Transcript of Open Session

Date: June 30, 2020
Case: State of Illinois Health Facilities and Services Review Board

Planet Depos
Phone: 888-433-3767
Fax: 888-503-3767
Email: transcripts@planetdepos.com
www.planetdepos.com

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION - MEETING

Bolingbrook, Illinois 60490

Tuesday, June 30, 2020

10:00 a.m.

BOARD MEMBERS PRESENT:

DEBRA SAVAGE, Chairwoman

GARY KAATZ

BOARD MEMBERS PRESENT VIRTUALLY:

DEANNA DEMUZIO

SANDRA MARTELL

LINDA RAY MURRAY

KENT SLATER

Job No. 257113B

Pages: 1 - 207

Reported by: Paula Quetsch, CSR, RPR

ALSO PRESENT:

COURTNEY AVERY, Administrator

MICHAEL CONSTANTINO, IDPH Staff

ANN GUILD, Compliance Manager

GEORGE ROATE, IDPH Staff

C O N T E N T S

P R O C E E D I N G S

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

MR. ROATE: Thank you, Madam Chair.

Gary Kaatz.

MEMBER KAATZ: Here.

MR. ROATE: Dr. Martell.

MEMBER MARTELL: Yes, present.

MR. ROATE: Dr. Murray.

MEMBER MURRAY: Here.

MR. ROATE: Mr. Slater.

CHAIRWOMAN SAVAGE: Are you there, Kent?

MS. AVERY: Mr. Slater?

MEMBER SLATER: Yes.

MR. ROATE: Thank you.

Ms. Savage.

CHAIRWOMAN SAVAGE: Present.

MR. ROATE: There are five in attendance.

CHAIRWOMAN SAVAGE: Thank you.

Now may I have a motion to go into closed session pursuant to Section 2(c)(1), 2(c)(5), 2(c)(11), and 2(c)(21) of the Open Meetings Act.

MEMBER KAATZ: So moved.

CHAIRWOMAN SAVAGE: A second.

MEMBER MURRAY: Second.

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

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

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

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

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

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

MEMBER KAATZ: So moved.

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

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

MEMBER SLATER: I'm sorry?

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

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

MS. AVERY: Senator, are you available?

Can everyone hear us?

MEMBER MARTELL: Yes.

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

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

been unmuted yet.

MS. AVERY: You're unmuted.

CHAIRWOMAN SAVAGE: We hear you.

MEMBER MARTELL: Okay. Then I'll second.

MS. AVERY: That was Dr. Martell?

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

CHAIRWOMAN SAVAGE: All in favor say aye.

(Ayes heard.)

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

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

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

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

CHAIRWOMAN SAVAGE: And may I have a second.

MEMBER MURRAY: This is Linda Murray, second.

CHAIRWOMAN SAVAGE: And all in fair say aye.

(Ayes heard.)

- - -

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

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

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

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

MEMBER MARTELL: It's the same here.

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

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

MEMBER MURRAY: This is Linda Murray, I second.

CHAIRWOMAN SAVAGE: And all in favor say aye.

(Ayes heard.)

- - -

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

So on the agenda is --

MS. AVERY: Madam Chair, may I clarify?

CHAIRWOMAN SAVAGE: Of course.

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

CHAIRWOMAN SAVAGE: Thank you.

(The following items were approved by the Chairwoman:)

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

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

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

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

Alteration of Project Funding Sources;

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

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

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

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

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

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

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

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

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

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

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

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

Hospital, Discontinue 14-Bed AMI Category of Service;

Q. Extension of Financial Commitment: 18-014 Carle Surgicenter, Danville, 12-Month Extension;

R. Extension of Financial Commitment: 19-032 Greater Chicago Ctr. for Adv. Surgery, 12-Month Extension;

S. Alteration: #18-025 University of Chicago Medical Center MOB increase the permit amount by 6.99%;

T. Discontinuation: #E-027-20 Good Samaritan Hospital, Mt. Vernon, Discontinue Open Heart Surgery;

U. Change of Ownership: #E-029-20 Hinsdale Surgical Center (Real Estate Only);

V. Change of Ownership: #E-030-20 Central Illinois Endoscopy Center (Real Estate Only);

W. HSHS St. Anthony Medical Center: Revise 2018 Surgical Data;

X. AMITA Health Hinsdale Hospital: Revise 2018 Cardiac Catheterization Data;

Y. AMITA Health Alexian Brothers Medical Center: Revise 2018 Cardiac Catheterization Data;

Z. #20-014: Carle Foundation Hospital, modernization project;

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

MOB project;

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

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

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

- - -

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

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

(No response.)

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

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

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

MEMBER MARTELL: 19-031?

CHAIRWOMAN SAVAGE: The Advanced Surgical Institute.

MEMBER MARTELL: Got it. I so move.

CHAIRWOMAN SAVAGE: And may I have a second.

MEMBER MURRAY: Second. Dr. Murray, second.

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

MS. AVERY: You can come to the table.

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

MR. CONSTANTINO: Courtney, there is.

MS. AVERY: Oh, there is?

MR. CONSTANTINO: Yes.

MS. AVERY: Who?

MR. CONSTANTINO: Two individuals.

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

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

MS. AVERY: I apologize.

(Whereupon, the witnesses were thereupon duly sworn.)

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

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

MS. AVERY: You have to speak really loudly.

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

CHAIRWOMAN SAVAGE: Dr. Murray, if you're --
MEMBER MURRAY: I can barely hear him.
MS. AVERY: We'll do our best.
DR. HANLON: Okay. I will talk very loud. Pardon me for that.
I am Dr. John Hanlon, president of OSF Healthcare Little Company of Mary Medical Center in Evergreen Park, Illinois. My remarks are in opposition to the proposed establishment of the freestanding two-room ambulatory surgery treatment center with a nonhospital-based freestanding cardiac cath laboratory as described in the permit application. My concerns are similar to those expressed by the Review Board members at your December meeting where the project was deferred.
I concur with the State Board staff report that approval will result in an incremental oversupply and contribute to the current excess capacity in the market for both cardiac catheterization labs and nonhospital-based ambulatory surgery procedure rooms. If approved, the project will fragment the delivery of cardiovascular services in the market and contribute

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

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

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

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

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

MR. ROATE: Two minutes.

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

May I be granted one more minute?

CHAIRWOMAN SAVAGE: Okay. One more minute.

DR. HANLON: Thank you.

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

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

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

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

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

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

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

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

market.

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

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

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

MR. ROATE: Two minutes.

MR. QUERCIAGROSSA: In conclusion, based

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

MR. CONSTANTINO: Two minutes.

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

I appreciate your consideration.

CHAIRWOMAN SAVAGE: Thank you.

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

(No response.)

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

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

- - -

CHAIRWOMAN SAVAGE: Please identify yourselves and be sworn in.

MR. NIEHAUS: Bryan Niehaus.

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

DR. SPEAR: Dr. William Spear.

DR. ZAIDI: Dr. Ali Zaidi.

(Whereupon, four witnesses were thereupon duly sworn.)

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

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

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

I need to make a couple of comments about

this application.

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

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

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

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

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

Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

for the difference of $1,597.

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

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

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

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

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

Thank you.

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

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

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

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

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

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

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

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

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

Thank you very much.

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

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

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

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

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

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

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

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

CHAIRWOMAN SAVAGE: Thank you.

Does anyone have any questions for our members here?

MEMBER KAATZ: Madam Chair, can I?

CHAIRWOMAN SAVAGE: Absolutely.

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

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

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

Medicaid; we have private insurance; we have HMOs.

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

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

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

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

CHAIRWOMAN SAVAGE: Yes.

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

setting versus a hospital setting?

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

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

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

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

DR. AL-KHALED: All complex intervention

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

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

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

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

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

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

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

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

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

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

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

MEMBER KAATZ: Thank you.

CHAIRWOMAN SAVAGE: Other questions?

MEMBER MARTELL: Yes. This is Dr. Martell.

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

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

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

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

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

and that was from OSF Little Company of Mary.

MEMBER MARTELL: Thank you for that clarification.

CHAIRWOMAN SAVAGE: Do we have any other questions?

(No response.)

CHAIRWOMAN SAVAGE: Okay. I do have a question.

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

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

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

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

Does that answer the question?

CHAIRWOMAN SAVAGE: It does.

MEMBER MARTELL: I have another question.

CHAIRWOMAN SAVAGE: Go ahead.

MEMBER MARTELL: It's for the staff members. I know that in October of 2019 we approved another ASC, and the volumes have not been reported. Do we have anything? I mean, we know that we went into a shutdown pretty quickly within almost the first quarter. Is there any update on the one that was approved in October to help us understand what their volumes have been like?

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

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

MR. CONSTANTINO: They will be, yes.

MEMBER MARTELL: Thank you.

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

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

CHAIRWOMAN SAVAGE: Thank you.

Any other questions?

(No response.)

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

MR. ROATE: Thank you, Madam Chair.

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

Senator Demuzio.

(No response.)

MR. ROATE: Senator Demuzio.

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

MR. ROATE: Okay. Mr. Kaatz.

MEMBER KAATZ: I'm opposed to the project.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Based on the staff report

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

MR. ROATE: Thank you.

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

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

MR. ROATE: Thank you.

Mr. Slater.

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

MR. ROATE: Thank you.

Chairwoman Savage.

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

MR. ROATE: Thank you.

Coming back to Senator Demuzio.

(No response.)

MR. ROATE: Shall we consider her absent?

CHAIRWOMAN SAVAGE: Absent, yes.

MR. ROATE: That's 5 votes in the

negative, 1 vote absent.

CHAIRWOMAN SAVAGE: So the application for permit is denied.

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

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

CHAIRWOMAN SAVAGE: May I make a correction?

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

CHAIRWOMAN SAVAGE: My apologies.

- - -

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

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

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

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

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

MEMBER KAATZ: Can you hear me now?

MEMBER MARTELL: Yes.

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

part of it.

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

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

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

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

CHAIRWOMAN SAVAGE: May I have a second.

MEMBER MARTELL: Dr. Martell, I so second.

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

AUDIENCE MEMBER: Yes, there are.

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

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

(No response.)

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

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

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

CHAIRWOMAN SAVAGE: That would be helpful.

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

CHAIRWOMAN SAVAGE: No, together would be helpful.

MR. SILBERMAN: Then I would acknowledge

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

(Whereupon, the witnesses were thereupon duly sworn.)

CHAIRWOMAN SAVAGE: Thank you.

Mike, please proceed with the State Board staff report.

MR. CONSTANTINO: Thank you, Madam Chair.

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

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

Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you. Okay. Mr. Silberman, Juan Morado, and others go forth.

MR. SILBERMAN: Yes, thank you. I will

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

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

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

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

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

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

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

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

And lastly, since today's project reflects

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

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

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

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

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

DR. OLUTADE: Thank you, Mark.

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

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

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

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

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

(Interrupted audio.)

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

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

DR. OLUTADE: Thank you. No problem.

I would just share the workaround that a

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

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

With that I'll hand over to Troy.

MR. DeDECKER: Thank you very much, Doctor.

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

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

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

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

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

Or more recently, a 52-year-old school

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

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

MS. CHAFIN: Thank you, Troy.

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

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

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

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

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

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

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

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

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

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

(Audio connection lost.)

CHAIRWOMAN SAVAGE: We lost you.

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

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

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

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

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

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

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

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

MR. MORADO: She should be online.

MR. SILBERMAN: Marty, are you online?

MS. CHAFIN: I am. I apologize.

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

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

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

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

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

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

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

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

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

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

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

Next slide.

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

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

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

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

The question again is how do we fill that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Under every need methodology there is

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

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

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

sufficient access for rehab beds in the region.

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

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

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

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

Gary.

MEMBER KAATZ: Thank you, Madam Chairwoman.

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

How many physiatrists will be practicing at the new hospital?

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

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

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

MEMBER KAATZ: Correct, making rounds.

MR. DeDECKER: Yes, we will.

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

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

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

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

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

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

MR. DeDECKER: No.

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

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

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

Thank you.

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

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

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

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

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

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

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

MEMBER MARTELL: Thank you.

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

MR. SILBERMAN: Marty, do you want to

address the challenges that the IRF faced?

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

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

MS. CHAFIN: Can you repeat that?

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

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

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

family visiting, therapy in space.

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

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

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

CHAIRWOMAN SAVAGE: It does. Thank you.

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

CHAIRWOMAN SAVAGE: Of course.

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

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

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

(No response.)

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

MR. ROATE: Thank you, Madam Chair.

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

Senator Demuzio.

(No response.)

MR. ROATE: Gary Kaatz.

MEMBER KAATZ: I vote yes.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: I vote yes in support of

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

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: -- the testimony.

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

CHAIRWOMAN SAVAGE: Repeat that, Linda.

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

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

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: I vote yes based on the testimony.

MR. ROATE: Thank you.

Chairwoman Savage.

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

MR. ROATE: Thank you.

That's 5 votes in the affirmative.

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

MR. SILBERMAN: Thank you very much.

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

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

MS. AVERY: Thank you.

- - -

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

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

MEMBER KAATZ: So moved.

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

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

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

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

CHAIRWOMAN SAVAGE: Thank you. Mike,

would you please present the State Board report.

MR. CONSTANTINO: Thank you, Madam Chair.

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

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

Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you.

Do any of the Board members have any questions?

(No response.)

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

MR. ROATE: Thank you, Madam Chair. Motion made by Mr. Kaatz, seconded by Dr. Martell.

Mr. Kaatz.

MEMBER KAATZ: I vote yes based on the

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

MR. ROATE: Thank you.

Dr. Martell.

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

MR. ROATE: Thank you.

Dr. Murray.

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

MR. ROATE: Thank you.

Mr. Slater.

(No response.)

MR. ROATE: Mr. Slater.

CHAIRWOMAN SAVAGE: I think he fell off.

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

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

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

MR. ROATE: Thank you.

Chairwoman Savage.

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

MR. ROATE: Thank you.

That's 5 votes in the affirmative.

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

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

CHAIRWOMAN SAVAGE: Thank you.

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

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

- - -

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

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

MEMBER MARTELL: I so move.

CHAIRWOMAN SAVAGE: May I have a second.

MEMBER KAATZ: I'll second that.

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

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

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

MR. MITCHELL: I couldn't hear that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. AVERY: They're on the phone.

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

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

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

MR. MITCHELL: Well, I have two proponents

Lee Francis and Bernice Mills-Thomas.

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

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

MS. AVERY: Thank you.

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

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

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

DR. FRANCIS: Thank you.

Bernice, do you want to go first?

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

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

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

MS. AVERY: Yes, please start.

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

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

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

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

I believe strongly that collaborative relationships in providing healthcare services

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

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

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

Thank you.

CHAIRWOMAN SAVAGE: The next proponent, please.

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

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

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

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

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

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

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

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

Thank you for your time and for hearing our testimony.

CHAIRWOMAN SAVAGE: Thank you.

Now if we can have the opponents speak.

(Audio reverberation.)

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

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

CHAIRWOMAN SAVAGE: It's echoing, yes.

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

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

MR. MITCHELL: Is Greg Will available?

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

MR. MITCHELL: Yes.

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

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

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

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

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

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

MR. WILL: Yeah, I can.

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

MR. WILL: Okay. Is this better?

CHAIRWOMAN SAVAGE: Talk a little more.

MR. WILL: Is this better?

CHAIRWOMAN SAVAGE: For now, yes. Thank you.

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

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

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

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

MR. ROATE: Two minutes.

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

MR. ROATE: Two minutes.

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

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

Thank you.

CHAIRWOMAN SAVAGE: Next.

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

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

CHAIRWOMAN SAVAGE: Yes. Thank you.

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

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

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

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

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

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

MR. ROATE: Two minutes.

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

MR. ROATE: Two minutes.

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

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

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

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

MR. MITCHELL: Wrap up your testimony, please.

MS. IGOE: Okay.

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

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

You're over the two minutes.

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

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

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

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

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

Ms. Smith, are you there?

MS. SMITH: Yes.

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

MS. SMITH: Can you hear me?

MR. MITCHELL: You need to speak up.

MS. SMITH: Can you hear me now?

MS. AVERY: Barely.

CHAIRWOMAN SAVAGE: A little bit louder, please.

MS. SMITH: Can you hear me better now?

MS. AVERY: Yes.

CHAIRWOMAN SAVAGE: Yes.

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

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

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

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

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

Thank you.

CHAIRWOMAN SAVAGE: Thank you. Next.

MR. MITCHELL: Is Marcus Buell available?

(Audio distortion.)

CHAIRWOMAN SAVAGE: Marcus?

(Audio distortion.)

CHAIRWOMAN SAVAGE: We can't hear you well.

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

(Audio distortion.)

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

Mitch, can you mute everyone?

Okay. Mitch, the next speaker, please. Thank you.

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

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

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

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

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

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

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

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

(Whereupon, five witnesses were thereupon

duly sworn.)

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

MR. CONSTANTINO: Thank you, Madam Chair.

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

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

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

Thank you, Madam Chair.

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

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

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

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

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

MEMBER MURRAY: This presentation is hard to hear.

MS. AVERY: Pull it close.

CHAIRWOMAN SAVAGE: Literally on top of it.

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

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

MS. AVERY: Okay.

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

five years.

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

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

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

Since the opening of Feinberg Galter 20 years

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

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

As stated in our CON application, while

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

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

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

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

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

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

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

increase in bed capacity will allow for it.

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

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

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

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

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

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

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

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

Thank you.

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

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

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

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

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

MEMBER KAATZ: I do.

MEMBER MURRAY: Yes, I have a question.

MEMBER KAATZ: I'll defer.

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

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

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

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

MS. ORTH: That is correct.

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

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

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

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

It's a really important question.

Thank you.

MEMBER MARTELL: I also have a question,

Madam Chair.

CHAIRWOMAN SAVAGE: Yes, Dr. Martell.

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

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

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

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

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

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

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

Thank you.

CHAIRWOMAN SAVAGE: Gary.

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

MS. MURPHY: I can answer that.

MS. AVERY: Really loud.

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

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

CHAIRWOMAN SAVAGE: Gary.

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

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

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

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

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

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

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

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

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

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

MEMBER KAATZ: Yeah, yeah.

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

MEMBER KAATZ: Thank you.

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

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

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

CHAIRWOMAN SAVAGE: And then I see that

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

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

CHAIRWOMAN SAVAGE: Right.

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

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

CHAIRWOMAN SAVAGE: Okay. Thank you.

Does anyone else have any other questions?

(No response.)

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

MR. ROATE: Thank you, Madam Chair.

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

Senator Demuzio.

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

MR. ROATE: Thank you.

Mr. Kaatz.

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

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. Murray.

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

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes, based on staff report.

MR. ROATE: Thank you.

Chairwoman Savage.

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

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

CHAIRWOMAN SAVAGE: The application for permit is approved.

MS. CREAMER: Thank you so much.

- - -

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

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

MS. AVERY: Yes, I did.

MS. IGOE: -- for the next project?

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

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

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

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

community that is hurting for healthcare or healthcare access.

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

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

Northwestern Medicine has no business opening

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

MR. ROATE: Two minutes.

MS. IGOE: Thank you.

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

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

MR. MITCHELL: Yes.

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

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

fits this pattern.

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

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

CHAIRWOMAN SAVAGE: Thank you. Any other speakers?

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

(No response.)

MR. MITCHELL: Ms. Smith.

MS. SMITH: Can you hear me?

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

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

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

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

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

MR. ROATE: Two minutes.

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

CHAIRWOMAN SAVAGE: Thank you. And those

are the only participants, correct, Mr. Mitchell?

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

(No response.)

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

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

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

MR. MITCHELL: What was that, Courtney?

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

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

MS. AVERY: Okay. Thank you.

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

MS. AVERY: Would you, please.

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

(No response.)

MS. AVERY: Okay. Thank you, Mitch.

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

MEMBER KAATZ: I'll move.

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

MS. AVERY: Dr. Murray?

MEMBER MURRAY: Yes, I'll second.

CHAIRWOMAN SAVAGE: You're sworn in already.

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

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

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

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

Thank you, Madam Chair.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

substance abuse.

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

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

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

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

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

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

CHAIRWOMAN SAVAGE: Does the Board have any questions.

MEMBER KAATZ: Madam Chair.

CHAIRWOMAN SAVAGE: Gary, go ahead.

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

MS. ORTH: Actually, three.

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

MS. ORTH: Correct, and then physician practices.

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

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

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

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

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

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

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

MEMBER KAATZ: Yes.

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

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

MS. ORTH: Correct.

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

MS. ORTH: Correct.

MEMBER KAATZ: Perfect. Thank you.

CHAIRWOMAN SAVAGE: Any other questions from the Board?

(No response.)

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

MR. ROATE: Thank you, Madam Chair. Motion made by Mr. Kaatz seconded by Dr. Murray.

Senator Demuzio.

(No response.)

MR. ROATE: I'll come back.

Mr. Kaatz.

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

MR. ROATE: Thank you, sir.

Dr. Martell.

MEMBER MARTELL: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. Murray.

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

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes, based on staff report.

MR. ROATE: Thank you.

Senator Demuzio.

MEMBER DEMUZIO: George?

MR. ROATE: Yes, ma'am.

MEMBER DEMUZIO: Did you call my name?

MR. ROATE: Yes.

CHAIRWOMAN SAVAGE: How do you vote, Senator Demuzio?

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

MR. ROATE: Thank you.

Chairwoman Savage.

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

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

CHAIRWOMAN SAVAGE: Your application is approved. Thank you.

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

- - -

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

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

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

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

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

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

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

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

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

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

yourselves and being sworn in.

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

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

(Four witnesses were duly sworn.)

CHAIRWOMAN SAVAGE: Thank you.

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

MR. CONSTANTINO: Thank you, Madam Chair.

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

Thank you.

CHAIRWOMAN SAVAGE: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

MR. AXEL: Thank you.

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

single criterion that could possibly be met by the applicants.

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

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

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

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

CHAIRWOMAN SAVAGE: Any questions from our Board members?

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

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

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

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

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

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

MEMBER KAATZ: Thank you.

MR. BAIRD: You're welcome.

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

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

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

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

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

CHAIRWOMAN SAVAGE: Any other questions from the Board?

(No response.)

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

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

Senator Demuzio.

(No response.)

MR. ROATE: I'll return back.

Mr. Kaatz.

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

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: No, based on staff report.

MR. ROATE: Thank you.

Dr. Murray. Dr. Murray.

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

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

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: I vote yes based on the testimony.

MR. ROATE: Thank you. Senator Demuzio.

MEMBER DEMUZIO: George?

MR. ROATE: Yes, ma'am.

MEMBER DEMUZIO: Can you hear me?

CHAIRWOMAN SAVAGE: Yes. What is your vote?

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

MR. ROATE: Thank you.

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

MEMBER KAATZ: My vote was yes.

MR. ROATE: Okay, thank you.

Chairwoman Savage.

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

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

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

CHAIRWOMAN SAVAGE: Certainly.

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

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

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

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

MS. AVERY: Or have Mike respond to.

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

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

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

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

CHAIRWOMAN SAVAGE: Mr. Axel will speak now.

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

this on numerous occasions.

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

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

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

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

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

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

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

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

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

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

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

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

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

endo. The other ASTCs do not provide endoscopy services.

CHAIRWOMAN SAVAGE: Doctor, did you want to share?

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

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

MS. AVERY: Really loud, closer and louder.

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

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

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

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

MR. AXEL: Will we do a revote?

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

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

MEMBER MURRAY: Were you asking me?

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

MEMBER MURRAY: Yes, I vote no.

CHAIRWOMAN SAVAGE: Thank you.

Dr. Martell.

MEMBER MARTELL: I'm voting no.

CHAIRWOMAN SAVAGE: Thank you.

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

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

MR. AXEL: Thank you.

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

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

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

MEMBER MARTELL: I will, Courtney. Thank you.

MS. AVERY: Thank you.

- - -

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

CHAIRWOMAN SAVAGE: 19-015.

MS. AVERY: We're early.

(Audio disruption.)

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

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

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

MS. KNIGHT: Okay. You can hear me?

MS. AVERY: Are you driving?

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

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

somewhere where you can eliminate the background noise.

MS. KNIGHT: Can you repeat that?

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

MR. MITCHELL: Go ahead, Colandra.

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

MR. MITCHELL: Colandra?

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

MEMBER DEMUZIO: Hello?

CHAIRWOMAN SAVAGE: Is that you, Colandra?

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

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

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

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

MR. MITCHELL: Okay.

- - -

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

MS. GUILD: Yes, I do.

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

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

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

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

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

(No response.)

- - -

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

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

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

CHAIRWOMAN SAVAGE: That would be helpful.

Any questions anyone has?

(No response.)

- - -

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

MR. MITCHELL: Colandra, are you there?

MEMBER DEMUZIO: Hello?

MS. AVERY: Hold on, Senator.

MEMBER DEMUZIO: Hello?

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

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

MR. MITCHELL: Is Colandra Knight online?

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

CHAIRWOMAN SAVAGE: Colandra, are you back with us?

(No response.)

MR. MITCHELL: Colandra, are you there?

(No response.)

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

MEMBER MURRAY: This is Dr. Murray, I so move.

CHAIRWOMAN SAVAGE: A second.

MEMBER KAATZ: I will second that.

CHAIRWOMAN SAVAGE: Gary has seconded. Thank you.

And then if you folks could say your names and spell them for our court reporter, and then you'll be sworn.

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

MR. SHAZZAD: Asim Shazzad, A-s-i-m S-h-a-z-z-a-d.

MS. SMITH: Melissa --

MR. MITCHELL: Salman Azam is unmuted.

MR. AZAM: I'm here. This Salman Azam. S-a-l-m-a-n; last name Azam, A-z-a-m.

CHAIRWOMAN SAVAGE: Try that again.

MS. SMITH: Melissa Smith, M-e-l-i-s-s-a S-m-i-t-h.

MR. SHAZZAD: Dr. Tauseef Sarguroh just pulled up outside. He'll be probably a minute or two, if that's okay.

CHAIRWOMAN SAVAGE: Yes.

MR. SHAZZAD: T-a-u-s-e-e-f S-a-r-g-u-r-o-h.

CHAIRWOMAN SAVAGE: Okay. So we'll swear

these folks in and then we'll swear them in when they return.

(Whereupon, four witness were duly sworn.)

CHAIRWOMAN SAVAGE: Mike, if you could read us our State Board staff report.

MR. CONSTANTINO: Thank you, Madam Chair.

The applicants are proposing to establish a 14-station ESRD facility in Chicago Heights, Illinois.

The cost of the project is approximately $2.6 million, and the expected completion date is May 31st, 2021.

This application received an intent to deny, and the transcript from that meeting is included at the end of your report. There were also letters of opposition received by the State Board staff, no letters of support.

Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you. Okay. We have one more person to be sworn in. You can sit down, that's fine, and then what you'll do is say your name, spell your name, and she'll swear you in.

DR. SARGUROH: So my first name is Tauseef, T-a-u-s-e-e-f. My last name is Sarguroh,

S-a-r-g-u-r-o-h.

(Witness sworn.)

MS. AVERY: Mr. Mitchell, do we have Colandra Knight on the line yet?

MR. MITCHELL: No, I haven't been able to make any contact with Colandra. I see her listed but we're not getting through to her.

CHAIRWOMAN SAVAGE: If that changes, if you can put that in the chat, and then we'll make room for her if the timing is right.

Okay. If you would like to proceed with your presentation to the Board.

DR. SALAKO: Good afternoon, members of the Board.

MS. AVERY: You're going to have to speak very loud because they have to hear on that speaker down there.

DR. SALAKO: Thank you for allowing us to present during this very interesting time during the COVID pandemic. Unfortunately, I can't see all your faces, but it is what it is.

Here we are with our clinic in Chicago Heights, and one of the things that will be mentioned during the course of our presentation

today is that we did modify the application a few months ago after the first intent to deny to request 8 -- a minimum of 8 of those 14 stations to be transitional care units, which we will talk about in some detail during this presentation what a transitional care unit is and how that model works for us and is going to be a positive impact for the dialysis patients in that community.

You heard DCC's story before, so you're familiar with us. We're a local Illinois company owned and managed by physicians. We're a minority-owned company. We're a success story in Illinois. We can proudly say that we are the fastest growing company that focuses on home dialysis today in the United States.

Part of our request for this unit in Chicago Heights is to have 8 stations for -- at least 8 stations for transitional care units is our focus on getting the patients home. During this presentation you will hear from Chief Operating Officer Asim Shazzad talk to you about TCUs. You will hear from our head nurse Ms. Melissa Smith, who is a champion of home dialysis talk about the importance of getting the

patients home and using the TCU to get them home. You will also hear from one of my medical directors, Dr. Tauseef Sarguroh on what he has experienced especially in the last three months since the time of COVID.

I would like to say starting off the bat that -- well, I'll let them start and I will wrap up everyone's thoughts and processes.

MS. SMITH: Good afternoon. My name is Melissa Smith. I'm the director of operations for Dialysis Care Center, and I am also a home therapy nurse. I am speaking on behalf of the patients and families that will benefit from the proposed end center with a transitional care unit on the premises.

As many of you have heard in past presentations by us, end-stage renal disease is a terminal diagnosis unless a patient receives a transplant, recovers function miraculously, or chooses comfort care in hospice.

To be given this diagnosis suddenly is overwhelming and confusing. Not only are patients grieving the loss of their previous lifestyle, they're now expected to choose what type of

dialysis they would like to have. To make this even more stressful, the team often needs an answer within hours of the diagnosis. This decision is a heavy burden on patients and their families and should not have to be made quickly.

The transitional care unit has been designed to give patients the necessary time to make an informed decision about their future dialysis care. They're able to start dialysis immediately in the transitional unit without the pressure of making a life changing about their future before they have had a chance to research their dialysis options, be presented with formal modality education, and discuss their choices with their loved ones. Transitional care allows them to feel better physically, followed by consistent and thorough education on their dialysis options, including home therapy.

Home therapy patient ambassadors would be able to visit with clients and share their personal stories, answer questions based on experience, and provide valuable insight into the home program. Patients would have then have several weeks to undergo education and make an

informed decision. This would allow patients to truly understand the benefits of all modalities but with an emphasis on home therapy as the ultimate outcome.

The transitional care program would allow patients to fully understand that home therapy is the future of dialysis care in our new COVID world. They would be able to see the significant benefits of home therapy during the time of the COVID pandemic and how the home program allows patients to remain healthy and safe in the comfort of their home while still receiving optimal dialysis care and telehealth communication with their care team.

Although not all patients are candidates for home therapy, the transitional care unit will allow for better screening, education, and informed decision making for those who would be able to benefit from a home therapy program.

Thank you for your time and consideration of the future of dialysis care with the addition of transitional care options for patients and their loved ones.

DR. SARGUROH: Good afternoon everyone. Thank you for allowing us this opportunity to talk

about this transitional care unit. My name is Dr. Sarguroh, and I'm the medical director at one of the units at the Olympia Fields/Chicago Heights area.

I was earlier here for the initial unit, and I'm back now after a few months, and things have drastically changed over the last three months with regards to the pandemic and the disease processes that we're seeing these days at the hospital.

One of the things that -- I've personally been part of the front force in this pandemic, and I have seen a lot of these COVID patients needing dialysis. You know, we have had a lot of COVID nephropathy, and patients who have made it have recovered their renal function, and they go on to do better off of dialysis after their acute kidney injury resolves. I do feel strongly that the transitional care unit not just gives us an opportunity to treat end-stage renal disease patients just like Melissa mentioned but also helps COVID patients who might have kidney disease or have the need for dialysis also make decisions where they can do dialysis at home and eventually

recover renal function.

I am proud to say that our home program based out of Olympia Fields has no COVID-positive patients. Also, I'm proud to say that our end center unit has had only one COVID-positive patient.

So we've done great as far as taking care of our patient population, and also, as far as me being a nephrologist in the area, I have seen in the last three months -- and we've spent hours of our time taking care of these really sick COVID patients, and they're on ventilators for weeks before they recover, and almost 60 percent of these patients who are in the ICU have some form of kidney involvement.

I appreciate you giving us the opportunity to come in front of the Board and presenting our case, and I hope that you make a decision in our favor.

MR. SHAZZAD: First of all, I would like to thank the Board members for coming and for being here especially during these hard times.

Overall, we had a positive SAR report besides the excess of stations. Those excess of stations, we modified our application to be a TCU,

transitional care unit. I know Fresenius did an in-service previously on TCUs, so I'm not going to go into too much detail about what a TCU is but I'll cover the basics.

A TCU offers the patients more education than the traditional dialysis. It gives them options on home hemodialysis, on peritoneal dialysis, transplants. The TCU setting eases them into dialysis. The patients make their most informed treatment plan options, and we know this when the patients are on TCU, more than half of them do home dialysis.

Fresenius released an article on June 17th, announced that they are only going to do TCU units. They're opening about 100 TCU units this year. Also, before us DaVita and Fresenius both presented TCU applications. None of them were denied. Chicago Heights needs a TCU center. They don't have any, so I would strongly urge the Board to approve this for the patients in Chicago Heights.

That's all I have. I'll answer any questions.

DR. SALAKO: Thank you, Board members. I appreciate your time today.

As my colleagues have said that you probably are well aware, the whole idea of a TCU is we want the situation to create a new environment for dialysis patients. Studies have shown across our clinics in the Chicagoland area, we have 35 of our patients dialyzed -- or 35 percent of all patients dialyze at home. None of our home patients in the last 14 weeks have tested positive for COVID.

That's a big deal. That means that these patients are not going to be a burden on the healthcare system. They've taken the strain and reduced it on the healthcare system. A lot of patients who developed COVID ended up in the in-centers or got cross-contaminated from COVID at an in-center. So it's safer for patients to dialyze at home. Studies have also shown that patients who dialyze at home have better mortality morbidity.

It's always been a head scratcher for us in the dialysis industry to say how can we increase patient participation at home. Peritoneal dialysis, we have one of the highest percentage of patients of peritoneal dialysis in Illinois. We have one of the highest rates of patients on home hemodialysis.

With a TCU model now what we're trying to do is continue our success story, getting patients home. If we get those patients in a TCU unit, we can aggressively educate them; we can aggressively train them; we can get them to a level of comfort cannulating themselves, being very familiar with the machines. Over a period of four to six weeks seeing other people around them go home they're encouraged to go home. They feel, "If the person dialyzing next to me can do it, I can do it, too." And I think that's where we all need to be.

There's a study out there that wants us to get to 20 percent of dialysis patients dialyzing at home by 2025. We at DCC, we're already over that threshold. 33 percent of our patients are dialyzing at home already, but we want to get to 40 percent.

If you have the opportunity to look at all the opposition to our application, it's all down to the fact that the opposition was DaVita trying to use the CON Board as a means to stifle competition. We've come into the market; we've provided very good care; our physician partners are excellent, and we've been able to give patients in very

underserved communities where we are in Chicago Heights, in the City of Chicago, in the depressed parts of Rockford, we've been able to provide for our patients, build clinics where they are not building clinics.

As I said earlier, we're very proud of our roots, growing up, hiring people from the state of Illinois, hiring minorities. We're very proud of what we are, and we really would like our success story to go to the next level. And the next level is we would like to have at least an end-station TCU clinic in Chicago Heights that serves a very big population and aggressively using that tool to increase the percentage of our patients that dialyze at home. It is good medicine; it is good policy; it is good public health, and we appreciate the Board sporting us to accomplish that goal.

MR. SHAZZAD: Just wanted to add two things that I missed. After we amended our application for TCU as of June 1st we did not get any opposition from DaVita or Fresenius.

Also, I know there was some confusion about this being a respite clinic. It is not a respite

clinic; it is a true TCU clinic in Chicago Heights.

I have our attorney on the line if you guys have any questions. I think he would like to add a few comments if he's able to, as well. I think he's logged in on the computer.

CHAIRWOMAN SAVAGE: Do we have the attorney for the Dialysis Care Center on the line? You have to be sworn in, so could you please spell your last name for our court reporter first.

MR. AZAM: Absolutely. The first name is Salman, S-a-l-m-a-n. The last name is Azam, A-z-a-m.

(Witness sworn.)

CHAIRWOMAN SAVAGE: Please proceed.

MR. AZAM: Thank you. I want to thank the Board for getting together today, and I apologize for my not being able to be there in person at this time.

I think this is a very important application. It's not -- it's not an application just for a transitional care unit but an application for a larger and necessary change.

I think that a lot of us are already aware of the CMS and the Federal push to be headed

towards more home therapies and a transition to more home care, a patient centric care model. We've heard, you know, "Patients over paper," and that's exactly what we're trying to deal with today. We're not looking at number of chairs; we're looking at this model that the Federal government is looking to go towards. And when they put their timeline in front of us, and there was a timeline of a couple of years to really be aggressive with this push, at that time there was no global pandemic that has basically put this at the forefront. This is not only an initiative, but it's a need because it is more -- it resonates more with the safety of our patients and the well-being of our patients.

My colleagues that went before me have told you the numbers, and the success, and the needs for the transitional care units because of our company's access with home therapies and home dialysis. We can't get there without our transitional care unit, and right now I think patient safety, patient needs, and patient health is what we are entrusted with as a dialysis provider and the Board is entrusted with as constituents of

the state of Illinois that need healthcare and in this specific need, dialysis care.

As companies all over try to adapt to become safer and adapt to more health conscious ways to serve customers, we have to think about dialysis care patients who are high-risk individuals because of their illness, and allowing for transitional care is basically not only doing what is necessary to keep them safe and also to deal with their health, but also it is an opportunity to set an example, to take a lead in these new initiatives that we are looking to roll out.

So while we endeavor to be the best, while we see other companies pivoting and shifting, whether it's alcohol companies making sanitizers or, you know, people making masks, I think this is our effort, our way to go ahead and take -- to make an example, to take initiative on building towards, you know, patients over papers, to transition into more home therapies and therapies that are safer for our population. And by allowing a transitional care unit, it's not only our request, but I really believe that in this time our responsibility to take the lead and go to

the forefront.

We always see lagging behind even on these kinds of transitional care and home therapies with other developed nations, and we will see the nexus that we're also suffering in this pandemic. It is a time and an opportunity for us to reverse that, to take the lead and show that we can implement these programs and these initiatives as well as everybody else. And there's no better time than the present with what is going on for us to implement this, to take the initiative and take a real stand here and go for this transitional care unit, which has obviously, as my colleagues have shown you, produced better results, is patient preference and patient centric.

Let's once again put patients over paper. Let's go ahead and vote for this transitional care unit for the betterment of patients in this demographic in Chicago Ridge and the state of Illinois.

Thank you, Board.

CHAIRWOMAN SAVAGE: Thank you.

Do we have any other public participation here in the room?

MR. SHAZZAD: If the Board has any questions.

CHAIRWOMAN SAVAGE: Well, we are going to hear from whomever the opposition person is on the phone. So, Mike, do you have someone who is apparently reading Colandra Knight's statement?

MS. AVERY: No. We're not accepting her statement.

CHAIRWOMAN SAVAGE: No?

MR. MITCHELL: Yes, I have John Bice on the line. John, are you there?

MR. BICE: Hello. I'm here. Can you hear me?

CHAIRWOMAN SAVAGE: Yes, we can.

MR. BICE: All right. So I will read directly from Colandra Knight's statement.

MS. AVERY: Sorry to interrupt you, but we cannot allow that. That's against our rules. I had a discussion with Anne Cooper. The testimony must be yours. You cannot read on behalf of someone else in public participation. So at this time we will not be able to accept it. So we'll have to strike that from -- we won't allow that to be read into the record.

CHAIRWOMAN SAVAGE: But if you have your own testimony, you may testify.

(No response.)

CHAIRWOMAN SAVAGE: Okay. So, George, would you like to do a roll call -- actually, first, do we have any questions? Good Lord, such craziness today.

MEMBER KAATZ: Madam Chair, if I may.

Help me get a better understanding. I read the staff report, and I see that there's a dramatic excess capacity, and you're asking for new beds for the transitional care program. Why are you not able to just convert some of your existing beds to transitional care beds, please?

DR. SALAKO: Good question, sir.

First, it's the design of the facility. Two points.

MS. AVERY: Sir, louder.

DR. SALAKO: Yes, ma'am.

MS. AVERY: Thank you.

DR. SALAKO: First, it's the way the facilities are being designed. Okay? It's almost akin to, you know, back in the days when you had wards and now you have separate side rooms. The

way those facilities are designed, they're kind of in two- to four-person co-parts. Whereas, in a dialysis unit and we have 20 chairs in there, 10 against this wall, 10 against that wall, and a nurse's station in the middle.

TCUs, the way they're designed, it's going to be more like pockets of four here, pockets of four so that there's training and the nurse -- the whole idea is you want to have an environment in which the nurses can have more hands-on training and supervision of the patients as against the technician just giving the patients hemodialysis, coming and leaving.

So that's one piece. There's a physical plant -- there's a physical plant component to it. The second component is that we in that community, we have two other things. Our utilization in our clinics there, our clinics are full. Okay? So those are traditional in-center clinics. So for us to do that, we will have to A, discharge patients out of our clinics, send them somewhere else, reengineer our clinics, rebuild them into TCUs, and then convert a preexisting clinic into a TCU. From a developmental operational point of

view that just will not work.

So there are two components. One, the layout is different. Two, we just don't have the capacity. So as much as there are excess chairs for several other providers, we just opened a clinic earlier this year, and that clinic is already at 75 percent utilization. So we just don't have the chairs.

We would like to have those chairs. We would like to provide the continuum of care for our patients, and several of our patients, several of our doctors, you know, they would like those patients to stay in it while they know the quality of care we'll give them. That's an integral part.

MEMBER KAATZ: Roughly what is your average length of stay for a patient on hemodialysis right now?

MS. AVERY: If you don't get a transplant, hemodialysis is the rest of your life. Now, the transplant rate in the United States has hovered around 72 percent. That hasn't changed in the last 20 years. In our business today 30 percent of our patients dialyze at home better than any of the LDs. The LDs are at about 10 or 12 percent.

Most of them the goal is 15 percent.

So we really push our patients to go home. Dr. Sarguroh is one of our medical directors can talk to you more about it but this is our goal. And what we're going to do here is this, and I can tell you from a purely business perspective -- I know the doctors will talk about caring for patients. For the dialysis patient it's good to dialyze at home; your mortality is better; your morbidity is better. From a business perspective it's better to have a patient at home. That's why CMS is pushing for it; that's why they have these initiatives.

If you look at the hospitalization rates of the dialysis patients, patients who dialyze at home go to the hospital a third of the times that the patients at an in-center. If you're a Medicare patient, each day in the hospital is 2 to $3,000 to CMS. Those patients that dialyze at home do so much better.

One of the things about COVID is very interesting. You have a patient who gets -- who is coming to dialysis on public transportation with other patients that -- how do you space people

in a van that's bringing four patients to dialysis? So you get a lot of cross-contamination. Our patients who dialyze at home get it brought to their doorstep, their loved ones move it into their rooms, they're dialyzing in their home. Not one of our home patients got diagnosed with COVID. That's why we really, really want to do this. This would really be a game changer for patients.

DR. SARGUROH: I'm going to add to what Dr. Salako had to say, and I'm going to be honest here, I do not understand the business aspect of this, you know, but as far as the medical aspect of transitioning these in-center hemo patients to home therapy, I've personally been involved in that transition of care, and I am proud to say that the patients that we've transitioned to home and I'm taking care of these patients at our clinic have done exceptionally good over the last three months even with the COVID pandemic going on.

We're not setting up clinic for these patients, so we speak to them over the phone or video, and we take care of their needs without them having to come in to see us. And I think they're doing great, their numbers look good, and

just patients are doing better without, you know, having the risk of contracting COVID at least over the last few months, and I have a feeling that COVID is going to stay around for a lot longer.

MR. SHAZZAD: I just wanted to add one thing off the SAR report. In the SAR report it says that March 31st the closest unit we had was at 98 percent utilization. After March 31st we're at 130 percent utilization. We opened a fourth shift, as well, and we just can't accommodate TCUs in that setting.

MEMBER KAATZ: Thank you.

CHAIRWOMAN SAVAGE: If I can ask, what about the newer facility that was in the report as about 44 percent?

MR. SHAZZAD: I would say that's not even in the -- I know it says 5 mile GSA. It's Hazel Crest. This is Chicago Heights. It's three suburbs away -- three or four suburbs away, actually, and that's already at 75 percent. The data has this as March 31st, once again, it's dated.

CHAIRWOMAN SAVAGE: Thank you.

Dr. Murray, do you have any specific questions?

MEMBER MURRAY: Well, I guess I'm just --

CHAIRWOMAN SAVAGE: I do but I want to make sure we get you guys first.

MEMBER MURRAY: Yes. I guess I'm really -- it's hard to hear, so I apologize for that, but I just don't understand how adding these beds helps -- these stations helps with, quote, transitioning to home dialysis.

Is there some difference between -- is there something special about transition spaces that I'm unaware of? Can't you change -- I mean, now we transition people in the present spaces you have in the facilities; right?

DR. SARGUROH: Dr. Murray, this is Dr. Sarguroh. Let me take that question.

CHAIRWOMAN SAVAGE: Can you hear him, Dr. Murray?

DR. SARGUROH: Dr. Murray, can you hear me?

CHAIRWOMAN SAVAGE: Yes. Go ahead.

DR. SARGUROH: I'm going to go back to what Dr. Salako was speaking about the design of these units and how these patients are in pods of four each. And what happens is in a conventional in-center hemodialysis unit the stations are

spread out, the patients don't interact with each other. As far as group training is concerned, we don't see that at all at a conventional in-center dialysis unit.

With these transitional care units, there is more focus on educating these patients about their home therapy options. And as far as training and educating is concerned, it's more convenient, if not better to talk to these patients, educate them, and then transition them to these home therapies.

And we've tried that in our in-center conventional hemo units, as well. We've been doing that. I have personally transitioned these patients to home therapies. It just makes a transitional care unit more convenient for us to do more of that and have better results.

CHAIRWOMAN SAVAGE: Mr. Slater, do you have any questions?

(No response.)

CHAIRWOMAN SAVAGE: Did you have something more, Dr. Murray?

MEMBER MURRAY: I just wanted to make sure that I'm understanding because I want to be fair

because, you know, it's so difficult to hear.

I do understand -- what I think I heard you say is that when you're transitioning a patient from a dialysis unit to home dialysis, a lot more education and hands-on helping the patient understand how to do what's necessary.

DR. SARGUROH: That is exactly right.

MEMBER MURRAY: And I can see how a space designed specifically for that might be a little different. But what I'm having trouble understanding -- you know, this is not like excess stations of 10 or 15 in this area, it's 128 excess stations. And even one of your facilities I think was below 50 percent, if my memory serves, below 50 percent capacity.

So I guess my real question is, is it possible to better assign these stations without actually adding more stations? What your application is really having trouble with is that in this specific area there is so much excess. Even within the two facilities that you operate, one is at 90 percent plus, and one is at under 50 percent.

So I'm not really convinced that adding

these beds is the only way to go -- or the best way to go is a better way to say it.

DR. SARGUROH: Dr. Murray, you're exactly right about your initial statement where you said it's more hands-on, more educational. The two facilities that we have in that area, one is Olympia Fields and the other one is Hazel Crest. Olympia Fields is almost at 90 percent -- it's 130 percent and the Hazel Crest unit as of today is 75 percent capacity. As of today it's 75 percent capacity.

So the two units that we have in that area are doing good, and we're using those two units as part of our transitional care at this point, you know, and having these extra stations with that design is more hands-on, more education, and more transition to home therapies.

So just following up on your initial statement, that's how I personally feel about this.

DR. SALAKO: One other comment, Dr. Murray. The second clinic in Hazel Crest that we opened last year at 75 percent, we have a dedicated COVID shift on that unit. That is one -- that clinic, a particular shift of patients there is dedicated

for COVID patients.

That is also a big deal for us because cross-contamination is something we absolutely want to avoid. So what happens is most dialysis clinics open Monday/Wednesday/Friday - Tuesday/Thursday/Saturday. So on a Tuesday/Thursday/Saturday shift, we try to do the morning and afternoon shift, finish as early as possible, and we leave all of the evening shift sometimes two patients, sometimes up to four patients depending on where those COVID-positive patients become COVID negative.

But it's imperative that we keep that COVID shift opened because in that community we're one of very few clinics that are accepting COVID patients. You have to get the staff ready for it; you have to give them special PPE; you have to clean the facility down after treatment. It's a huge operational exercise to have this one clinic in that community treating COVID patients.

We're proud of it. We're proud of what we're doing in the community. Every day I'm proud of my staff who have to leave home, put themselves at risk and treat COVID-positive patients. And as Dr. Sarguroh said, as we have seen unfortunately,

COVID is going to be with us for a while until we get a vaccine. That's the reality we all have to deal with, and we have -- as dialysis providers, we must find a strategy that reduces exposure of our patients, and the way to do it is to get the majority of your patients dialyzing in the safety of their homes where they have the minimal chance of contracting COVID from other people.

We cannot do this, unfortunately, in a facility we don't own or don't control or a provider that doesn't share our values. We just can't do it. I wish we could.

DR. SARGUROH: Dr. Murray, if you can hear me, I'm also excited to share this with you and the Board. A lot of our patients went to the Hazel Crest unit, so that area, you know, in Chicagoland was a hotbed of COVID. We saw a lot of COVID-positive patients who were very critically ill, and a lot of them had COVID nephropathies that required dialysis. And I'm still fascinated by how COVID affects the kidneys and the number of patients that end up needing dialysis, but I am proud and excited to share this with you that a lot of our patients that went through that

specific Hazel Crest unit and were part of that COVID shift have actually recovered renal function and are off of dialysis now, and I'm really excited to share this with you. I think it's part of because of the care we give to these patients and the follow-up that we have, and I am really proud and excited to share this with the Board.

CHAIRWOMAN SAVAGE: Anything further, Dr. Murray?

MEMBER MURRAY: No, thank you.

CHAIRWOMAN SAVAGE: Thank you. Okay. So I guess with your TCU patients, where are they primarily coming from then? Are they coming from those other two clinics to be in your new facility potentially with your six-bed stations and your eight other stations of TCU?

DR. SALAKO: Primarily -- several. You know, the way we -- in that community -- first of all, in our clinic in Olympia Fields, we have a fourth shift there, and the fourth-shift patients are dialyzing until 10:00, 12:00 at night. In the summer it's acceptable; in the winter it's dangerous. So for us -- it's patient's choice. We were hoping they could go somewhere else, but

we really need to offload that shift. That's one.

The second thing is several patients who have -- who are expressing an intention to go to home, we can now put them together and treat them and educate them as a co-part. So that is one group of patients who will go there.

The folks who benefit the most are the new ones to dialysis. They're the ones who are most likely going to go home if you treat them in a TCU unit within the first six weeks of starting dialysis. So what you're going to get is this -- habits are difficult to change. If someone has been used to coming to a dialysis unit every day, they've gotten a relationship with the transportation company; they like the transportation driver; it's so difficult to change habits.

What we find is that when patients are new to dialysis and you introduce them to dialysis in the TCU with the proviso that, "Listen, I want you to learn to cannulate yourself; I want you to learn to set up a machine; this machine is the kind of machine you're going to use at home," that mindset, that programming is a lot easier for the patient in achieving the goal of dialyzing at home.

I can tell you that if you have a patient who has been there for three years, you're not going to get that patient to go home. You're going to get a patient who is new to dialysis, comes in, sees the nurses every day, the nurses assure them, "These are the needles, start sticking yourself after the second week." Three weeks into it they come in and say, "Where is your caregiver at home," help them set up this machine, say, "This alarm means this; this alarm means that." Four weeks into it, five weeks into it do a home visit and say, "Where are you going to put this machine in your house?" That's where the access is going to come from. It's a painstaking process; you have to be passionate about it; you don't get brownie points for doing it, but eventually we all know it is best for the patient.

I'm a physician. I pray I don't go into dialysis, but if I ever have to do it, I will dialyze in my house every day at night rather than go to an in-center facility for three hours three times a week, a lot stress on my heart, and my outcomes will be a whole lot better.

MR. AZAM: Just to add to that, a little

bit of history of why DCC would be very good at this is because history will show that Dialysis Care Center was actually started as a home therapy. We believe in home dialysis; we believe in home therapies; it's still an integral part of our business system. We're just taking the corporate responsibility at this time to push it even more.

Now, I don't know about everybody else in that space in Chicago Heights, where home therapies and home dialysis serves on their scale, but it's a very important part of our system, and we are wanting to push it. And that just kind of furthers the point that Dr. Salako said. In a facility that we do not own, in a facility whose priorities we cannot control, we cannot effectively transition these patients because we don't have that control.

And in effect, to further this agenda -- which is not just for COVID. Remember I talked about patients before, patients before paper, I talked about the CMS initiative. This is an initiative that we need to go to anyway. We just think that it needs to get sped up because of the

situation around us.

But this is not just to address a temporary situation; this is for the long-term benefit of patients, and we think that no one else is as uniquely qualified because of our commitment to home dialysis and home therapies along with our in-center experience, and that's why we want to take this time and this opportunity to further this.

CHAIRWOMAN SAVAGE: If I could ask a little bit more about the patients that are going to be coming to your facility. So, you know, I know you're getting a lot of new patients because of COVID sadly, but hopefully eventually that will end we pray. But nonetheless, if the patients do go on the home dialysis we'll call it, those patients will probably continue doing that most likely for the rest of their time.

So if you're going to take people from your 90/130 percent place and try and convert them, where else is this volume going to come from that's going to undo this 128 stations where only one is functioning at 80 percent? I understand they're not yours, but nonetheless there's plenty of dialysis available. I believe you said

something about Fresenius possibility having 100 percent of their people going to TC, which I've not heard about.

But how is that going to work? Because at the moment I just can't understand why we would need to add -- even if we said the TCC was somehow separate and you would never do dialysis as a station, we have 134 excess stations, so that would be your 6 that you would still be using, or we'd have 142 if we included the TCC beds themselves.

DR. SARGUROH: So let me go back to the first statement that you made, ma'am. COVID, the incidence of -- and I've been working almost every day for the last eight months, and I see things at the hospital. The incidence of COVID in our area is going down, and the hospitals are less and less COVID patients. I think sometime a couple of months ago we had 110 positive inpatient COVIDs; we're now down to 10 in the hospital I go to.

So the incidence is definitely going down. People just in general are taking more precautions. That's one.

So where do these patients come from? We

and my partners in that area provide care to a lot of CKD patients, a lot of CDE patients. And just -- hello, can you hear me?

So we provide care to a lot of CKD patients, me and my partners. And the Hazel Crest unit that opened in October last year, we're at 75 percent capacity.

So yes, we're in the process of transitioning these patients to home and our numbers show -- our numbers show we have the largest home program in that area. We have been transitioning these patients to home therapies. It's just so much easier as a physician to have these patients in our network and then to educate them, give them hands-on training because they're part of our network. It's just an easier transition. It's just the logistics of how we provide care, and that's what makes it easier.

There are three hospitals in that area that we go to, and so we see patients that need dialysis not just because of progression of their chronic kidney disease to end-stage renal disease, but also we get crash and burn at the hospitals that initiate -- have to go on hemodialysis, and

we transition them over to home therapies depending on what their requirement is.

So that's really how we work around these logistics.

MR. SHAZZAD: I just wanted to add, I just wanted to clarify that Fresenius, they're not doing 100 percent of the patients, they're planning on opening 100 new TCUs this year nationwide. Just wanted to make that clarification.

And I do want to add one thing, I'm sorry. In this Fresenius article I just want to read word for word. "The company has found over 50 percent of TCU patients will choose a home dialysis modality after completing this experience compared to approximately 15 percent of new patients on average choosing home when they start dialysis in a traditional dialysis facility."

So it's a huge percentage difference, 15 and 50 percent.

MS. SMITH: I just wanted to add I've trained over 100 patients in the years that I've been doing dialysis, and this transitional care unit is something I wish we would have had this whole time.

Because as Dr. Sarguroh was stating, we have a lot of patients that kind of crash and fall into dialysis, so they fall into our laps. These patients are very challenging to train because they show up in the clinic, they know nothing about having kidney disease to begin with, and now they're in a clinic and have a tube hanging out of their stomach. They agreed to it in the hospital, but they didn't really know anything about it. So we spend on average about four weeks trying to calm their emotional stressors of whether they made the right decision or not.

So the TCU units will actually be able to capture those patients and allow them to feel when they make the decision to do the dialysis at home that they had time to think about it before they just had to say yes or no to a tube in their stomach. So then they can come in and feel like they were actually able to fully participate in their training, that they actually got to make that choice, they had time to think about it, and those are the patients that are super successful in the home setting.

So the importance of the TCU unit, it

really will capture that group of patients and really give them a firm, solid complement to their choices for the home therapy.

CHAIRWOMAN SAVAGE: Any other questions, Dr. Martell?

MS. AVERY: Mitch, can you unmute Dr. Martell? Okay. There she is.

CHAIRWOMAN SAVAGE: Dr. Martell, Sandra, can you hear us? Dr. Martell, can you hear us?

MEMBER SLATER: This is Slater. I would move to grant the permit.

MS. AVERY: One second, Mr. Slater.

CHAIRWOMAN SAVAGE: Sandra Martell, can you hear us?

MEMBER MARTELL: Yes, I can.

CHAIRWOMAN SAVAGE: Did you have any questions for our applicants here?

MEMBER MARTELL: No, I did not.

CHAIRWOMAN SAVAGE: Okay. Thank you.

Okay. So would -- may I have a motion to establish a 14-bed --

MS. AVERY: We have the motion. Call the roll.

CHAIRWOMAN SAVAGE: Oh, we did that

already, good Lord. George, would you like to call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Dr. Murray, seconded by Mr. Kaatz.

Senator Demuzio.

(No response.)

MR. ROATE: I'll come back.

Gary Kaatz.

MEMBER KAATZ: I will vote yes on this, but I'm very concerned about the staff report, I'm very concerned over the supply, the excess capacity. I would love to the applicants to come back at a point in time in the future to report on their progress.

DR. SALAKO: Absolutely.

MR. SHAZZAD: Definitely.

MR. ROATE: Thank you.

Dr. Martell.

CHAIRWOMAN SAVAGE: Dr. Martell, you're on mute.

MEMBER MARTELL: I have significant concerns, as well, on the capacity issues and concerns and reframing of this particular, so my

vote would be no.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: I'm persuaded by the staff report and I vote no.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: This is an unnecessary duplication of services. I vote no.

MR. ROATE: Thank you.

Back to Senator Demuzio.

MEMBER DEMUZIO: Yes, based on some of the testimony I heard today and the report, staff report.

MR. ROATE: Thank you.

Chairwoman Savage.

CHAIRWOMAN SAVAGE: I vote no based on the capacity issues, and I wish the TCC could take off a little bit better. I was a little bit swayed by the testimony, but I think, you know, the capacity is just a problem.

So possibly a different location, but, again, please do come back and update us on your progress.

MR. ROATE: Thank you, Madam Chair.

That's 4 votes in the negative, 2 votes in the affirmative.

CHAIRWOMAN SAVAGE: So this permit --

MS. AVERY: You will receive an opportunity for administrative review and to reply. Thank you.

CHAIRWOMAN SAVAGE: I call this meeting to end -- adjourn.

MS. AVERY: Thanks everyone. We'll get better at this.

(Off the record at 4:23 p.m.)

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

_____

Notary Public in and for the
State of Illinois

I

M

Q