to work on that.

23 CHAIRWOMAN SAVAGE: Okay. Thank you.

24 Does anyone else have any other questions?

1 (No response.)

2 CHAIRWOMAN SAVAGE: Okay. George, can you
3 call the roll, please.

4 MR. ROATE: Thank you, Madam Chair.

5 Motion made by Dr. Martell, seconded by
6 Mr. Kaatz.

7 Senator Demuzio.

8 MEMBER DEMUZIO: Yes, based on the staff
9 report particularly.

10 MR. ROATE: Thank you.

11 Mr. Kaatz.

12 MEMBER KAATZ: Yes. Based on the merits
13 of the presentation and the plan itself, the
14 documentation of the situation, yes, I vote yes.

15 MR. ROATE: Thank you.

16 Dr. Martell.

17 MEMBER MARTELL: Yes, based on the staff
18 report.

19 MR. ROATE: Thank you.

20 Dr. Murray.

21 MEMBER MURRAY: I'm voting yes based on
22 the staff report and testimonies.

23 MR. ROATE: Thank you.

24 Mr. Slater.

1 MEMBER SLATER: Yes, based on staff report.

2 MR. ROATE: Thank you.

3 Chairwoman Savage.

4 CHAIRWOMAN SAVAGE: Yes, based on staff
5 report and testimony.

6 MR. ROATE: Thank you.

7 That's 6 votes in the affirmative.

8 CHAIRWOMAN SAVAGE: The application for
9 permit is approved.

10 MS. CREAMER: Thank you so much.

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1 MS. AVERY: Anne Igoe, are you still on
2 the phone -- on the thingy.

3 MS. IGOE: This is Anne Igoe. Did you
4 just announce --

5 MS. AVERY: Yes, I did.

6 MS. IGOE: -- for the next project?

7 MS. AVERY: Yes, I did. I sent you an
8 email. Do you have anyone for Project No. 20-013,
9 the medical office building?

10 MS. IGOE: So as I stated earlier, my name
11 is Anne Igoe, and I serve as vice president for
12 our hospital for SEIU healthcare, and we are here
13 in opposition to Project 20-13.

14 We are protesting Northwestern's misplaced
15 priorities when it comes to their decision to
16 invest 30 million in a medical office building in
17 Bloomingdale while many Northwestern patients
18 struggle with racial and economic health
19 disparities and cannot access basic health
20 services in their communities.

21 Bloomingdale is a primarily white community
22 with an abundance of healthcare facilities, a high
23 life expectancy rate, a low uninsured rate, and a
24 relatively high household income, definitely not a

1 community that is hurting for healthcare or
2 healthcare access.

3 It is not a fluke that Northwestern Medicine
4 is asking to open a new facility in a community
5 that doesn't need a new facility. Of Northwestern
6 Medicine's 600-plus patient care sites, none are
7 located in the medically underserved communities
8 of Chicago's south or west sides.

9 Yes, Northwestern now proposes to add yet
10 another suburban facility while continuing to shun
11 Chicago's neediest communities. Enough is enough.
12 Northwestern is one of the largest and deepest
13 pocketed health systems in Illinois. It has a
14 moral obligation and the financial resources to
15 invest in bringing affordable and acceptable
16 healthcare to the black and brown communities on
17 Chicago's south and west sides that experience the
18 greatest need for services. In these communities
19 people are literally dying for the lack of access
20 to care as evidenced by life expectancy as much as
21 30 years lower in these communities than in some
22 of the more affluent neighborhoods where Northwestern
23 Medicine tends to operate.

24 Northwestern Medicine has no business opening

1 a new facility in Bloomingdale while people are
2 suffering and dying due to a lack of care on
3 Chicago's south and west sides. Specifically I
4 refer you to the neighborhoods of Auburn Gresham,
5 Rosewood, and Chatham that are some of the highest
6 users and utilizers of the emergency room for
7 which they're requesting expansion and yet don't
8 have access to a nearby Northwestern Medicine
9 facility.

10 MR. ROATE: Two minutes.

11 MS. IGOE: Thank you.

12 MR. MITCHELL: Do we have testimony from
13 Greg Will or Kim Smith on this project?

14 MR. WILL: This is Greg Will. Can you
15 hear me?

16 MR. MITCHELL: Yes.

17 MR. WILL: I do have testimony. It will
18 be brief. Again, I'll be speaking in the context
19 of this application for us. I'm being brief
20 because it's similar to what was at issue in the
21 previous application you considered.

22 As mentioned before, Northwestern has
23 grown from flagship to being a system by building
24 and acquiring in suburban areas. Bloomingdale

1 fits this pattern.

2 My main point is just to indicate kind of
3 what we're talking about to draw a contrast.
4 Bloomingdale has plenty of health services,
5 including two existing Northwestern facilities, an
6 uninsured rate of 4 percent, household income of
7 over 85,000 a year.

8 Again, there's medically underserved
9 communities on Chicago's south and west sides near
10 to the Northwestern flagship where the system does
11 not have a site of care. The roughly 30 million
12 Northwestern proposes to spend in Bloomingdale
13 could go a very long way and better spent if
14 invested by Northwestern in those communities.

15 CHAIRWOMAN SAVAGE: Thank you. Any other
16 speakers?

17 MR. MITCHELL: Does Kimberly Smith want to
18 testify to this project?

19 (No response.)

20 MR. MITCHELL: Ms. Smith.

21 MS. SMITH: Can you hear me?

22 MR. MITCHELL: Okay. Thank you. So let
23 me reintroduce myself. My name is Kim Smith. I'm
24 a patient care tech at Northwestern, and I've been

1 there for 17 years. The reason that I'm speaking
2 out in regards to this project is because, again,
3 as an employee of Northwestern and being there for
4 several years, I see the comings and goings in the
5 building continuously of every area except the
6 south and west sides. Predominantly the employees
7 that work there, we live in these areas, and
8 nothing is in close proximity to us.

9 The fact that they are building this
10 facility and not thinking about the workers, so
11 when you think about the situation that just
12 transpired for the pandemic and how it affected us
13 as employees directly and how we were going
14 without, and to know now that our employer has
15 notified us that we're going without certain
16 contributions or increases to our wages in order
17 to ensure that we have livable wages, but the
18 economy still goes on we feel is a disservice to
19 us and is a disservice to our community directly.

20 We know that the pandemic started, and we
21 were considered essential workers because we know
22 we are essential workers, and that we have several
23 people, housekeepers, transporters, techs that
24 were affected directly with the spread of the

1 infection, not being allowed to get any workers'
2 compensation, continuously going without income,
3 but yet still the facility Northwestern continues
4 to build as if we do not have an important role.
5 So, in fact, minimum wage goes up this week, and
6 we're just a little above it, that's not fair to
7 us. You know, when we don't have to pay to live --
8 because we can't afford to live where we're
9 working, so we have to commute a far distance.
10 When you think about people not having the right
11 to make enough money so we can pay our rent, pay
12 our utilities, even have food on the table. This
13 is the easiest way for Northwestern to stop going
14 on bypass, this is the easiest way for them to be
15 able to fix the real problem that they have.
16 Northwestern wants to put millions and millions of
17 dollars into a facility that's going to be an
18 office building instead of facilitating what we
19 have already.

20 MR. ROATE: Two minutes.

21 MS. SMITH: This is the issue and concern
22 that we have when we're talking about the building
23 of this building. Thank you.

24 CHAIRWOMAN SAVAGE: Thank you. And those

1 are the only participants, correct, Mr. Mitchell?

2 MR. MITCHELL: I need to ask if Bernice
3 Mills-Thomas has any comment on this project. Are
4 you there, Bernice?

5 (No response.)

6 MR. MITCHELL: Apparently not. So I guess
7 that's all the testimony.

8 CHAIRWOMAN SAVAGE: Okay. Thank you so
9 much. So next on the agenda --

10 MS. AVERY: I see her listed, Mitch. I
11 just want to make sure that they know we called
12 her because I see her listed as an attendee and
13 her mic is muted.

14 MR. MITCHELL: What was that, Courtney?

15 MS. AVERY: I see that she's listed on the
16 attendees.

17 MR. MITCHELL: Yes. I unmuted her and I
18 asked if she was there, but I didn't get any
19 response.

20 MS. AVERY: Okay. Thank you.

21 MR. MITCHELL: I'll ask one last time.

22 MS. AVERY: Would you, please.

23 CHAIRWOMAN SAVAGE: Bernice, are you
24 interested in speaking on this project?

1 (No response.)

2 MS. AVERY: Okay. Thank you, Mitch.

3 CHAIRWOMAN SAVAGE: So on our agenda we
4 have Project H-04, Project 20-013, Northwestern
5 Medicine Bloomingdale, medical office building,
6 Bloomingdale. May I have a motion to approve
7 Project 20-013, Northwestern Medicine Bloomingdale
8 to establish a medical office building in
9 Bloomingdale.

10 MEMBER KAATZ: I'll move.

11 CHAIRWOMAN SAVAGE: Gary has moved. May I
12 have a second? Board members, you are muted so
13 unmute.

14 MS. AVERY: Dr. Murray?

15 MEMBER MURRAY: Yes, I'll second.

16 CHAIRWOMAN SAVAGE: You're sworn in
17 already.

18 So can you proceed, Mike, with your State
19 Board report?

20 MR. CONSTANTINO: Thank you, Madam Chair.
21 The applicants are proposing to establish a
22 medical office building to house physician office
23 space, diagnostic imaging, and physical therapy.
24 The proposed building will be located in

1 Bloomingdale, Illinois. The cost of the project
2 is approximately 28.9 million, and the expected
3 completion date is June 30th, 2022.

4 There was a public hearing on this project.
5 We did receive comments at that public hearing.
6 We did not receive any support or opposition
7 letters by the State Board staff.

8 Thank you, Madam Chair.

9 CHAIRWOMAN SAVAGE: Thank you. And if
10 you'd like to proceed with any presentation.

11 MS. ORTH: Great thanks. Again, I'm
12 Bridget Orth, director of regulatory planning for
13 Northwestern Medicine. We are before you today
14 with our proposed Bloomingdale medical office
15 building.

16 While our legacy has had a presence in
17 this location for 14 years, this project allows us
18 to consolidate three medical office sites located
19 within 5 miles of each other into one larger
20 modernized location.

21 The consolidation will improve efficiency,
22 accommodate existing demand for Northwestern
23 Medicine services, and allow for the colocation of
24 specialty services. The colocation of services

1 will increase collaboration among different
2 providers and provide wider coordination of
3 secondary care. At the same time the colocation
4 of services will drive cost efficiencies by
5 reducing duplication of technology and equipment.

6 Northwestern Medicine is strategically
7 focused on providing ambulatory access points
8 across our service areas to improve our ability to
9 meet the needs of our patients where they live and
10 work. Many factors are evaluated in determining a
11 location of MN Medical office buildings such as
12 drive time to an NM hospital, the ability -- the
13 availability of appropriate space, and community
14 need.

15 From increasing efficiencies and
16 streamlining access in Bloomingdale, to building
17 on existing community relationships to identify
18 and build an NM site on the south side of Chicago,
19 as we stated in our earlier testimony, we look
20 forward to bringing forward future sites for your
21 consideration throughout our service areas to
22 better serve our communities.

23 The communities served by Northwestern
24 Medicine are complex and diverse, encompassing

1 rural, suburban, and urban areas with a range of
2 socioeconomic statuses and social determinates of
3 health that correspond to those demographics.
4 Northwestern Medicine is committed to providing
5 care that takes into consideration the cultures
6 and environments in which our patients live and
7 work and is responsive to their needs.

8 In order to assess those needs, every
9 three years each Northwestern Medicine Hospital
10 conducts a community health needs assessment.
11 Each CHNA includes robust data collection,
12 including direct input from community members in
13 order to identify and prioritize the greatest
14 health needs of the individual community.
15 Northwestern Medicine works closely with community
16 partners throughout Chicagoland, including health
17 and social service partners to jointly develop
18 community-based health initiatives designed to
19 address identified health needs and work to reduce
20 healthcare disparities.

21 In the Chicago community most directly
22 served by Northwestern Memorial Hospital, we have
23 made significant investment, including workforce
24 development and local hiring and purchasing

1 practices in the most vulnerable zip codes through
2 out partnership with Senator Dick Durbin's Hospital
3 Engagement Action and Leadership or the HEAL
4 initiative.

5 Northwestern Medicine has cultivated
6 long-standing relationships with FQHCs and free
7 care clinics, including Erie Family Health Center,
8 Near North Health Service Corporation, and
9 Community Health to provide convenient, culturally
10 appropriate care for medically underserved
11 populations. We also collaborate with community
12 partners such as Bright Star Community Outreach
13 and Kelly Hall YMCA to address the underlying
14 social determinates of health.

15 The Greater DuPage County community is
16 most directly served by Northwestern Medicine
17 Central DuPage Hospital as well as through a
18 network of Northwestern Medicine diagnostic and
19 immediate care sites. Through its most recently
20 conducted CHNA, NMCDH is working to improve the
21 health of its community and decrease health
22 disparities by prioritizing the community health
23 needs of 1) access to healthcare services,
24 2) chronic disease, and 3) mental health and

1 substance abuse.

2 To address these needs Northwestern
3 Medicine has made significant investments in
4 community health education, provided funding to
5 local community health and social services
6 providers, and established strong partnerships
7 with area schools and health departments.
8 NMCDH has cultivated a long-standing partnership
9 with DuPage Health Coalition which works to make
10 healthcare more accessible for lower income
11 families seeking high quality care.

12 NMCDH is a significant supporter of DuPage
13 Health Coalition's Access DuPage program which
14 directly provides healthcare services to
15 low-income DuPage residents. In 2016 Northwestern
16 Medicine entered into a formal agreement with
17 VNA Healthcare, a patient-centered community-based
18 nonprofit healthcare provider serving lower income
19 residents of Chicago suburbs in order to create a
20 streamlined process for referring patients to
21 Northwestern Medicine facilities.

22 Northwestern medicine continues to invest
23 in our communities to improve residents' health
24 status, to reduce health disparities, and to

1 provide increased accessibility to healthcare
2 services for all residents. To do so we invest in
3 programs, community partnerships, and our people,
4 as well as facilities. A site such as the
5 Bloomingdale medical office building is only
6 one version of this investment.

7 The proposed Bloomingdale medical office
8 building will increase access to care and improve
9 efficiencies for the greater DuPage County
10 community. The proposed site is conveniently
11 located less than 7 miles away from NMCDH, who is
12 by far the largest provider of both Medicaid and
13 charity care in DuPage County. If our project is
14 approved today, the medical office building will
15 be open in early 2022, providing convenient access
16 to an immediate care center, diagnostic imaging,
17 physical therapy, primary care providers, and
18 specialty care providers.

19 We would like to thank the Board staff for
20 their guidance in review of this project. The
21 project is in full compliance with all applicable
22 Board criteria which is reflected by an
23 all-positive State staff report. We're happy to
24 answer questions the Board may have.

1 CHAIRWOMAN SAVAGE: Does the Board have
2 any questions.

3 MEMBER KAATZ: Madam Chair.

4 CHAIRWOMAN SAVAGE: Gary, go ahead.

5 MEMBER KAATZ: If I read your application
6 correctly, you're basically -- I'm sorry -- if I
7 read it right, you're going to consolidate
8 two existing offices into one new one.

9 MS. ORTH: Actually, three.

10 MEMBER KAATZ: And the new one is
11 basically going to be advanced radiology with an
12 MRI, et cetera, and physical therapy?

13 MS. ORTH: Correct, and then physician
14 practices.

15 MEMBER KAATZ: That was what I was leading
16 to. So do you envision like rheumatology being
17 there?

18 MS. ORTH: Dan knows the specifics on
19 which physicians are going in.

20 MR. CALLAHAN: This is Dan Callahan,
21 project manager.

22 Rheumatology is currently not in there,
23 but there are plans for expansion of that RMG,
24 practice or Regional Medical Group practice.

1 The practices that are currently going to
2 be going in there are primary care, GI, endo,
3 cardiology, ortho, and then like previously said,
4 diagnostic imaging, as well as physical therapy
5 and immediate care.

6 MEMBER KAATZ: Could you give me an example,
7 please, of -- you've mentioned this a couple of
8 times -- how you're really viewing this project as
9 being cost effective compared to what is currently
10 going on now?

11 MS. ORTH: Are you referring to how to
12 prioritize this project versus other things?

13 MEMBER KAATZ: Yes.

14 MS. ORTH: Two of the facilities that are
15 being consolidated were leases, so we didn't own
16 them. So part of the reason why this one is on a
17 more advanced time line is because we had to
18 decide whether to renew those leases or to make
19 the move.

20 MEMBER KAATZ: So you're doing away with
21 two existing leases?

22 MS. ORTH: Correct.

23 MEMBER KAATZ: And building a new facility
24 that you will own?

1 MS. ORTH: Correct.

2 MEMBER KAATZ: Perfect. Thank you.

3 CHAIRWOMAN SAVAGE: Any other questions
4 from the Board?

5 (No response.)

6 CHAIRWOMAN SAVAGE: Okay. George, if you
7 can call the roll, please.

8 MR. ROATE: Thank you, Madam Chair.

9 Motion made by Mr. Kaatz seconded by Dr. Murray.
10 Senator Demuzio.

11 (No response.)

12 MR. ROATE: I'll come back.

13 Mr. Kaatz.

14 MEMBER KAATZ: I vote yes based on the
15 staff report and the presentation.

16 MR. ROATE: Thank you, sir.

17 Dr. Martell.

18 MEMBER MARTELL: Yes, based on the staff
19 report.

20 MR. ROATE: Thank you.

21 Dr. Murray.

22 MEMBER MURRAY: I vote yes based on the
23 staff report.

24 MR. ROATE: Thank you.

1 Mr. Slater.

2 MEMBER SLATER: Yes, based on staff report.

3 MR. ROATE: Thank you.

4 Senator Demuzio.

5 MEMBER DEMUZIO: George?

6 MR. ROATE: Yes, ma'am.

7 MEMBER DEMUZIO: Did you call my name?

8 MR. ROATE: Yes.

9 CHAIRWOMAN SAVAGE: How do you vote,
10 Senator Demuzio?

11 MEMBER DEMUZIO: I vote yes based on the
12 staff report and the testimony.

13 MR. ROATE: Thank you.

14 Chairwoman Savage.

15 CHAIRWOMAN SAVAGE: I vote yes based on
16 the State Board report.

17 MR. ROATE: Thank you. That's 6 votes in
18 the affirmative.

19 CHAIRWOMAN SAVAGE: Your application is
20 approved. Thank you.

21 (Recess taken, 2:38 p.m. to 2:44 p.m.)

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1 CHAIRWOMAN SAVAGE: Do we have any public
2 participation for Lincoln Park Gastroenterology
3 Center?

4 MR. MITCHELL: No, I don't believe we have
5 any online testimony.

6 CHAIRWOMAN SAVAGE: Okay. Thank you. So
7 next on our agenda is H-05, Project 20-012,
8 Lincoln Park Gastroenterology Center, Chicago.

9 May I have a motion to approve
10 Project 20-012 to establish a single specialty
11 ambulatory surgical treatment center in Chicago.

12 MEMBER MURRAY: This is Dr. Murray. I
13 so move.

14 MEMBER MARTELL: This is Dr. Martell. I
15 second.

16 CHAIRWOMAN SAVAGE: Thank you. So please
17 introduce yourselves and then be sworn in.

18 MR. BAIRD: Thank you. Would the Board
19 mind if I remove my mask to be able to speak?

20 Okay. Great. My name is John Baird. I'm
21 the president and CEO of AMITA St. Joseph's
22 Hospital in Chicago.

23 CHAIRWOMAN SAVAGE: We're not having
24 testimony right now. You're just introducing

1 yourselves and being sworn in.

2 MR. BAIRD: Okay. And I'll introduce my
3 colleagues. To my left is Dr. Lawrence Gluskin.
4 Dr. Gluskin has been a practicing gastroenterologist
5 at AMITA St. Joseph's since 1983 and current
6 chairman of the section of gastroenterology and
7 the medical director of the proposed ASTC. And to
8 my right is Jack Axel, our CON consultant. And
9 also to my left is Darcy Lorenzen, vice president
10 of Digestive Health, Bariatric and Women's
11 Services - AMITA Health.

12 THE COURT REPORTER: Will you all raise
13 your right hands.

14 (Four witnesses were duly sworn.)

15 CHAIRWOMAN SAVAGE: Thank you.

16 Mike, would you please present the State
17 Board staff report.

18 MR. CONSTANTINO: Thank you, Madam Chair.

19 The applicants are proposing the
20 establishment of a single specialty ASTC in
21 Chicago, Illinois on the campus of Presence
22 St. Joseph's Hospital in Chicago. The cost of the
23 project is approximately \$8 million, and the
24 expected completion date is October 31st, 2021.

1 Thank you.

2 CHAIRWOMAN SAVAGE: Thank you.

3 Okay. If you'd like to proceed with your
4 presentation.

5 MR. BAIRD: Great. Again, I want to thank
6 the Board members for your time today as we
7 present our application for the establishment of
8 this ambulatory surgical treatment center limited
9 to gastroenterology specific specialty procedures.
10 The GI ASTC would be located in an existing
11 ambulatory center on the campus of St. Joseph's
12 Hospital, Chicago.

13 In 2013 this Board approved the construction
14 of a developer-owned ambulatory care building
15 connected to and immediately to the west of AMITA --
16 what's now known as AMITA Health St. Joseph's
17 Hospital in Chicago. That building contains a
18 hospital-leased procedure suite, and virtually all
19 of the hospital's outpatient endoscopy procedures
20 transition from the hospital's surgical suite to
21 that ambulatory procedure site, and that's still
22 the case with billings done by the hospital at the
23 hospital rate and in the current space is licensed
24 as a hospital outpatient department.

1 As this Board has seen in recent years,
2 certain types of procedures, including most
3 endoscopic procedures have been migrating out of
4 the hospital to lower cost ambulatory settings
5 such as physicians' offices and other ambulatory
6 centers. When we learned of the gastroenterologists'
7 interest in an ambulatory surgery center, it seemed
8 like a no-brainer to investigate a conversion of
9 the procedure suite that's already in place.

10 After a number of positive meetings between
11 the hospital and AMITA representatives and the
12 physicians, we engaged our legal team on the concept
13 and structure of this joint venture GI ASTC, and
14 that's the project that we're presenting to you
15 today.

16 In the most general terms, AMITA's parent,
17 Ascension Health, is providing the initial
18 financing for the required renovation to meet IDPH
19 ASTC licensure standards for the initial purchase
20 of equipment and for the project's soft costs.
21 The hospital is providing equipment currently in
22 use, and approximately 14 gastroenterologists
23 either as individuals or groups have indicated
24 their desire to enter into an agreement to purchase

1 up to 49 percent interest in the ASTC prior to
2 licensure.

3 From the hospital's perspective, we think
4 this is a great situation and a great deal for all
5 patients, community, physicians, and the hospital.

6 From the hospital perspective, this allows
7 us to have a controlling interest in what we believe
8 will be a very successful surgery center and allow
9 us to maintain and grow our relationships with the
10 participating gastroenterologists.

11 From the physician's perspective, it
12 allows them to acquire ownership interest in a
13 surgery center with very minimal front-end
14 expenses.

15 From the community perspective it allows
16 us to better meet the customer and patients'
17 demand of the triple A, lower costs, higher
18 quality, and a better patient experience.

19 With that I'd like to turn it over to
20 Mr. Axel to address the staff report.

21 MR. AXEL: Thank you.

22 The application was evaluated against a
23 total of 23 criteria and was found to be in
24 compliance with 21 of those 23, including every

1 single criterion that could possibly be met by the
2 applicants.

3 What I mean by that is that the two negatives
4 were Criteria 1110230 C6 and C7, both of which
5 address the existing supply of operating rooms and
6 procedure rooms located within 10 miles of the
7 St. Joseph's site. That area, by the way, runs
8 from University of Chicago on the south, to
9 Evanston on the north, and to the western limits
10 of Chicago.

11 Because of other hospitals and ASTCs that
12 are not meeting their target utilization levels
13 for both their ORs and their various types of
14 procedure rooms, these two criteria cannot be met.
15 I think it's worth noting that per Table 1 in the
16 staff report, only two ASTCs within the 10-mile
17 service area provide endoscopy services. One of
18 those is the area's only endoscopy center, and as
19 noted in the table, it's operating in excess of
20 the target utilization level. The other ASTC is
21 approved to provide a variety of services, has had
22 licensure issues in recent years, and did a total
23 of 11 procedures during 2018, none of which were
24 endoscopic.

1 Turning to the staff report's 21 positive
2 findings, every criterion related to the demand
3 for service, to patient origin, to project cost,
4 square footage, to the number of procedure rooms
5 to be provided, and to financing were found to be
6 in compliance with your standards. Those memories
7 of the Board that have reviewed numerous ASTC
8 projects will recognize that that level of
9 compliance doesn't happen with regularity.

10 With that we thank you for your attention,
11 and we'd be happy to answer any questions you
12 may have.

13 CHAIRWOMAN SAVAGE: Any questions from our
14 Board members?

15 Gary -- oh, one second, Gary is going to
16 speak first.

17 MEMBER KAATZ: Could you help me with this?
18 What are your clinical limits going to be in the
19 new facility? You're not going to do retrograde
20 cannulations, I suspect, but tell me where you
21 think you're going with your clinical limitations,
22 please.

23 MR. BAIRD: I'll ask Dr. Gluskin to
24 address that.

1 DR. GLUSKIN: Our current plan would be to
2 do the basic endoscopic procedures, upper endoscopy,
3 colonoscopy, feeding or PEG tube placements. That's
4 the main goal right now. We talked possibly about
5 in the future endoscopic ultrasound, but even that
6 is not in the plans for right now and just limited
7 to just the basic procedures that we actually are
8 doing every day.

9 MEMBER KAATZ: And are you going to charge
10 outpatient rates now and not the hospital rates,
11 or are you going to continue with hospital rates?

12 MR. BAIRD: No, we would be moving this to
13 ambulatory rates, as you know, significantly lower
14 than current hospital rates.

15 MEMBER KAATZ: Thank you.

16 MR. BAIRD: You're welcome.

17 CHAIRWOMAN SAVAGE: Any other questions?
18 I believe, Dr. Martell, you were up next.

19 MEMBER MARTELL: Yes. I had a question
20 regarding if there's a current backlog in procedures
21 given the capacity throughout the region.

22 MR. BAIRD: I would say that there is a
23 backlog of procedures. Certainly, we're seeing a
24 migration of many of these types of procedures to

1 ambulatory settings and to in some cases physician's
2 offices. Certainly, CMS is incentivizing more and
3 more procedures to be moved to this type of setting,
4 insurance companies -- United Healthcare has a
5 site of service requirement to move endoscopies to
6 this type of area, as well. So yes, there is a
7 backlog and a need for -- a stronger demand than
8 there is a supply of ambulatory GI settings
9 like this.

10 MR. AXEL: And if I could just jump in for
11 a second. Dr. Martell, as you're certainly aware,
12 there is a real push for screenings right now, and
13 that's been going on for the past couple years, and
14 we expect the volume of screenings to be going up.

15 CHAIRWOMAN SAVAGE: Any other questions
16 from the Board?

17 (No response.)

18 CHAIRWOMAN SAVAGE: George, if you could
19 do the roll call.

20 MR. ROATE: Motion made by Dr. Murray,
21 seconded by Dr. Martell.

22 Senator Demuzio.

23 (No response.)

24 MR. ROATE: I'll return back.

1 Mr. Kaatz.

2 MEMBER KAATZ: I vote yes based on the
3 staff report.

4 MR. ROATE: Thank you.

5 Dr. Martell.

6 MEMBER MARTELL: No, based on staff report.

7 MR. ROATE: Thank you.

8 Dr. Murray. Dr. Murray.

9 CHAIRWOMAN SAVAGE: You're on mute,
10 Dr. Murray.

11 MEMBER MURRAY: Yes. I vote no based on
12 staff report.

13 MR. ROATE: Thank you.

14 Mr. Slater.

15 MEMBER SLATER: I vote yes based on the
16 testimony.

17 MR. ROATE: Thank you. Senator Demuzio.

18 MEMBER DEMUZIO: George?

19 MR. ROATE: Yes, ma'am.

20 MEMBER DEMUZIO: Can you hear me?

21 CHAIRWOMAN SAVAGE: Yes. What is your vote?

22 MEMBER DEMUZIO: I vote yes based upon the
23 report and testimony.

24 MR. ROATE: Thank you.

1 If I may ask, Mr. Kaatz, what was your
2 vote again?

3 MEMBER KAATZ: My vote was yes.

4 MR. ROATE: Okay, thank you.

5 Chairwoman Savage.

6 CHAIRWOMAN SAVAGE: And my vote is yes
7 based on the testimony and staff report.

8 MR. ROATE: Thank you. That's 4 in the
9 affirmative, 2 votes in the negative.

10 MR. AXEL: Ms. Savage, may I make a
11 comment, please?

12 CHAIRWOMAN SAVAGE: Certainly.

13 MR. AXEL: I'm somewhat surprised by the
14 vote, and I just want to make sure that all of the
15 Board members understood what the two negatives
16 were. And I want to make sure because there is no
17 ASTC project that can meet those two criterion
18 anywhere in the state of Illinois, whether it be a
19 GI project or anything else.

20 We've gone through this in the past with
21 other projects, and I just want to make sure that
22 everybody understood the negative -- the two negative
23 findings which were the same issue, and if there
24 is any confusion, I would ask for a revote.

1 MS. AVERY: You can ask the two to rescind
2 if they want or if they have questions based on
3 what he just said.

4 CHAIRWOMAN SAVAGE: Dr. Martell and
5 Dr. Murray, would you like to rescind your vote,
6 or would you like to ask any questions at this time?

7 MS. AVERY: Or have Mike respond to.

8 CHAIRWOMAN SAVAGE: Or if Mike would like
9 to share any facts.

10 MR. CONSTANTINO: Well, what Jack said is
11 true; there's only two ASTCs within that area that
12 are providing this service right now. However,
13 we're required to look at both hospitals and all
14 ASTCs within that given area.

15 MS. AVERY: Dr. Martell and Dr. Murray,
16 did you hear Mike's explanation?

17 MEMBER MARTELL: It was hard to hear, but
18 I read the report and my concern is the number --
19 the number of facilities below capacity in that
20 region, and I think that that's a concern I had
21 for maldistribution of services.

22 CHAIRWOMAN SAVAGE: Mr. Axel will speak now.

23 MR. AXEL: I would like to address that
24 specific issue, and Mike and I have talked about

1 this on numerous occasions.

2 The hospital -- the underused operating rooms
3 and procedure rooms in the area run the gamut from
4 operating rooms designated specifically from -- to
5 open heart -- excuse me -- designated specifically
6 from open heart surgery, to other types of invasive
7 surgery, to procedure rooms ranging from laser eye
8 rooms, to the endoscopy rooms. The endoscopy, by
9 the way, are all located in one surgery center.
10 That surgery center is operating in excess of the
11 part of the, and the volumes in the area also
12 include other types of procedure rooms, laser eye
13 rooms, pain management rooms, and there's also a
14 couple others.

15 In terms of access to rooms for endoscopy
16 in a nonhospital setting, there is no access.
17 Dr. Gluskin and the other dozen or so physicians
18 interested in this facility, yes, they could get
19 privileges at the only center that provides
20 endoscopy in the 10-mile area that has specific
21 rooms for endoscopy, but the problem is because
22 the high utilization of that facility, for them to
23 get time in one of those rooms, it's going to be
24 Thursday at 5:00 or Wednesday at 7:00 p.m.

1 The access issue is the key here. And when
2 you're talking about access to endoscopy rooms
3 outside of the hospitals proper, the expensive
4 hospitals, there is no access.

5 And I say that by the way with all due
6 respect. Mike and I have talked about this on
7 numerous occasions.

8 CHAIRWOMAN SAVAGE: Any other questions or
9 a decision on whether you wish to rescind your
10 vote at this time?

11 MEMBER MURRAY: I want to be clear on the
12 answer he just gave. I think I heard him say that
13 there was not excess facilities outside of the
14 hospital, but now, the ones that are located in
15 the hospital, they still do some outpatient
16 procedures; is that not correct?

17 MR. AXEL: That is correct but they're
18 being done at anywhere, depending on the hospital,
19 from 30 to 40 percent higher rates than you would
20 find in an ASTC and the rates that would be used
21 at this facility.

22 And you are getting one insurance company
23 after another telling the physicians, "You may no
24 longer do these procedures in the hospital

1 setting; you have to take them to a lower cost
2 setting."

3 And perhaps Dr. Gluskin would like to give
4 his experience with that.

5 DR. GLUSKIN: That is correct. A number
6 of insurance companies, especially United
7 Healthcare, I've been unable to --

8 MEMBER MARTELL: So I want to do a
9 follow-up because when I looked at the report at
10 the hospital's equation in there, we had some
11 ASTCs throughout that are still not at capacity.
12 Are you saying that you're unable to schedule in
13 those facilities?

14 MR. AXEL: What I'm saying -- I'll let
15 Dr. Gluskin jump in. What I'm saying is the ASTCs
16 in the area that have endoscopy rooms, there are
17 only two. There's the one that has four rooms
18 that is running over capacity, and there is the
19 second facility that technically has an endoscopy
20 room. It is a facility that has had licensure
21 issues recently in the past, and the most recent
22 data provided to the Board shows that they did
23 only 11 procedure in the entire surgery center
24 during 2018, and of those 11, none of them were

1 endo. The other ASTCs do not provide endoscopy
2 services.

3 CHAIRWOMAN SAVAGE: Doctor, did you want
4 to share?

5 DR. GLUSKIN: Again, I agree with Jack and
6 there's an endoscopic center in the south loop that
7 just does endoscopy. That's the only one that's
8 purely just endoscopy, and that center is located
9 far away. They actually are overutilized, so
10 there would be no single-specialty endoscopy center
11 in our area at all within a 10-mile radius. And I
12 think, as you can see from the report, about
13 82 percent of our patients are within the area
14 located by St. Joseph Hospital in that area. So
15 going further would be a hardship, also, for the
16 patients who normally come to St. Joseph's Hospital.

17 MR. BAIRD: This is John Baird. I just
18 wanted to add, I think --

19 MS. AVERY: Really loud, closer and louder.

20 MR. BAIRD: We have close to
21 14 gastroenterologists now interested in this, and
22 they recognize, again, as Mr. Axel had said, that
23 the CMS, Medicare, and insurances are actually
24 incentivizing and moving these procedures to an

1 ASTC site like this. So thus, the reason that we
2 want to do this, to lower costs for consumers. Of
3 course, with that much lower cost going from
4 hospital prices to ambulatory prices, that's
5 passed on to consumers through their deductibles
6 and copays, as well.

7 So we do think there's a tremendous demand.
8 As you can see in the report, by the second year
9 we believe we'd have close to 10,000 endoscopy
10 procedures in this project.

11 CHAIRWOMAN SAVAGE: Dr. Martell or
12 Dr. Murray, any other questions?

13 MR. AXEL: Will we do a revote?

14 CHAIRWOMAN SAVAGE: Please speak up if you
15 wish to rescind your vote. Or if you wish to keep
16 it, please just say that again one more time.

17 Dr. Martell, can you just repeat your
18 vote then.

19 MEMBER MURRAY: Were you asking me?

20 CHAIRWOMAN SAVAGE: Yes, you can go and
21 then Dr. Martell, if you could just repeat --

22 MEMBER MURRAY: Yes, I vote no.

23 CHAIRWOMAN SAVAGE: Thank you.

24 Dr. Martell.

1 MEMBER MARTELL: I'm voting no.

2 CHAIRWOMAN SAVAGE: Thank you.

3 MR. ROATE: Vote stands 4 in the affirmative,
4 2 in the negative.

5 CHAIRWOMAN SAVAGE: And the application
6 for permit is -- the motion fails, and we will
7 follow up with you very soon.

8 MR. AXEL: Thank you.

9 MS. AVERY: Dr. Martell, are we still
10 under the hard stop for you.

11 MEMBER MARTELL: Yes. I'm going to have
12 to cut off at this point.

13 MS. AVERY: I will text you -- after
14 you're done, can you text me when you're done?

15 MEMBER MARTELL: I will, Courtney.
16 Thank you.

17 MS. AVERY: Thank you.

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1 MS. AVERY: Mike Mitchell, do we have the
2 public participation, people that want to provide
3 testimony on Project --

4 CHAIRWOMAN SAVAGE: 19-015.

5 MS. AVERY: We're early.

6 (Audio disruption.)

7 MS. AVERY: Okay. Mike Mitchell, did you
8 hear me? Hold on, I'll contact Anne Cooper.

9 CHAIRWOMAN SAVAGE: Thank you for your
10 patience and flexibility and understanding with
11 our interesting process that we have during these
12 crazy times.

13 MS. AVERY: You have a lot of background
14 noise. Is there a way to eliminate the background
15 noise?

16 MS. KNIGHT: Okay. You can hear me?

17 MS. AVERY: Are you driving?

18 MS. KNIGHT: Okay. Would you like me to
19 start now?

20 MS. AVERY: No. I would like to know if
21 you're driving because we're picking up your
22 background noise. Are you mobile? No, we cannot
23 hear you because you have a lot of background
24 noise. Are you driving or outside? Can you get

1 somewhere where you can eliminate the background
2 noise.

3 MS. KNIGHT: Can you repeat that?

4 MS. AVERY: Mike, can you send her a
5 message?

6 MR. MITCHELL: Go ahead, Colandra.

7 CHAIRWOMAN SAVAGE: Colandra, do you want
8 to try to speak now?

9 MR. MITCHELL: Colandra?

10 (An off-the-record discussion was held.)

11 MEMBER DEMUZIO: Hello?

12 CHAIRWOMAN SAVAGE: Is that you, Colandra?

13 MS. AVERY: No, that's Senator Demuzio.

14 Hold on, Senator, we're waiting for the
15 next person to speak.

16 CHAIRWOMAN SAVAGE: Were in public
17 participation for 19-015.

18 MS. AVERY: Mike Mitchell, we're going to
19 proceed with the agenda and just skip over to
20 other business and then come back to that. So
21 give us 10 minutes if she comes back on.

22 MR. MITCHELL: Okay.

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1 CHAIRWOMAN SAVAGE: So, Ann, do you have a
2 legislative update?

3 MS. GUILD: Yes, I do.

4 Senate Bill 2541 passed both chambers of
5 the General Assembly. It was part of the Hospital
6 Assessment bill, and as many of you are probably
7 aware, there's been recent concern about hospital --
8 not just hospital, healthcare facility closures
9 and notification to the public, legislators, the
10 community. This bill makes some changes to our
11 process, and that change is that we are no longer
12 able -- once the bill gets signed into law we are
13 no longer able to deem a project complete until we
14 have proof that there is a list of people that
15 have been notified 30 days in advance of
16 submission of the application.

17 The list is broader than our typical
18 notification that occurs after a project is deemed
19 complete. It includes the municipality, the
20 director of public health, and the director of
21 healthcare and family services in addition to the
22 legislators.

23 So I'm just bringing this to your attention.
24 It will change some of our processes. The bill

1 was sent to the governor on June 17. The governor
2 has 60 days to sign it, so we are likely to see a
3 change in our processes fairly soon.

4 If anyone has any questions I'd be happy
5 to answer them.

6 (No response.)

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1 CHAIRWOMAN SAVAGE: And, Courtney, if you
2 can provide our financial report.

3 MS. AVERY: Yes. The report is in your
4 packet. If you have any questions, I will try to
5 answer those questions.

6 Also, I'm going to ask Kim Palmer for our
7 next report to probably make a presentation,
8 especially if we're meeting virtually, so that we
9 can get a better understanding of what fiscal year
10 2021 is going to look like, get a forecast on that.

11 CHAIRWOMAN SAVAGE: That would be helpful.

12 Any questions anyone has?

13 (No response.)

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1 CHAIRWOMAN SAVAGE: Okay. We're looking
2 back on Colandra.

3 MR. MITCHELL: Colandra, are you there?

4 MEMBER DEMUZIO: Hello?

5 MS. AVERY: Hold on, Senator.

6 MEMBER DEMUZIO: Hello?

7 MS. AVERY: Hi, Senator. We're still here.

8 CHAIRWOMAN SAVAGE: We're still looking
9 for our public participant on Colandra Knight.

10 MR. MITCHELL: Is Colandra Knight online?

11 MS. AVERY: I just got a text message that
12 she's dialing back in.

13 CHAIRWOMAN SAVAGE: Colandra, are you back
14 with us?

15 (No response.)

16 MR. MITCHELL: Colandra, are you there?

17 (No response.)

18 CHAIRWOMAN SAVAGE: Okay. So next on the
19 agenda, Project I-01, Project 19-015, Dialysis
20 Care Center Chicago Heights. May I have a motion
21 to approve Project 19-015 to establish a 14-station
22 end-stage renal dialysis facility in Chicago Heights.

23 MEMBER MURRAY: This is Dr. Murray, I
24 so move.

1 CHAIRWOMAN SAVAGE: A second.

2 MEMBER KAATZ: I will second that.

3 CHAIRWOMAN SAVAGE: Gary has seconded.

4 Thank you.

5 And then if you folks could say your names
6 and spell them for our court reporter, and then
7 you'll be sworn.

8 DR. SALAKO: Babajide Salako.

9 B-a-b-a-j-i-d-e; last name Salako, S-a-l-a-k-o.

10 MR. SHAZZAD: Asim Shazzad, A-s-i-m

11 S-h-a-z-z-a-d.

12 MS. SMITH: Melissa --

13 MR. MITCHELL: Salman Azam is unmuted.

14 MR. AZAM: I'm here. This Salman Azam.

15 S-a-l-m-a-n; last name Azam, A-z-a-m.

16 CHAIRWOMAN SAVAGE: Try that again.

17 MS. SMITH: Melissa Smith, M-e-l-i-s-s-a

18 S-m-i-t-h.

19 MR. SHAZZAD: Dr. Tauseef Sarguroh just
20 pulled up outside. He'll be probably a minute or
21 two, if that's okay.

22 CHAIRWOMAN SAVAGE: Yes.

23 MR. SHAZZAD: T-a-u-s-e-e-f S-a-r-g-u-r-o-h.

24 CHAIRWOMAN SAVAGE: Okay. So we'll swear

1 these folks in and then we'll swear them in when
2 they return.

3 (Whereupon, four witness were duly sworn.)

4 CHAIRWOMAN SAVAGE: Mike, if you could
5 read us our State Board staff report.

6 MR. CONSTANTINO: Thank you, Madam Chair.

7 The applicants are proposing to establish
8 a 14-station ESRD facility in Chicago Heights,
9 Illinois.

10 The cost of the project is approximately
11 \$2.6 million, and the expected completion date is
12 May 31st, 2021.

13 This application received an intent to
14 deny, and the transcript from that meeting is
15 included at the end of your report. There were
16 also letters of opposition received by the State
17 Board staff, no letters of support.

18 Thank you, Madam Chair.

19 CHAIRWOMAN SAVAGE: Thank you. Okay. We
20 have one more person to be sworn in. You can sit
21 down, that's fine, and then what you'll do is say
22 your name, spell your name, and she'll swear you in.

23 DR. SARGUROH: So my first name is
24 Tauseef, T-a-u-s-e-e-f. My last name is Sarguroh,

1 S-a-r-g-u-r-o-h.

2 (Witness sworn.)

3 MS. AVERY: Mr. Mitchell, do we have
4 Colandra Knight on the line yet?

5 MR. MITCHELL: No, I haven't been able to
6 make any contact with Colandra. I see her listed
7 but we're not getting through to her.

8 CHAIRWOMAN SAVAGE: If that changes, if
9 you can put that in the chat, and then we'll make
10 room for her if the timing is right.

11 Okay. If you would like to proceed with
12 your presentation to the Board.

13 DR. SALAKO: Good afternoon, members of
14 the Board.

15 MS. AVERY: You're going to have to speak
16 very loud because they have to hear on that
17 speaker down there.

18 DR. SALAKO: Thank you for allowing us to
19 present during this very interesting time during
20 the COVID pandemic. Unfortunately, I can't see
21 all your faces, but it is what it is.

22 Here we are with our clinic in Chicago
23 Heights, and one of the things that will be
24 mentioned during the course of our presentation

1 today is that we did modify the application a few
2 months ago after the first intent to deny to
3 request 8 -- a minimum of 8 of those 14 stations
4 to be transitional care units, which we will talk
5 about in some detail during this presentation what
6 a transitional care unit is and how that model
7 works for us and is going to be a positive impact
8 for the dialysis patients in that community.

9 You heard DCC's story before, so you're
10 familiar with us. We're a local Illinois company
11 owned and managed by physicians. We're a
12 minority-owned company. We're a success story in
13 Illinois. We can proudly say that we are the
14 fastest growing company that focuses on home
15 dialysis today in the United States.

16 Part of our request for this unit in
17 Chicago Heights is to have 8 stations for -- at
18 least 8 stations for transitional care units is
19 our focus on getting the patients home. During
20 this presentation you will hear from Chief
21 Operating Officer Asim Shazzad talk to you about
22 TCUs. You will hear from our head nurse
23 Ms. Melissa Smith, who is a champion of home
24 dialysis talk about the importance of getting the

1 patients home and using the TCU to get them home.
2 You will also hear from one of my medical directors,
3 Dr. Tauseef Sarguroh on what he has experienced
4 especially in the last three months since the time
5 of COVID.

6 I would like to say starting off the bat
7 that -- well, I'll let them start and I will wrap
8 up everyone's thoughts and processes.

9 MS. SMITH: Good afternoon. My name is
10 Melissa Smith. I'm the director of operations for
11 Dialysis Care Center, and I am also a home therapy
12 nurse. I am speaking on behalf of the patients
13 and families that will benefit from the proposed
14 end center with a transitional care unit on the
15 premises.

16 As many of you have heard in past
17 presentations by us, end-stage renal disease is a
18 terminal diagnosis unless a patient receives a
19 transplant, recovers function miraculously, or
20 chooses comfort care in hospice.

21 To be given this diagnosis suddenly is
22 overwhelming and confusing. Not only are patients
23 grieving the loss of their previous lifestyle,
24 they're now expected to choose what type of

1 dialysis they would like to have. To make this
2 even more stressful, the team often needs an
3 answer within hours of the diagnosis. This
4 decision is a heavy burden on patients and their
5 families and should not have to be made quickly.

6 The transitional care unit has been
7 designed to give patients the necessary time to
8 make an informed decision about their future
9 dialysis care. They're able to start dialysis
10 immediately in the transitional unit without the
11 pressure of making a life changing about their
12 future before they have had a chance to research
13 their dialysis options, be presented with formal
14 modality education, and discuss their choices with
15 their loved ones. Transitional care allows them to
16 feel better physically, followed by consistent and
17 thorough education on their dialysis options,
18 including home therapy.

19 Home therapy patient ambassadors would be
20 able to visit with clients and share their
21 personal stories, answer questions based on
22 experience, and provide valuable insight into the
23 home program. Patients would have then have
24 several weeks to undergo education and make an

1 informed decision. This would allow patients to
2 truly understand the benefits of all modalities
3 but with an emphasis on home therapy as the
4 ultimate outcome.

5 The transitional care program would allow
6 patients to fully understand that home therapy is
7 the future of dialysis care in our new COVID world.
8 They would be able to see the significant benefits
9 of home therapy during the time of the COVID
10 pandemic and how the home program allows patients
11 to remain healthy and safe in the comfort of their
12 home while still receiving optimal dialysis care
13 and telehealth communication with their care team.

14 Although not all patients are candidates
15 for home therapy, the transitional care unit will
16 allow for better screening, education, and
17 informed decision making for those who would be
18 able to benefit from a home therapy program.

19 Thank you for your time and consideration
20 of the future of dialysis care with the addition
21 of transitional care options for patients and
22 their loved ones.

23 DR. SARGUROH: Good afternoon everyone.
24 Thank you for allowing us this opportunity to talk

1 about this transitional care unit. My name is
2 Dr. Sarguroh, and I'm the medical director at
3 one of the units at the Olympia Fields/Chicago
4 Heights area.

5 I was earlier here for the initial unit, and
6 I'm back now after a few months, and things have
7 drastically changed over the last three months
8 with regards to the pandemic and the disease
9 processes that we're seeing these days at the
10 hospital.

11 One of the things that -- I've personally
12 been part of the front force in this pandemic, and
13 I have seen a lot of these COVID patients needing
14 dialysis. You know, we have had a lot of COVID
15 nephropathy, and patients who have made it have
16 recovered their renal function, and they go on to
17 do better off of dialysis after their acute kidney
18 injury resolves. I do feel strongly that the
19 transitional care unit not just gives us an
20 opportunity to treat end-stage renal disease
21 patients just like Melissa mentioned but also
22 helps COVID patients who might have kidney disease
23 or have the need for dialysis also make decisions
24 where they can do dialysis at home and eventually

1 recover renal function.

2 I am proud to say that our home program
3 based out of Olympia Fields has no COVID-positive
4 patients. Also, I'm proud to say that our end
5 center unit has had only one COVID-positive patient.

6 So we've done great as far as taking care
7 of our patient population, and also, as far as me
8 being a nephrologist in the area, I have seen in
9 the last three months -- and we've spent hours of
10 our time taking care of these really sick COVID
11 patients, and they're on ventilators for weeks
12 before they recover, and almost 60 percent of
13 these patients who are in the ICU have some form
14 of kidney involvement.

15 I appreciate you giving us the opportunity
16 to come in front of the Board and presenting our
17 case, and I hope that you make a decision in our
18 favor.

19 MR. SHAZZAD: First of all, I would like
20 to thank the Board members for coming and for
21 being here especially during these hard times.

22 Overall, we had a positive SAR report
23 besides the excess of stations. Those excess of
24 stations, we modified our application to be a TCU,

1 transitional care unit. I know Fresenius did an
2 in-service previously on TCUs, so I'm not going to
3 go into too much detail about what a TCU is but
4 I'll cover the basics.

5 A TCU offers the patients more education
6 than the traditional dialysis. It gives them
7 options on home hemodialysis, on peritoneal
8 dialysis, transplants. The TCU setting eases them
9 into dialysis. The patients make their most
10 informed treatment plan options, and we know this
11 when the patients are on TCU, more than half of
12 them do home dialysis.

13 Fresenius released an article on June 17th,
14 announced that they are only going to do TCU units.
15 They're opening about 100 TCU units this year.
16 Also, before us DaVita and Fresenius both presented
17 TCU applications. None of them were denied.
18 Chicago Heights needs a TCU center. They don't
19 have any, so I would strongly urge the Board to
20 approve this for the patients in Chicago Heights.

21 That's all I have. I'll answer any
22 questions.

23 DR. SALAKO: Thank you, Board members. I
24 appreciate your time today.

1 As my colleagues have said that you probably
2 are well aware, the whole idea of a TCU is we want
3 the situation to create a new environment for
4 dialysis patients. Studies have shown across our
5 clinics in the Chicagoland area, we have 35 of our
6 patients dialyzed -- or 35 percent of all patients
7 dialyze at home. None of our home patients in the
8 last 14 weeks have tested positive for COVID.

9 That's a big deal. That means that these
10 patients are not going to be a burden on the
11 healthcare system. They've taken the strain and
12 reduced it on the healthcare system. A lot of
13 patients who developed COVID ended up in the
14 in-centers or got cross-contaminated from COVID at
15 an in-center. So it's safer for patients to
16 dialyze at home. Studies have also shown that
17 patients who dialyze at home have better mortality
18 morbidity.

19 It's always been a head scratcher for us
20 in the dialysis industry to say how can we increase
21 patient participation at home. Peritoneal dialysis,
22 we have one of the highest percentage of patients
23 of peritoneal dialysis in Illinois. We have one of
24 the highest rates of patients on home hemodialysis.

1 With a TCU model now what we're trying to
2 do is continue our success story, getting patients
3 home. If we get those patients in a TCU unit, we
4 can aggressively educate them; we can aggressively
5 train them; we can get them to a level of comfort
6 cannulating themselves, being very familiar with
7 the machines. Over a period of four to six weeks
8 seeing other people around them go home they're
9 encouraged to go home. They feel, "If the person
10 dialyzing next to me can do it, I can do it, too."
11 And I think that's where we all need to be.

12 There's a study out there that wants us to
13 get to 20 percent of dialysis patients dialyzing
14 at home by 2025. We at DCC, we're already over
15 that threshold. 33 percent of our patients are
16 dialyzing at home already, but we want to get to
17 40 percent.

18 If you have the opportunity to look at all
19 the opposition to our application, it's all down
20 to the fact that the opposition was DaVita trying to
21 use the CON Board as a means to stifle competition.
22 We've come into the market; we've provided very
23 good care; our physician partners are excellent,
24 and we've been able to give patients in very

1 underserved communities where we are in Chicago
2 Heights, in the City of Chicago, in the depressed
3 parts of Rockford, we've been able to provide for
4 our patients, build clinics where they are not
5 building clinics.

6 As I said earlier, we're very proud of our
7 roots, growing up, hiring people from the state of
8 Illinois, hiring minorities. We're very proud of
9 what we are, and we really would like our success
10 story to go to the next level. And the next level
11 is we would like to have at least an end-station
12 TCU clinic in Chicago Heights that serves a very
13 big population and aggressively using that tool to
14 increase the percentage of our patients that
15 dialyze at home. It is good medicine; it is good
16 policy; it is good public health, and we
17 appreciate the Board sporting us to accomplish
18 that goal.

19 MR. SHAZZAD: Just wanted to add two things
20 that I missed. After we amended our application
21 for TCU as of June 1st we did not get any
22 opposition from DaVita or Fresenius.

23 Also, I know there was some confusion about
24 this being a respite clinic. It is not a respite

1 clinic; it is a true TCU clinic in Chicago Heights.

2 I have our attorney on the line if you
3 guys have any questions. I think he would like to
4 add a few comments if he's able to, as well. I
5 think he's logged in on the computer.

6 CHAIRWOMAN SAVAGE: Do we have the
7 attorney for the Dialysis Care Center on the line?
8 You have to be sworn in, so could you please spell
9 your last name for our court reporter first.

10 MR. AZAM: Absolutely. The first name is
11 Salman, S-a-l-m-a-n. The last name is Azam,
12 A-z-a-m.

13 (Witness sworn.)

14 CHAIRWOMAN SAVAGE: Please proceed.

15 MR. AZAM: Thank you. I want to thank the
16 Board for getting together today, and I apologize
17 for my not being able to be there in person at
18 this time.

19 I think this is a very important application.
20 It's not -- it's not an application just for a
21 transitional care unit but an application for a
22 larger and necessary change.

23 I think that a lot of us are already aware
24 of the CMS and the Federal push to be headed

1 towards more home therapies and a transition to
2 more home care, a patient centric care model.
3 We've heard, you know, "Patients over paper," and
4 that's exactly what we're trying to deal with
5 today. We're not looking at number of chairs;
6 we're looking at this model that the Federal
7 government is looking to go towards. And when
8 they put their timeline in front of us, and there
9 was a timeline of a couple of years to really be
10 aggressive with this push, at that time there was
11 no global pandemic that has basically put this at
12 the forefront. This is not only an initiative,
13 but it's a need because it is more -- it resonates
14 more with the safety of our patients and the
15 well-being of our patients.

16 My colleagues that went before me have
17 told you the numbers, and the success, and the
18 needs for the transitional care units because of
19 our company's access with home therapies and home
20 dialysis. We can't get there without our
21 transitional care unit, and right now I think
22 patient safety, patient needs, and patient health
23 is what we are entrusted with as a dialysis provider
24 and the Board is entrusted with as constituents of

1 the state of Illinois that need healthcare and in
2 this specific need, dialysis care.

3 As companies all over try to adapt to become
4 safer and adapt to more health conscious ways to
5 serve customers, we have to think about dialysis
6 care patients who are high-risk individuals because
7 of their illness, and allowing for transitional
8 care is basically not only doing what is necessary
9 to keep them safe and also to deal with their
10 health, but also it is an opportunity to set an
11 example, to take a lead in these new initiatives
12 that we are looking to roll out.

13 So while we endeavor to be the best, while
14 we see other companies pivoting and shifting,
15 whether it's alcohol companies making sanitizers
16 or, you know, people making masks, I think this is
17 our effort, our way to go ahead and take -- to
18 make an example, to take initiative on building
19 towards, you know, patients over papers, to
20 transition into more home therapies and therapies
21 that are safer for our population. And by
22 allowing a transitional care unit, it's not only
23 our request, but I really believe that in this
24 time our responsibility to take the lead and go to

1 the forefront.

2 We always see lagging behind even on these
3 kinds of transitional care and home therapies with
4 other developed nations, and we will see the nexus
5 that we're also suffering in this pandemic. It is
6 a time and an opportunity for us to reverse that,
7 to take the lead and show that we can implement
8 these programs and these initiatives as well as
9 everybody else. And there's no better time than
10 the present with what is going on for us to
11 implement this, to take the initiative and take a
12 real stand here and go for this transitional care
13 unit, which has obviously, as my colleagues have
14 shown you, produced better results, is patient
15 preference and patient centric.

16 Let's once again put patients over paper.
17 Let's go ahead and vote for this transitional care
18 unit for the betterment of patients in this
19 demographic in Chicago Ridge and the state of
20 Illinois.

21 Thank you, Board.

22 CHAIRWOMAN SAVAGE: Thank you.

23 Do we have any other public participation
24 here in the room?

1 MR. SHAZZAD: If the Board has any
2 questions.

3 CHAIRWOMAN SAVAGE: Well, we are going to
4 hear from whomever the opposition person is on the
5 phone. So, Mike, do you have someone who is
6 apparently reading Colandra Knight's statement?

7 MS. AVERY: No. We're not accepting her
8 statement.

9 CHAIRWOMAN SAVAGE: No?

10 MR. MITCHELL: Yes, I have John Bice on
11 the line. John, are you there?

12 MR. BICE: Hello. I'm here. Can you
13 hear me?

14 CHAIRWOMAN SAVAGE: Yes, we can.

15 MR. BICE: All right. So I will read
16 directly from Colandra Knight's statement.

17 MS. AVERY: Sorry to interrupt you, but we
18 cannot allow that. That's against our rules. I
19 had a discussion with Anne Cooper. The testimony
20 must be yours. You cannot read on behalf of
21 someone else in public participation. So at this
22 time we will not be able to accept it. So we'll
23 have to strike that from -- we won't allow that to
24 be read into the record.

1 CHAIRWOMAN SAVAGE: But if you have your
2 own testimony, you may testify.

3 (No response.)

4 CHAIRWOMAN SAVAGE: Okay. So, George,
5 would you like to do a roll call -- actually,
6 first, do we have any questions? Good Lord, such
7 craziness today.

8 MEMBER KAATZ: Madam Chair, if I may.

9 Help me get a better understanding. I read
10 the staff report, and I see that there's a dramatic
11 excess capacity, and you're asking for new beds
12 for the transitional care program. Why are you
13 not able to just convert some of your existing
14 beds to transitional care beds, please?

15 DR. SALAKO: Good question, sir.

16 First, it's the design of the facility.
17 Two points.

18 MS. AVERY: Sir, louder.

19 DR. SALAKO: Yes, ma'am.

20 MS. AVERY: Thank you.

21 DR. SALAKO: First, it's the way the
22 facilities are being designed. Okay? It's almost
23 akin to, you know, back in the days when you had
24 wards and now you have separate side rooms. The

1 way those facilities are designed, they're kind of
2 in two- to four-person co-parts. Whereas, in a
3 dialysis unit and we have 20 chairs in there,
4 10 against this wall, 10 against that wall, and a
5 nurse's station in the middle.

6 TCUs, the way they're designed, it's going
7 to be more like pockets of four here, pockets of
8 four so that there's training and the nurse -- the
9 whole idea is you want to have an environment in
10 which the nurses can have more hands-on training
11 and supervision of the patients as against the
12 technician just giving the patients hemodialysis,
13 coming and leaving.

14 So that's one piece. There's a physical
15 plant -- there's a physical plant component to it.
16 The second component is that we in that community,
17 we have two other things. Our utilization in our
18 clinics there, our clinics are full. Okay? So
19 those are traditional in-center clinics. So for
20 us to do that, we will have to A, discharge
21 patients out of our clinics, send them somewhere
22 else, reengineer our clinics, rebuild them into
23 TCUs, and then convert a preexisting clinic into a
24 TCU. From a developmental operational point of

1 view that just will not work.

2 So there are two components. One, the
3 layout is different. Two, we just don't have the
4 capacity. So as much as there are excess chairs
5 for several other providers, we just opened a
6 clinic earlier this year, and that clinic is
7 already at 75 percent utilization. So we just
8 don't have the chairs.

9 We would like to have those chairs. We
10 would like to provide the continuum of care for
11 our patients, and several of our patients, several
12 of our doctors, you know, they would like those
13 patients to stay in it while they know the quality
14 of care we'll give them. That's an integral part.

15 MEMBER KAATZ: Roughly what is your average
16 length of stay for a patient on hemodialysis
17 right now?

18 MS. AVERY: If you don't get a transplant,
19 hemodialysis is the rest of your life. Now, the
20 transplant rate in the United States has hovered
21 around 72 percent. That hasn't changed in the
22 last 20 years. In our business today 30 percent
23 of our patients dialyze at home better than any of
24 the LDs. The LDs are at about 10 or 12 percent.

1 Most of them the goal is 15 percent.

2 So we really push our patients to go home.

3 Dr. Sarguroh is one of our medical directors can
4 talk to you more about it but this is our goal.

5 And what we're going to do here is this, and I can
6 tell you from a purely business perspective -- I
7 know the doctors will talk about caring for
8 patients. For the dialysis patient it's good to
9 dialyze at home; your mortality is better; your
10 morbidity is better. From a business perspective
11 it's better to have a patient at home. That's why
12 CMS is pushing for it; that's why they have these
13 initiatives.

14 If you look at the hospitalization rates
15 of the dialysis patients, patients who dialyze at
16 home go to the hospital a third of the times that
17 the patients at an in-center. If you're a
18 Medicare patient, each day in the hospital is 2 to
19 \$3,000 to CMS. Those patients that dialyze at
20 home do so much better.

21 One of the things about COVID is very
22 interesting. You have a patient who gets -- who
23 is coming to dialysis on public transportation
24 with other patients that -- how do you space people

1 in a van that's bringing four patients to dialysis?
2 So you get a lot of cross-contamination. Our
3 patients who dialyze at home get it brought to
4 their doorstep, their loved ones move it into
5 their rooms, they're dialyzing in their home. Not
6 one of our home patients got diagnosed with COVID.
7 That's why we really, really want to do this.
8 This would really be a game changer for patients.

9 DR. SARGUROH: I'm going to add to what
10 Dr. Salako had to say, and I'm going to be honest
11 here, I do not understand the business aspect of
12 this, you know, but as far as the medical aspect
13 of transitioning these in-center hemo patients to
14 home therapy, I've personally been involved in
15 that transition of care, and I am proud to say
16 that the patients that we've transitioned to home
17 and I'm taking care of these patients at our clinic
18 have done exceptionally good over the last three
19 months even with the COVID pandemic going on.

20 We're not setting up clinic for these
21 patients, so we speak to them over the phone or
22 video, and we take care of their needs without
23 them having to come in to see us. And I think
24 they're doing great, their numbers look good, and

1 just patients are doing better without, you know,
2 having the risk of contracting COVID at least over
3 the last few months, and I have a feeling that
4 COVID is going to stay around for a lot longer.

5 MR. SHAZZAD: I just wanted to add one thing
6 off the SAR report. In the SAR report it says
7 that March 31st the closest unit we had was at
8 98 percent utilization. After March 31st we're at
9 130 percent utilization. We opened a fourth
10 shift, as well, and we just can't accommodate TCUs
11 in that setting.

12 MEMBER KAATZ: Thank you.

13 CHAIRWOMAN SAVAGE: If I can ask, what
14 about the newer facility that was in the report as
15 about 44 percent?

16 MR. SHAZZAD: I would say that's not even
17 in the -- I know it says 5 mile GSA. It's Hazel
18 Crest. This is Chicago Heights. It's three suburbs
19 away -- three or four suburbs away, actually, and
20 that's already at 75 percent. The data has this
21 as March 31st, once again, it's dated.

22 CHAIRWOMAN SAVAGE: Thank you.

23 Dr. Murray, do you have any specific
24 questions?

1 MEMBER MURRAY: Well, I guess I'm just --

2 CHAIRWOMAN SAVAGE: I do but I want to
3 make sure we get you guys first.

4 MEMBER MURRAY: Yes. I guess I'm really --
5 it's hard to hear, so I apologize for that, but I
6 just don't understand how adding these beds helps --
7 these stations helps with, quote, transitioning to
8 home dialysis.

9 Is there some difference between -- is
10 there something special about transition spaces
11 that I'm unaware of? Can't you change -- I mean,
12 now we transition people in the present spaces you
13 have in the facilities; right?

14 DR. SARGUROH: Dr. Murray, this is
15 Dr. Sarguroh. Let me take that question.

16 CHAIRWOMAN SAVAGE: Can you hear him,
17 Dr. Murray?

18 DR. SARGUROH: Dr. Murray, can you hear me?

19 CHAIRWOMAN SAVAGE: Yes. Go ahead.

20 DR. SARGUROH: I'm going to go back to
21 what Dr. Salako was speaking about the design of
22 these units and how these patients are in pods of
23 four each. And what happens is in a conventional
24 in-center hemodialysis unit the stations are

1 spread out, the patients don't interact with each
2 other. As far as group training is concerned, we
3 don't see that at all at a conventional in-center
4 dialysis unit.

5 With these transitional care units, there
6 is more focus on educating these patients about
7 their home therapy options. And as far as
8 training and educating is concerned, it's more
9 convenient, if not better to talk to these
10 patients, educate them, and then transition them
11 to these home therapies.

12 And we've tried that in our in-center
13 conventional hemo units, as well. We've been
14 doing that. I have personally transitioned these
15 patients to home therapies. It just makes a
16 transitional care unit more convenient for us to
17 do more of that and have better results.

18 CHAIRWOMAN SAVAGE: Mr. Slater, do you
19 have any questions?

20 (No response.)

21 CHAIRWOMAN SAVAGE: Did you have something
22 more, Dr. Murray?

23 MEMBER MURRAY: I just wanted to make sure
24 that I'm understanding because I want to be fair

1 because, you know, it's so difficult to hear.

2 I do understand -- what I think I heard
3 you say is that when you're transitioning a
4 patient from a dialysis unit to home dialysis, a
5 lot more education and hands-on helping the
6 patient understand how to do what's necessary.

7 DR. SARGUROH: That is exactly right.

8 MEMBER MURRAY: And I can see how a space
9 designed specifically for that might be a little
10 different. But what I'm having trouble
11 understanding -- you know, this is not like excess
12 stations of 10 or 15 in this area, it's 128 excess
13 stations. And even one of your facilities I think
14 was below 50 percent, if my memory serves, below
15 50 percent capacity.

16 So I guess my real question is, is it
17 possible to better assign these stations without
18 actually adding more stations? What your
19 application is really having trouble with is that
20 in this specific area there is so much excess.
21 Even within the two facilities that you operate,
22 one is at 90 percent plus, and one is at under
23 50 percent.

24 So I'm not really convinced that adding

1 these beds is the only way to go -- or the best
2 way to go is a better way to say it.

3 DR. SARGUROH: Dr. Murray, you're exactly
4 right about your initial statement where you said
5 it's more hands-on, more educational. The
6 two facilities that we have in that area, one is
7 Olympia Fields and the other one is Hazel Crest.
8 Olympia Fields is almost at 90 percent -- it's
9 130 percent and the Hazel Crest unit as of today
10 is 75 percent capacity. As of today it's
11 75 percent capacity.

12 So the two units that we have in that area
13 are doing good, and we're using those two units as
14 part of our transitional care at this point, you
15 know, and having these extra stations with that
16 design is more hands-on, more education, and more
17 transition to home therapies.

18 So just following up on your initial
19 statement, that's how I personally feel about this.

20 DR. SALAKO: One other comment, Dr. Murray.
21 The second clinic in Hazel Crest that we opened
22 last year at 75 percent, we have a dedicated COVID
23 shift on that unit. That is one -- that clinic, a
24 particular shift of patients there is dedicated

1 for COVID patients.

2 That is also a big deal for us because
3 cross-contamination is something we absolutely want
4 to avoid. So what happens is most dialysis clinics
5 open Monday/Wednesday/Friday - Tuesday/Thursday/
6 Saturday. So on a Tuesday/Thursday/Saturday shift,
7 we try to do the morning and afternoon shift,
8 finish as early as possible, and we leave all of
9 the evening shift sometimes two patients, sometimes
10 up to four patients depending on where those
11 COVID-positive patients become COVID negative.

12 But it's imperative that we keep that
13 COVID shift opened because in that community we're
14 one of very few clinics that are accepting COVID
15 patients. You have to get the staff ready for it;
16 you have to give them special PPE; you have to
17 clean the facility down after treatment. It's a
18 huge operational exercise to have this one clinic
19 in that community treating COVID patients.

20 We're proud of it. We're proud of what
21 we're doing in the community. Every day I'm proud
22 of my staff who have to leave home, put themselves
23 at risk and treat COVID-positive patients. And as
24 Dr. Sarguroh said, as we have seen unfortunately,

1 COVID is going to be with us for a while until we
2 get a vaccine. That's the reality we all have to
3 deal with, and we have -- as dialysis providers,
4 we must find a strategy that reduces exposure of
5 our patients, and the way to do it is to get the
6 majority of your patients dialyzing in the safety
7 of their homes where they have the minimal chance
8 of contracting COVID from other people.

9 We cannot do this, unfortunately, in a
10 facility we don't own or don't control or a
11 provider that doesn't share our values. We just
12 can't do it. I wish we could.

13 DR. SARGUROH: Dr. Murray, if you can hear
14 me, I'm also excited to share this with you and
15 the Board. A lot of our patients went to the
16 Hazel Crest unit, so that area, you know, in
17 Chicagoland was a hotbed of COVID. We saw a lot
18 of COVID-positive patients who were very critically
19 ill, and a lot of them had COVID nephropathies
20 that required dialysis. And I'm still fascinated
21 by how COVID affects the kidneys and the number of
22 patients that end up needing dialysis, but I am
23 proud and excited to share this with you that a
24 lot of our patients that went through that

1 specific Hazel Crest unit and were part of that
2 COVID shift have actually recovered renal function
3 and are off of dialysis now, and I'm really
4 excited to share this with you. I think it's part
5 of because of the care we give to these patients
6 and the follow-up that we have, and I am really
7 proud and excited to share this with the Board.

8 CHAIRWOMAN SAVAGE: Anything further,
9 Dr. Murray?

10 MEMBER MURRAY: No, thank you.

11 CHAIRWOMAN SAVAGE: Thank you. Okay. So
12 I guess with your TCU patients, where are they
13 primarily coming from then? Are they coming from
14 those other two clinics to be in your new facility
15 potentially with your six-bed stations and your
16 eight other stations of TCU?

17 DR. SALAKO: Primarily -- several. You
18 know, the way we -- in that community -- first of
19 all, in our clinic in Olympia Fields, we have a
20 fourth shift there, and the fourth-shift patients
21 are dialyzing until 10:00, 12:00 at night. In the
22 summer it's acceptable; in the winter it's
23 dangerous. So for us -- it's patient's choice.
24 We were hoping they could go somewhere else, but

1 we really need to offload that shift. That's one.

2 The second thing is several patients who
3 have -- who are expressing an intention to go to
4 home, we can now put them together and treat them
5 and educate them as a co-part. So that is one
6 group of patients who will go there.

7 The folks who benefit the most are the new
8 ones to dialysis. They're the ones who are most
9 likely going to go home if you treat them in a
10 TCU unit within the first six weeks of starting
11 dialysis. So what you're going to get is this --
12 habits are difficult to change. If someone has
13 been used to coming to a dialysis unit every day,
14 they've gotten a relationship with the transportation
15 company; they like the transportation driver; it's
16 so difficult to change habits.

17 What we find is that when patients are new
18 to dialysis and you introduce them to dialysis in
19 the TCU with the proviso that, "Listen, I want you
20 to learn to cannulate yourself; I want you to
21 learn to set up a machine; this machine is the
22 kind of machine you're going to use at home," that
23 mindset, that programming is a lot easier for the
24 patient in achieving the goal of dialyzing at home.

1 I can tell you that if you have a patient
2 who has been there for three years, you're not
3 going to get that patient to go home. You're
4 going to get a patient who is new to dialysis,
5 comes in, sees the nurses every day, the nurses
6 assure them, "These are the needles, start sticking
7 yourself after the second week." Three weeks into
8 it they come in and say, "Where is your caregiver
9 at home," help them set up this machine, say,
10 "This alarm means this; this alarm means that."
11 Four weeks into it, five weeks into it do a home
12 visit and say, "Where are you going to put this
13 machine in your house?" That's where the access
14 is going to come from. It's a painstaking
15 process; you have to be passionate about it; you
16 don't get brownie points for doing it, but
17 eventually we all know it is best for the patient.

18 I'm a physician. I pray I don't go into
19 dialysis, but if I ever have to do it, I will
20 dialyze in my house every day at night rather than
21 go to an in-center facility for three hours three
22 times a week, a lot stress on my heart, and my
23 outcomes will be a whole lot better.

24 MR. AZAM: Just to add to that, a little

1 bit of history of why DCC would be very good at
2 this is because history will show that Dialysis
3 Care Center was actually started as a home
4 therapy. We believe in home dialysis; we believe
5 in home therapies; it's still an integral part of
6 our business system. We're just taking the
7 corporate responsibility at this time to push it
8 even more.

9 Now, I don't know about everybody else in
10 that space in Chicago Heights, where home
11 therapies and home dialysis serves on their scale,
12 but it's a very important part of our system, and
13 we are wanting to push it. And that just kind of
14 furthers the point that Dr. Salako said. In a
15 facility that we do not own, in a facility whose
16 priorities we cannot control, we cannot effectively
17 transition these patients because we don't have
18 that control.

19 And in effect, to further this agenda --
20 which is not just for COVID. Remember I talked
21 about patients before, patients before paper, I
22 talked about the CMS initiative. This is an
23 initiative that we need to go to anyway. We just
24 think that it needs to get sped up because of the

1 situation around us.

2 But this is not just to address a
3 temporary situation; this is for the long-term
4 benefit of patients, and we think that no one else
5 is as uniquely qualified because of our commitment
6 to home dialysis and home therapies along with our
7 in-center experience, and that's why we want to
8 take this time and this opportunity to further this.

9 CHAIRWOMAN SAVAGE: If I could ask a little
10 bit more about the patients that are going to be
11 coming to your facility. So, you know, I know
12 you're getting a lot of new patients because of
13 COVID sadly, but hopefully eventually that will
14 end we pray. But nonetheless, if the patients do
15 go on the home dialysis we'll call it, those
16 patients will probably continue doing that most
17 likely for the rest of their time.

18 So if you're going to take people from
19 your 90/130 percent place and try and convert
20 them, where else is this volume going to come from
21 that's going to undo this 128 stations where only
22 one is functioning at 80 percent? I understand
23 they're not yours, but nonetheless there's plenty
24 of dialysis available. I believe you said

1 something about Fresenius possibility having
2 100 percent of their people going to TC, which
3 I've not heard about.

4 But how is that going to work? Because at
5 the moment I just can't understand why we would
6 need to add -- even if we said the TCC was somehow
7 separate and you would never do dialysis as a
8 station, we have 134 excess stations, so that
9 would be your 6 that you would still be using, or
10 we'd have 142 if we included the TCC beds
11 themselves.

12 DR. SARGUROH: So let me go back to the
13 first statement that you made, ma'am. COVID, the
14 incidence of -- and I've been working almost every
15 day for the last eight months, and I see things at
16 the hospital. The incidence of COVID in our area
17 is going down, and the hospitals are less and less
18 COVID patients. I think sometime a couple of
19 months ago we had 110 positive inpatient COVIDs;
20 we're now down to 10 in the hospital I go to.

21 So the incidence is definitely going down.
22 People just in general are taking more
23 precautions. That's one.

24 So where do these patients come from? We

1 and my partners in that area provide care to a lot
2 of CKD patients, a lot of CDE patients. And just --
3 hello, can you hear me?

4 So we provide care to a lot of CKD patients,
5 me and my partners. And the Hazel Crest unit that
6 opened in October last year, we're at 75 percent
7 capacity.

8 So yes, we're in the process of
9 transitioning these patients to home and our
10 numbers show -- our numbers show we have the
11 largest home program in that area. We have been
12 transitioning these patients to home therapies.
13 It's just so much easier as a physician to have
14 these patients in our network and then to educate
15 them, give them hands-on training because they're
16 part of our network. It's just an easier transition.
17 It's just the logistics of how we provide care,
18 and that's what makes it easier.

19 There are three hospitals in that area
20 that we go to, and so we see patients that need
21 dialysis not just because of progression of their
22 chronic kidney disease to end-stage renal disease,
23 but also we get crash and burn at the hospitals
24 that initiate -- have to go on hemodialysis, and

1 we transition them over to home therapies
2 depending on what their requirement is.

3 So that's really how we work around these
4 logistics.

5 MR. SHAZZAD: I just wanted to add, I just
6 wanted to clarify that Fresenius, they're not
7 doing 100 percent of the patients, they're planning
8 on opening 100 new TCUs this year nationwide.
9 Just wanted to make that clarification.

10 And I do want to add one thing, I'm sorry.
11 In this Fresenius article I just want to read word
12 for word. "The company has found over 50 percent
13 of TCU patients will choose a home dialysis
14 modality after completing this experience compared
15 to approximately 15 percent of new patients on
16 average choosing home when they start dialysis in
17 a traditional dialysis facility."

18 So it's a huge percentage difference,
19 15 and 50 percent.

20 MS. SMITH: I just wanted to add I've
21 trained over 100 patients in the years that I've
22 been doing dialysis, and this transitional care
23 unit is something I wish we would have had this
24 whole time.

1 Because as Dr. Sarguroh was stating, we
2 have a lot of patients that kind of crash and fall
3 into dialysis, so they fall into our laps. These
4 patients are very challenging to train because
5 they show up in the clinic, they know nothing
6 about having kidney disease to begin with, and now
7 they're in a clinic and have a tube hanging out of
8 their stomach. They agreed to it in the hospital,
9 but they didn't really know anything about it. So
10 we spend on average about four weeks trying to
11 calm their emotional stressors of whether they
12 made the right decision or not.

13 So the TCU units will actually be able to
14 capture those patients and allow them to feel when
15 they make the decision to do the dialysis at home
16 that they had time to think about it before they
17 just had to say yes or no to a tube in their
18 stomach. So then they can come in and feel like
19 they were actually able to fully participate in
20 their training, that they actually got to make
21 that choice, they had time to think about it, and
22 those are the patients that are super successful
23 in the home setting.

24 So the importance of the TCU unit, it

1 really will capture that group of patients and
2 really give them a firm, solid complement to their
3 choices for the home therapy.

4 CHAIRWOMAN SAVAGE: Any other questions,
5 Dr. Martell?

6 MS. AVERY: Mitch, can you unmute
7 Dr. Martell? Okay. There she is.

8 CHAIRWOMAN SAVAGE: Dr. Martell, Sandra,
9 can you hear us? Dr. Martell, can you hear us?

10 MEMBER SLATER: This is Slater. I would
11 move to grant the permit.

12 MS. AVERY: One second, Mr. Slater.

13 CHAIRWOMAN SAVAGE: Sandra Martell, can
14 you hear us?

15 MEMBER MARTELL: Yes, I can.

16 CHAIRWOMAN SAVAGE: Did you have any
17 questions for our applicants here?

18 MEMBER MARTELL: No, I did not.

19 CHAIRWOMAN SAVAGE: Okay. Thank you.

20 Okay. So would -- may I have a motion to
21 establish a 14-bed --

22 MS. AVERY: We have the motion. Call
23 the roll.

24 CHAIRWOMAN SAVAGE: Oh, we did that

1 already, good Lord. George, would you like to
2 call the roll.

3 MR. ROATE: Thank you, Madam Chair.

4 Motion made by Dr. Murray, seconded by
5 Mr. Kaatz.

6 Senator Demuzio.

7 (No response.)

8 MR. ROATE: I'll come back.

9 Gary Kaatz.

10 MEMBER KAATZ: I will vote yes on this,
11 but I'm very concerned about the staff report, I'm
12 very concerned over the supply, the excess
13 capacity. I would love to the applicants to come
14 back at a point in time in the future to report on
15 their progress.

16 DR. SALAKO: Absolutely.

17 MR. SHAZZAD: Definitely.

18 MR. ROATE: Thank you.

19 Dr. Martell.

20 CHAIRWOMAN SAVAGE: Dr. Martell, you're
21 on mute.

22 MEMBER MARTELL: I have significant
23 concerns, as well, on the capacity issues and
24 concerns and reframing of this particular, so my

1 vote would be no.

2 MR. ROATE: Thank you.

3 Dr. Murray.

4 MEMBER MURRAY: I'm persuaded by the staff
5 report and I vote no.

6 MR. ROATE: Thank you.

7 Mr. Slater.

8 MEMBER SLATER: This is an unnecessary
9 duplication of services. I vote no.

10 MR. ROATE: Thank you.

11 Back to Senator Demuzio.

12 MEMBER DEMUZIO: Yes, based on some of the
13 testimony I heard today and the report, staff
14 report.

15 MR. ROATE: Thank you.

16 Chairwoman Savage.

17 CHAIRWOMAN SAVAGE: I vote no based on the
18 capacity issues, and I wish the TCC could take off
19 a little bit better. I was a little bit swayed by
20 the testimony, but I think, you know, the capacity
21 is just a problem.

22 So possibly a different location, but,
23 again, please do come back and update us on your
24 progress.

1 MR. ROATE: Thank you, Madam Chair.

2 That's 4 votes in the negative, 2 votes in
3 the affirmative.

4 CHAIRWOMAN SAVAGE: So this permit --

5 MS. AVERY: You will receive an
6 opportunity for administrative review and to
7 reply. Thank you.

8 CHAIRWOMAN SAVAGE: I call this meeting to
9 end -- adjourn.

10 MS. AVERY: Thanks everyone. We'll get
11 better at this.

12 (Off the record at 4:23 p.m.)
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CERTIFICATE OF SHORTHAND REPORTER

I, Paula M. Quetsch, Certified Shorthand Reporter No. 084-003733, CSR, RPR, and a Notary Public in and for the County of Kane, State of Illinois, the officer before whom the foregoing proceedings were taken, do certify that the foregoing transcript is a true and correct record of the proceedings, that said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision, and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 22nd day of July, 2020.

My commission expires: October 16, 2021



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