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# Transcript of Full Meeting

**Date:** February 27, 2018

**Case:** State of Illinois Health Facilities and Services Review Board

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

3  
4 FULL MEETING

5  
6 Bolingbrook, Illinois 60490

7 Tuesday, February 27, 2018

8 9:02 a.m.

9  
10  
11 BOARD MEMBERS PRESENT:

12 KATHY OLSON, Chairwoman

13 RICHARD SEWELL, Vice Chairman

14 BRAD BURZYNSKI

15 BARBARA HEMME

16 JOHN MC GLASSON, SR.

17 RON MC NEIL

18 MARIANNE ETERNO MURPHY

19  
20  
21 Job No. 167322

22 Pages: 1 - 316

23 Reported by: Melanie L. Humphrey-Sonntag,

24 CSR, RDR, CRR, FAPR

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1 EX OFFICIO MEMBERS PRESENT:

2 BILL DART, IDPH

3 ARVIND K. GOYAL, IHFS

4

5 ALSO PRESENT:

6 JEANNIE MITCHELL, General Counsel

7 COURTNEY AVERY, Administrator

8 MICHAEL CONSTANTINO, IDPH Staff

9 ANN GUILD, Compliance Manager

10 GEORGE ROATE, IDPH Staff

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

2 CHAIRWOMAN OLSON: I'd like to call the  
3 meeting to order, please.

4 First, I'd like to welcome new Board  
5 Members Barbara Hemme and Ron McNeil.

6 Thank you and welcome aboard. I look  
7 forward to working with both of you.

8 May I have a roll call, please.

9 MR. ROATE: Yes, Madam Chair.

10 Brad -- Senator Burzynski.

11 MEMBER BURZYNSKI: Here.

12 MR. ROATE: Deanna Demuzio is absent.

13 Ms. Hemme.

14 MEMBER HEMME: Here.

15 MR. ROATE: Mr. Johnson is absent.

16 Mr. McGlasson.

17 MEMBER MC GLASSON: Yes, sir.

18 MR. ROATE: Mr. McNeil.

19 MEMBER MC NEIL: Present.

20 MR. ROATE: Ms. Murphy.

21 MEMBER MURPHY: Here.

22 MR. ROATE: Mr. Sewell.

23 VICE CHAIRMAN SEWELL: Here.

24 MR. ROATE: Madam Chair.

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1 CHAIRWOMAN OLSON: Here.

2 MR. ROATE: Seven in attendance.

3 CHAIRWOMAN OLSON: Thank you.

4 Next is executive session. May I have a  
5 motion to go into closed session pursuant to  
6 Sections 2(c)(1) --

7 VICE CHAIRMAN SEWELL: So moved.

8 MEMBER BURZYNSKI: Second.

9 CHAIRWOMAN OLSON: -- 2(c)(5), 2(c)(11),  
10 and 2(c)(21) of the Open Meetings Act.

11 Now, Mr. Sewell.

12 VICE CHAIRMAN SEWELL: I still move.

13 CHAIRWOMAN OLSON: All right.

14 MEMBER BURZYNSKI: I still second.

15 CHAIRWOMAN OLSON: All in favor say aye.

16 (Ayes heard.)

17 CHAIRWOMAN OLSON: We are in executive  
18 session for approximately 15 minutes. I need to  
19 have everybody clear the room, please.

20 (At 9:03 a.m. the Board adjourned into  
21 executive session. Open session proceedings  
22 resumed at 9:23 a.m. as follows:)

23 CHAIRWOMAN OLSON: If you can be seated,  
24 please, we'd like to proceed.



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1           Is there activity to come out of executive  
2 session?

3           (No response.)

4           CHAIRWOMAN OLSON: Is there activity to  
5 come out of executive session?

6           MS. MITCHELL: Yes.

7           May I have a motion to approve a final  
8 order of dismissal for Foxpoint Dialysis.

9           CHAIRWOMAN OLSON: May I have a motion,  
10 please.

11          MEMBER BURZYNSKI: So moved.

12          CHAIRWOMAN OLSON: And a second.

13          MEMBER MURPHY: Second.

14          CHAIRWOMAN OLSON: All those in favor  
15 say aye.

16          (Ayes heard.)

17          CHAIRWOMAN OLSON: The motion passes.

18          May I have a motion to approve the  
19 January 9th, 2018, meeting transcripts, please.

20          MEMBER MURPHY: Motion.

21          VICE CHAIRMAN SEWELL: Second.

22          CHAIRWOMAN OLSON: All those in favor  
23 say aye.

24          (Ayes heard.)

1 CHAIRWOMAN OLSON: Opposed, like sign.

2 (No response.)

3 CHAIRWOMAN OLSON: The motion passes.

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1 CHAIRWOMAN OLSON: The next order of  
2 business is public participation.

3 I will ask that if you have comments for  
4 the court reporter, that you leave them on the  
5 corner of the table so she can pick them up.

6 We have over 50 people for public  
7 participation today. When your two minutes are  
8 up, I'm going to be told in George's loudest  
9 outside voice, and you're going to have to stop  
10 immediately.

11 It's two minutes -- I mean, do the math.  
12 Over 50 times two minutes is a long public  
13 participation, so please -- I don't mean to be  
14 rude when I cut you off, but you're going to get  
15 two minutes and two minutes only.

16 So, Jeannie, if we can have the first  
17 five, please.

18 MS. MITCHELL: Please come up.

19 Illinois State Senator Steve Stadelman,  
20 Illinois State Representative John Cabello,  
21 Illinois State Representative Neeley Erickson,  
22 Hayden Creque for Dave Syverson, and Javon Bae.

23 CHAIRWOMAN OLSON: Go ahead, Steve.

24 Go ahead, Steve. You can start, please.

1           SENATOR STADELMAN: Good morning.

2           My name is Steve Stadelman, and I have the  
3 privilege of representing SwedishAmerican Hospital  
4 and the greater Rockford area in the Illinois  
5 General Assembly in the 34th District as Senator,  
6 and I'm here to express my strong support for the  
7 certificate of need application of SwedishAmerican  
8 Hospital to modernize its downtown Rockford  
9 facility.

10          The docket for this application includes  
11 formal letters of support from both Republican and  
12 Democratic members of the Illinois General  
13 Assembly who represent areas of Rockford including  
14 Representative Litesa Wallace, Representative  
15 Joe Sosnowski, and Representative John Cabello,  
16 who is to my right.

17          As will be described by other witnesses  
18 here today, including the Mayor of Rockford and  
19 chairman of the Winnebago County Board, there is  
20 widespread support, community support, for this  
21 application. This is a straightforward  
22 modernization project. There are no new services  
23 being added. There is even a reduction in total  
24 hospital beds.

1           For a hospital that's 106 years old and  
2           that sits within a Federally designated medically  
3           underserved area, the need for modernization is  
4           clear. This project will improve access to  
5           quality health care facilities as intended by the  
6           Illinois Health Facilities Planning Act.

7           A great many Rockford area citizens  
8           consider SwedishAmerican Hospital to be their  
9           medical home. The hospital has an outstanding  
10          record of service and has earned numerous  
11          prestigious awards.

12          So, again, this project will improve the  
13          quality of health care in a medically underserved  
14          area. This hospital is willing and sees the  
15          importance, also, of investing in the inner city  
16          of the Rockford area and deserves your support.

17          Thank you.

18          CHAIRWOMAN OLSON: Thank you,  
19          Representative Stadelman.

20          Thank you.

21          REPRESENTATIVE CABELLO: Good morning,  
22          members of the Review Board. My name is  
23          John Cabello, and I have the privilege of serving  
24          the citizens of the 68th District, which includes

1 portions of Rockford and the greater Rockford area  
2 as their Illinois State Representative.

3 I am here today in strong support of the  
4 modernization proposal of SwedishAmerican  
5 Hospital.

6 As a Rockford police officer, I have been  
7 to Swedish Hospital a great many times with crime  
8 and accident victims and am well acquainted with  
9 its excellent staff and its facilities that need  
10 modernization. SwedishAmerican Hospital is a  
11 vital institution that has served the entire  
12 Winnebago County region for over 100 years.

13 Approval of the certificate of need  
14 application now before your agency will ensure the  
15 continued vibrancy of this important institution.  
16 It will also bring needed economic activity to  
17 downtown Rockford. The proposed 126 million  
18 modernization will include private inpatient rooms  
19 as well as modernized emergency room, operating  
20 rooms, and other needed services.

21 Historically Swedes has been the largest  
22 birthing center in Rockford and the only hospital  
23 to receive the Healthgrades Labor and Delivery  
24 Excellence Award. The proposed Women and

1 Children's Center will assure continued access to  
2 the highest quality care of the Rockford area  
3 facilities.

4 I would respectfully request your  
5 favorable consideration of this certificate of  
6 need.

7 I also do want to say that, you know,  
8 I have been in all the hospitals since 1993 as a  
9 policeman, and I can tell you that all of the  
10 hospitals are a great asset to our community, but  
11 Swedes is just a bit different.

12 They have done an amazing job transforming  
13 the community around it. It was crime-ridden,  
14 dilapidated. They invested heavily into that  
15 region of our city, and I think that that's what  
16 they're going to continue to do. And, again,  
17 I would strongly recommend the pass.

18 Thank you very much.

19 CHAIRWOMAN OLSON: Thank you.

20 Next, please.

21 MS. ERICKSON: Hi. My name is Neeley  
22 Erickson. I'm the legislative aide for State  
23 Representative Joe Sosnowski. Unfortunately, he  
24 was unable to be here today; however, he sent me

1 on his behalf to read some remarks to the  
2 committee members.

3 "Dear Committee: I continue to support  
4 SwedishAmerican Hospital's certificate of need  
5 application, and I strongly reiterate my support  
6 for this important project. This modernization  
7 strategy put forth by SwedishAmerican Hospital  
8 will better facilitate patient care by improving  
9 women and children's health facilities and convert  
10 patient rooms into private rooms.

11 "The total gross square feet for the  
12 facility is 215,634, which includes the  
13 establishment of a 115,000-square-foot facility  
14 for a Women and Children's Health Center. The  
15 projected cost is estimated around 126 million.

16 "This project will benefit the greater  
17 Rockford area by generating an expected 600 trade  
18 jobs as well as dozens of additional new health  
19 care opportunities and jobs upon its completion.

20 "The modernization of the existing  
21 facilities and the construction of the Women and  
22 Children's Health Center will provide critical  
23 modern health care services for the Rockford  
24 region.



1           "Again, by approving the certificate of  
2     need for SwedishAmerican, your Board will assure  
3     access to the highest quality of care for all area  
4     families. Thank you for your time and  
5     consideration."

6           CHAIRWOMAN OLSON: Thank you.  
7           Next, please.

8           MR. CREQUE: Good morning. My name is  
9     Hayden, H-a-y-d-e-n; Creque, C-r-e-q-u-e. I'm  
10    appearing on behalf of Senator Dave Syverson. And  
11    he has sent his remarks, which I'll submit at the  
12    end if I may read them in.

13          "Honorable Members of the Health  
14    Facilities Services Review Board, I am sorry  
15    I cannot join you in person today as the Senate is  
16    in session. I appreciate the opportunity to share  
17    my concerns and, unfortunately, express my  
18    opposition to UW/Swedes' application.

19          "We are blessed in Rockford to have three  
20    great health systems that service our region, each  
21    having areas of expertise that they focus on.  
22    While competition is good in most cases, it's not  
23    in all cases. You don't, for example, have two  
24    municipal fire or police departments because that

1 would increase costs.

2 "As a Board, you have limited transplant  
3 centers in Illinois. Why? Because of volume and,  
4 even more importantly, the specialists need enough  
5 work to hone their skills.

6 "The same is true when it comes to  
7 Level III NICU centers. As a state, we have  
8 established just three downstate centers located  
9 in Springfield, Peoria, and Mercy Health in  
10 Rockford. That was done because there was no  
11 justification for more and, to be a premier  
12 center, you need to have a team of highly trained  
13 subspecialists on-site doing enough volume to both  
14 hone their skills but also to be affordable.

15 "This proposal will dramatically raise  
16 health costs. Why? It's simple. Let's say as a  
17 hospital -- let's say a hospital has 20 different  
18 subspecialists to serve 400 babies. If they now  
19 are seeing just 300 babies, the number of  
20 specialists on-site do not change, just the cost  
21 goes up by 25 percent.

22 "Lastly, Illinois has lost a lot of  
23 jobs" --

24 MR. ROATE: Two minutes.

1 MR. CREQUE: -- "especially to  
2 Wisconsin" --

3 CHAIRWOMAN OLSON: Please conclude.

4 MR. CREQUE: "I urge the Board to vote no  
5 on this application that creates improper  
6 duplication."

7 Thank you.

8 CHAIRWOMAN OLSON: Thank you.

9 Thank you, all, for -- oh, I'm sorry.  
10 Please go ahead.

11 MR. BEA: Good morning.

12 My name is Javon Bea. I'm president and  
13 CEO of Mercy Health in Rockford. It's J-a-v-o-n  
14 B-e-a.

15 Mercy Health does not object to  
16 replacement of the medical/surgical beds in the  
17 UW/Swedes application. However, Mercy Health  
18 strongly objects to the fact that they're trying  
19 to bury, in the application, approval to build an  
20 irresponsible and duplicative 10-bed Level III  
21 NICU. It's harmful to Illinois young families  
22 whose Level III babies will be shipped to  
23 Wisconsin for many months, up to a year.

24 In addition, they're trying to get this

1 Board to approve the construction dollars now to  
2 actually build a Level III NICU before they have  
3 IDPH approval to actually operate a Level III NICU  
4 in the state of Illinois.

5 Level III preemie babies are few and far  
6 between, and that's why IDPH only designates one  
7 Level III NICU per region outside of Chicago,  
8 which is Mercy Health's 52-bed Level III NICU in  
9 Rockford.

10 Research has proven there's a higher death  
11 and disability rate in these small 10-bed NICUs  
12 like UW is proposing. With only a 10-bed unit,  
13 they cannot afford to employ the over 50 pediatric  
14 subspecialists in 19 different pediatric  
15 specialties that Mercy Health employs full-time  
16 on-site in Rockford.

17 And if they tell you they're going to send  
18 their pediatric specialists down from Wisconsin,  
19 these preemie, fragile, very acute preemie babies  
20 do not wait for a UW doc to come down from  
21 Wisconsin on their schedule.

22 If you grant UW the right to build this  
23 NICU now, they're going to then receive IDPH  
24 approval -- you'll be, in a sense, boxing IDPH in

1 a corner -- and this 10-bed unit will simply  
2 function as an advertising billboard for UW to  
3 deceive young families into thinking that their  
4 preemie babies can stay in Northern Illinois and  
5 stay in Rockford. In the midst of emotional  
6 trauma --

7 MR. ROATE: Two minutes.

8 MR. BEA: -- the UW doctor will simply  
9 explain --

10 CHAIRWOMAN OLSON: Please conclude.  
11 I need you to conclude.

12 MR. BEA: Okay. But the doc will simply  
13 explain the specialist isn't on-site and they have  
14 to go to the larger NICU in Wisconsin.

15 Thank you.

16 CHAIRWOMAN OLSON: Thank you, all.

17 MR. CREQUE: Where would you like these?

18 CHAIRWOMAN OLSON: Just put them on the  
19 corner of the table, please, your written comments  
20 for the court reporter. Just set them on the  
21 table and she'll pick them up.

22 Jeannie, the next five.

23 MS. MITCHELL: When you come up, before  
24 you begin your remarks, if you could please spell

1 your name for the court reporter.

2 Next up, Paul Van Den Heuvel, Pastor  
3 Ronald Alexander, Reverend Dr. Kenneth Board,  
4 Linn Carter, and Dr. Ken Cunningham.

5 And if you have written statements, if you  
6 could leave them at the table, leave them at the  
7 edge of the table, middle aisle.

8 CHAIRWOMAN OLSON: Somebody please go  
9 ahead.

10 MR. VAN DEN HEUVEL: Good morning.

11 I am Paul Van Den Heuvel, vice president  
12 of legal affairs and general counsel for Mercy  
13 Health.

14 My last name is spelled V-a-n capital  
15 D-e-n capital H-e-u-v-e-l. Can you hear me all  
16 right?

17 CHAIRWOMAN OLSON: Make sure you speak  
18 right into the microphone.

19 MR. VAN DEN HEUVEL: Sure.

20 The UW/Swedes CON application is not  
21 straightforward as to Level III NICU services.  
22 I want to be clear so that UW/Swedes and its legal  
23 counsel cannot confuse you today.

24 In June 2017 UW/Swedes received

1     perfunctory and automatic approval of a  
2     certificate of exemption to add 10 Level III NICU  
3     beds to its existing facility; however, that  
4     CON approval does not -- I repeat, does not --  
5     give them the right to construct or operate a  
6     Level III NICU. Both the approval of this Board  
7     and the Illinois Department of Public Health are  
8     needed to allow UW/Swedese to build and operate a  
9     duplicative Level III NICU.

10           In addition, UW/Swedese's existing census  
11     numbers don't even support the operation and  
12     construction of their existing 14-bed lower  
13     Level II nursery beds. In 2016 their census was  
14     just six, and that was before the loss of more  
15     than 1,000 births in 2017.

16           Furthermore, their application is based --  
17     improperly based on promised recruitment of  
18     specialists, each designed to improperly duplicate  
19     Level III NICU services and specialists available  
20     in the Rockford region. Promises of recruitment  
21     are entirely inconsistent with this Board's  
22     standards and practices. You have, instead,  
23     required referral letters from existing physicians  
24     or documented population growth.

1           Moreover, in November of 2015, this Board  
2           unanimously approved construction of  
3           Mercy Health's new I-90 facility with the  
4           understanding that it will house the region's only  
5           Level III NICU and perinatal center for an  
6           11-county area.

7           You possess the authority today to deny  
8           their request to construct their new 14-bed --

9           MR. ROATE: Two minutes.

10          MR. VAN DEN HEUVEL: -- facility as well  
11          as a Level III NICU.

12          Thank you.

13          CHAIRWOMAN OLSON: Thank you.

14          Next, please.

15          MS. CARTER: My name is Linn Carter,  
16          system director of women's and children's services  
17          at Mercy Health, L-i-n-n C-a-r-t-e-r. I'm also a  
18          perinatal clinical nurse specialist and have  
19          worked in the field for 28 years.

20          Mercy Health's existing Level III NICU was  
21          established in 1970, 48 years ago. In the late  
22          1970s the State of Illinois implemented the  
23          current regionalized perinatal program because  
24          premature and critically ill babies were



1 experiencing inconsistent outcomes. Research  
2 which prompted the development of regionalization  
3 still shows that newborns receive the best care  
4 and have the best chance of survival at a larger  
5 Level III NICU.

6 So what harm could adding one 10-bed NICU  
7 possibly cause? Well, according to research, it's  
8 bad for babies.

9 The region that we serve includes  
10 11 Illinois counties from the Illinois -- or from  
11 the Iowa border to the far east side of McHenry,  
12 from the Wisconsin border down south to I-80.  
13 Outside of Chicago the State has named just one  
14 hospital in each of three large rural areas --  
15 Springfield, Peoria, and Rockford -- to serve as a  
16 Level III NICU.

17 UW/Swedes' current Level II nursery  
18 handles babies from 30 weeks' gestation to full  
19 term. These older babies have much fewer  
20 complications.

21 Mercy Health employs neonatologists who  
22 are responsible for educating and training  
23 regional doctors and nurses in the initial  
24 stabilization of sick babies until Mercy Health's

1 specialized ground and air NICU natal transport  
2 team can transport them to our regional center.

3 If this regional volume is shared, neither  
4 Mercy Health nor UW/Swedes will be able to  
5 maintain the physicians, pediatric specialists,  
6 nurses, respiratory therapists, equipment,  
7 expertise, and skills needed to provide the best  
8 possible outcomes for these vulnerable babies.

9 For this reason, please deny this project.

10 CHAIRWOMAN OLSON: Thank you.

11 Next.

12 PASTOR ALEXANDER: Good morning, members  
13 of the Review Board. My name is Ronald Alexander,  
14 R-o-n-a-l-d A-l-e-x-a-n-d-e-r.

15 I serve as the pastor of the Hope  
16 Fellowship Church of Rockford. Our church is  
17 located right across the street from  
18 SwedishAmerican Hospital. Along with so many in  
19 the Rockford community and on behalf of my  
20 congregation and staff, virtually all of whom  
21 consider Swedes their medical home, I express our  
22 strong support of its modernization proposal.

23 Swedes has long been an essential part of  
24 our community, having faithfully served downtown

1 Rockford and its west side for over a  
2 hundred years. Your approval of this  
3 modernization project will help ensure its  
4 continued excellence. Your approval today will  
5 help ensure that the families served by Swedes  
6 receive the modern, high quality of care they  
7 deserve in an ever-evolving health care world.

8 For as long as I can recall, Swedes has  
9 been the largest birthing center in Rockford. The  
10 new Women's and Children's Center is a welcome and  
11 needed improvement in care for our mothers and  
12 children. They deserve no less.

13 The proposed modernization of Swedes  
14 includes private inpatient rooms and modernized  
15 emergency department facilities and operating  
16 rooms. This means higher quality care for those  
17 families that, like my congregation, consider  
18 Swedes their medical home.

19 Our church is grateful, along with our  
20 community, that Swedes has remained committed to  
21 the downtown Rockford area and its west side. It  
22 truly has been a community anchor, and we ask that  
23 you please approve this critically needed project.

24 Thank you.

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1 CHAIRWOMAN OLSON: Thank you.

2 Next.

3 REVEREND BOARD: Good morning, members of  
4 the Board. My name is Reverend Dr. Kenneth R.  
5 Board, K-e-n-n-e-t-h; Board, B-o-a-r-d, like  
6 "David."

7 I serve as the senior pastor of Pilgrim  
8 Baptist Church of Rockford, in southwest Rockford,  
9 the oldest African-American Baptist church in  
10 Rockford. I'm also honored to serve as the second  
11 vice chair of the board of directors of  
12 SwedishAmerican Hospital.

13 I'm here this morning to express my  
14 fervent support for the SwedishAmerican expansion  
15 and modernization project, No. 17-019. I believe  
16 that this project is in the best interests of the  
17 State of Illinois and the Review Board to approve  
18 this certificate of need application for  
19 SwedishAmerican's master facility plan project.

20 I can tell you that support for this  
21 expansion from community leaders and elected  
22 officials has been extraordinary and wide-ranging.  
23 My colleagues in Rockford's faith community see  
24 many distinct advantages to SwedishAmerican

1 expanding their downtown campus, as does our Mayor  
2 and our entire bipartisan Springfield delegation.

3 Federal officials including United States  
4 Senators and our local members of Congress have  
5 joined our Rockford contingent to all speak with  
6 one voice, unified in a strong desire to see  
7 SwedishAmerican expand their excellent care in our  
8 community.

9 All communities in the Rockford area  
10 deserve continued access to excellent care near  
11 the center of the city, and SwedishAmerican is in  
12 the center of our city, and I speak on behalf of  
13 my mostly west side congregants when I express  
14 that belief. Expanding SwedishAmerican's downtown  
15 campus to serve the entire community is consistent  
16 with our organization.

17 I dedicate so many hours serving not just  
18 children but also SwedishAmerican. I see  
19 firsthand a health care provider who cares for the  
20 entire community with compassion and respect.  
21 Expanding the SwedishAmerican campus will benefit  
22 more than newborn babies, surgical patients,  
23 emergency visits, and inpatient care.

24 In a broader sense, the city of

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1 Rockford --

2 MR. ROATE: Two minutes.

3 REVEREND BOARD: I ask that you will  
4 support and approve this CON.

5 Thank you for your time and your  
6 attention.

7 CHAIRWOMAN OLSON: Thank you, all. Please  
8 leave your comments on the table for the court  
9 reporter. Thank you.

10 Next five.

11 MS. MITCHELL: Next five, again for  
12 SwedishAmerican Hospital, Project 17-019, Pastor  
13 Joseph Dixon, Dr. John Dorsey, Frank Haney,  
14 Dr. Gillian Headley, and Dr. Frank Hernandez.

15 Please remember to state and spell your  
16 name before you begin your remarks.

17 CHAIRWOMAN OLSON: You can go ahead and  
18 start.

19 PASTOR DIXON: Good morning. I'm Pastor  
20 Joseph Dixon, J-o-s-e-p-h D-i-x-o-n.

21 My name is Joseph Dixon, and I serve as  
22 the senior pastor and founder of the All Nations  
23 Worship Center church. I also am currently the  
24 president of the Rockford Ministers Fellowship.

1 I stand here today representing our organization  
2 with a fellow clergyman, Pastor Anthony Greer, in  
3 support of Project 17-019, the modernization  
4 proposal of SwedishAmerican Hospital.

5 The Swedes modernization application is  
6 strongly supported by the Rockford Ministers  
7 Fellowship as well as our congregants which my  
8 colleagues and I represent.

9 A modern Swedish Hospital with updated  
10 medical equipment will address the current and  
11 growing disparity in immediately accessible health  
12 care resources on the west and south side of our  
13 city. The congregants we represent largely reside  
14 in a Federal-designated Health Professional  
15 Shortage Area. Our congregants are grateful to  
16 Swedes for having remained committed to the  
17 downtown area of Rockford as well as its west and  
18 south side communities.

19 The proposed new women's and children's  
20 tower, the updated emergency department, the  
21 additional mental health beds, and the private  
22 inpatient rooms are all features desperately  
23 needed in our community and very strongly  
24 supported.

1           Many of our congregants lack resources to  
2           travel to the east side of Rockford for extended  
3           health care and visitations. For us, proximity of  
4           Swedes is not only a convenience, it's a  
5           necessity.

6           For the African-American community in  
7           Rockford, approval of this application is of the  
8           highest priority. It is a matter of immediate  
9           accessibility, fairness, and equity. Ultimately --

10          MR. ROATE: Two minutes.

11          PASTOR DIXON: We ask --

12          CHAIRWOMAN OLSON: Please conclude.

13          PASTOR DIXON: We are in support of this  
14          project.

15          CHAIRWOMAN OLSON: Thank you.

16          Next.

17          MR. HANEY: Good morning.

18                My name is Frank Haney, F-r-a-n-k  
19                H-a-n-e-y, and I am proud to be the chairman of  
20                the Winnebago County Board, and I represent  
21                285,000 residents.

22                I'm here today to express my ardent  
23                support for the modernization of SwedishAmerican  
24                Hospital. This modernization project doesn't have



1 a single opponent on record, and the list of  
2 supporters is quite extraordinary: United States  
3 Senators Richard Durbin and Tammy Duckworth;  
4 Rockford's bipartisan congressional delegation,  
5 Cheri Bustos and Adam Kinzinger, along with their  
6 colleagues, Congressman Peter Roskam and Randy  
7 Hultgren; Rockford's bipartisan group of four  
8 elected state legislators; Rockford's Mayor,  
9 Tom McNamara, along with the former Mayor, Larry  
10 Morrissey; the Rockford Ministers Fellowship,  
11 along with other area clergy; five of the Rockford  
12 region's six hospitals have filed letters of  
13 support; several Rockford aldermen; our hometown  
14 newspaper, the Rockford Register-Star's editorial  
15 board endorsement; the Rockford Chamber of  
16 Commerce; our Convention and Visitors Bureau, and  
17 the Economic Development Council as well as  
18 Transform Rockford; the Northwest Illinois  
19 Building and Construction Trades; and more than  
20 2,000 local petition signatures and many more.

21 I have enthusiastically added my name to  
22 this list of supporters. Winnebago County has  
23 excellent choices for world-class health care, and  
24 SwedishAmerican has provided many of those

1 resources. By modernizing its main downtown  
2 campus, Swedes will be assured of many more years  
3 of excellent service.

4 It's an honor to be with you today. I ask  
5 for your support. I would also say that  
6 I represent citizens, not a hospital, none of our  
7 hospitals, which are excellent. I have no stake  
8 financially in any of them. I believe this is a  
9 good thing for our community.

10 Thank you very much.

11 CHAIRWOMAN OLSON: Thank you.

12 Next.

13 Can you please just pass the mic.

14 DR. DORSEY: Good morning.

15 My name is Dr. John Dorsey, chief medical  
16 officer of Mercy Health in Illinois, J-o-h-n  
17 D-o-r-s-e-y, and I'm speaking in opposition to the  
18 UW/SwedishAmerican CON application.

19 Recently the UW Hospital in Wisconsin  
20 finished an extensive expansion of their NICU,  
21 nearly doubling the number of NICU beds. In a  
22 Wisconsin State Journal article which I hold from  
23 August of 2017, their own NICU physician director  
24 stated specifically that this expansion would

1 allow that unit to accept more transfers from  
2 Northern Illinois.

3 The intent here is clear: This proposed  
4 UW/Swedes NICU expansion, if approved, will pluck  
5 these fragile infants from Illinois and transfer  
6 them to Wisconsin. And when that occurs, these  
7 neonates will literally pass by Mercy Health's new  
8 \$500 million Women's and Children's Hospital with  
9 a brand-new, state-of-the-art 52-bed Level III  
10 NICU and one of the country's only small-baby  
11 units.

12 Why would these babies be transferred  
13 hours and up to a hundred miles away? I believe  
14 the reason relates to the need for  
15 24/7 comprehensive physician service which no  
16 10-bed Level III NICU can support. At Mercy Health  
17 we employ over 50 pediatric physicians in  
18 19 specialties who provide local care 24/7 to our  
19 Level III NICU.

20 UW/Swedes cannot possibly provide the same  
21 comprehensive services locally in Rockford. Now,  
22 I'm not saying that the least complicated babies  
23 couldn't be kept here, but those who are the most  
24 ill and fragile who require super specialists will

1 have to go to Wisconsin because that's where those  
2 specialists practice, and any part-time presence  
3 of these specialists in Rockford would woefully  
4 neglect the full-time needs of these babies.

5 Finally, thinking about families, these  
6 babies are born often to young working families,  
7 financially struggling, and these kids have long  
8 lengths of stay, lasting months. How can our  
9 Illinois families add the burden of travel --  
10 costs to travel and lodging across state lines --  
11 to the already almost unbearable emotional factors  
12 that they are dealing with?

13 UW/Swedes' proposed 10-bed Level III NICU  
14 would be terrible for our fragile Illinois babies  
15 and their families and unnecessary duplication of  
16 service and will negatively impact their care.

17 And I urge you to deny this CON  
18 application.

19 CHAIRWOMAN OLSON: Thank you, Doctor.

20 Next.

21 DR. HEADLEY: My name is Dr. Gillian  
22 Headley, G-i-l-l-i-a-n H-e-a-d-l-e-y, and I'm the  
23 codirector of the State-designated regional  
24 perinatal center, Mercy Health Hospital, Rockton

1 Avenue.

2 As a board-certified neonatologist for the  
3 past 17 years, I have cared for over 6500 seriously  
4 ill and premature babies.

5 Being a large, Level III, 52-bed NICU  
6 allows Mercy Health to care for a large number of  
7 babies who are sick and premature and gives us a  
8 tremendous amount of experience in their care.

9 Research published in the New England  
10 Journal of Medicine and also in the Journal of  
11 Pediatrics has shown that outcomes for critically  
12 ill newborns are worse when they are cared for in  
13 small Level III NICUs due to the inability of  
14 specialists to hone in on their skills and enhance  
15 them.

16 This is the very reason the State of  
17 Illinois introduced regionalized perinatal centers  
18 in the '70s, because objective evidence showed  
19 that outcomes will improve in larger NICUs versus  
20 smaller ones with 15 beds or less.

21 Think about it. Would you want your  
22 family member to have heart surgery from a cardiac  
23 surgeon who performs only a few surgeries a year  
24 at a small program?

1           Where a critically ill baby receives NICU  
2     care makes a big difference to their outcome. It  
3     makes a difference if the Level III NICU is large  
4     or small. It makes a difference if the  
5     physicians, nurse practitioners, and nurses taking  
6     care of critically ill infants have more or less  
7     experience in the conditions being treated.

8           To expect that a small, 10-bed Level III  
9     NICU like the one UW/Swedes is proposing will have  
10    the same results as a state-of-the-art 52-bed  
11    Level III NICU with over 50 pediatric  
12    subspecialist physicians on-site is unrealistic.

13          To ask the Rockford community to accept  
14    the proposed 10-bed Level III NICU just as a  
15    choice is irresponsible. There is absolutely no  
16    need for this small, Level III NICU. There's no  
17    room for compromise or second best when babies'  
18    lives are at stake.

19          For this reason, I urge you to deny the  
20    UW/Swedes application.

21           CHAIRWOMAN OLSON: Thank you, Doctor.

22           Next.

23           DR. HERNANDEZ: Good morning.

24           My name is Dr. Frank Hernandez, F-r-a-n-k

1 H-e-r-n-a-n-d-e-z. I am one of seven  
2 board-certified neonatologists who currently staff  
3 the Level III NICU at Mercy Health Hospital's  
4 Rockton Avenue campus. Mercy Health's Level III  
5 NICU is not only staffed by seven full-time  
6 neonatologists 24 hours a day, seven days a week,  
7 but also six pediatric hospitalists --

8 THE COURT REPORTER: Excuse me. Take a  
9 breath, please.

10 (Laughter.)

11 DR. HERNANDEZ: I'm sorry.

12 -- neonatal nurse practitioners, neonatal  
13 nurses, and hundreds of other therapists and  
14 providers, all of whom are specially trained in  
15 the care of critically ill newborns. The high  
16 quality care critically ill infants receive from  
17 our team is demonstrated by our National Quality  
18 Improvement measurement scores.

19 The size and scope of Mercy Health's  
20 52-bed Level III NICU allows us to support and  
21 employ over 50 highly trained full-time pediatric  
22 physicians who represent the 19 different  
23 subspecialties who provide care on-site to the  
24 City of Rockford.

1           The size and scope of our Level III NICU  
2 allows us to bring even more subspecialists from  
3 Lurie Children's Hospital of Chicago to Rockford  
4 to perform highly specialized surgeries which are  
5 currently only performed at their downtown campus,  
6 things like complex cardiac repairs.

7           Our Level III NICU also allows us to staff  
8 and operate the only small-baby unit in the  
9 region. When our I-90 Women and Children's  
10 Hospital opens in a few short months, our new  
11 Level III NICU will further enhance care for the  
12 babies and the families in the Rockford area.

13           This duplication of Level III NICUs being  
14 proposed will not only waste valuable resources,  
15 it will threaten the lives of these severely  
16 premature and fragile infants who would  
17 undoubtedly be transferred hours away to  
18 Wisconsin. And it's been my experience that being  
19 separated from their critically ill newborns  
20 creates extreme emotional hardship for these  
21 families. It's a real factor that we see when  
22 babies are transferred even to us from outlying  
23 hospitals.

24           For these reasons I would urge you to deny



1 the UW/Swedes CON application.

2 Thank you.

3 CHAIRWOMAN OLSON: Thank you, Doctor.

4 Next, Jeannie.

5 MS. MITCHELL: Next up, Illinois State  
6 Director William Houlihan --

7 THE COURT REPORTER: Please leave your  
8 remarks.

9 MS. MITCHELL: -- Thomas McNamara, and  
10 Sue Ripsch.

11 If there is anyone that signed up to  
12 testify or participate in public participation for  
13 SwedishAmerican Hospital that I did not call,  
14 please come up at this time.

15 CHAIRWOMAN OLSON: Mr. Mayor, do you want  
16 to start?

17 MAYOR MC NAMARA: Good morning.

18 My name is Tom McNamara, T-o-m  
19 M-c-N-a-m-a-r-a. I'm the Mayor of the City of  
20 Rockford, and I am here today in strong support of  
21 Project No. 17-019, the modernization proposal of  
22 SwedishAmerican Hospital.

23 Rarely have you seen our community so  
24 unified behind something as we are behind this

1 modernization project. This modernization  
2 proposal is vital and a needed step towards  
3 meeting the health care needs of my hometown. It  
4 will bring proximate access to the highest level  
5 of care, especially to the west and south side of  
6 Rockford, and serve as a critical component of the  
7 revitalization of our downtown. My support is  
8 unqualified and enthusiastic.

9 The Winnebago County Health Department has  
10 identified maternal and child health and  
11 behavioral health as their top health priorities,  
12 and the city of Rockford is in the most need of  
13 these services. This proposal specifically  
14 addresses those needs.

15 The state-of-the-art Women's and  
16 Children's Center proposed by SwedishAmerican will  
17 greatly improve access and service to community  
18 areas and populations that have historically been  
19 underserved and at the highest risk of poor  
20 outcomes, including preterm and low birthweight  
21 infants.

22 The proposed modernization of the  
23 hospital's acute mental illness unit will also  
24 improve access and services to those with

1 behavioral health needs.

2 Your staff reflects no opposition, which  
3 certainly makes sense for a modernization proposal  
4 that involves no new services and a reduction in  
5 total hospital beds.

6 I ask you, on behalf of 147,000 residents  
7 of Rockford, to please support this project.

8 CHAIRWOMAN OLSON: Thank you, Mr. Mayor.

9 Next.

10 MR. HOULIHAN: William P. Houlihan.

11 William, W-i-l-l-i-a-m; P.; Houlihan,

12 H-o-u-l-i-h-a-n.

13 Good morning. My name is Bill Houlihan.

14 I serve as the state director for United States  
15 Senator Dick Durbin. Senator Durbin joins his  
16 Senate colleague from Illinois, Tammy Duckworth,  
17 in supporting the SwedishAmerican Hospital  
18 modernization project.

19 The official docket for this CON  
20 application also contains formal letters of  
21 support from the four members of Congress whose  
22 districts include the greater Rockford area,  
23 Cheri Bustos, Adam Kinzinger, Randy Hultgren, and  
24 Peter Roskam.

1           SwedishAmerican Hospital sits within a  
2   federally designated Health Professional Shortage  
3   Area. The hospital's been around for more than a  
4   century. The need for a modernized facility is  
5   self-evident. Granting this CON application would  
6   certainly further an important purpose of the  
7   Health Facilities Planning Act to assure modern  
8   facilities at Swedish.

9           Because this project involves no new  
10   services and a reduction of beds, there should be  
11   no cause for concern. Indeed, the official docket  
12   for the CON application contains letters of  
13   support from St. Francis Center, from FHN Memorial  
14   Hospital, Katherine Shaw Bethea Hospital, Beloit  
15   Health Systems.

16           There's also correspondence from Mercy  
17   Rockford Hospital that, while opposing a previous  
18   and already approved exemption application to  
19   establish the NICU unit, it expresses support for  
20   the modernization of the SwedishAmerican Hospital.

21           In short, there appears to be a consensus  
22   among all Rockford areas hospital in favor of the  
23   modernization proposal before you today.

24           The major modernizations and new

1 construction projects that this Board has already  
2 approved for the two other Rockford health systems  
3 is certainly the best for the Rockford area and a  
4 positive step toward the important goal of  
5 creating modern facilities and bringing quality  
6 health care to the region. Senator Durbin hopes  
7 that SwedishAmerican Hospital will be allowed to  
8 do the same with this much needed modernization  
9 project.

10 From elected officials to civic  
11 organizations, from clergy to business groups,  
12 from labor leaders and thousands of citizens who  
13 signed petitions, the Rockford community has  
14 coalesced behind this CON application. Senator  
15 Durbin adds his voice of support and respectfully  
16 asks that you give favorable consideration today  
17 to this worthy modernization project.

18 Thank you so much.

19 CHAIRWOMAN OLSON: Thank you.

20 Next.

21 MS. RIPSCH: Good morning.

22 CHAIRWOMAN OLSON: Good morning.

23 MS. RIPSCH: My name is Sue Ripsch,  
24 and I'm the vice president of Mercy Health.

1 S-u-e R-i-p-s-c-h.

2 I am here today to oppose UW/Swedes' CON  
3 application.

4 The creation of another Level III NICU in  
5 the same region as Mercy Health's State-designated  
6 52-bed Level III NICU is irresponsible and costly  
7 and, most importantly, will dilute, divert, and  
8 misdirect services, a result that diminishes  
9 patient care for all the precious babies in need  
10 of Level III NICU services.

11 UW/Swedes' application is based on  
12 inaccurate data that is nearly two years old. In  
13 January of 2017 Crusader Community Health, a  
14 federally qualified health center in Rockford  
15 serving its at-risk population, moved their  
16 births, totaling more than 1,000 annually, from  
17 UW/Swedes to Mercy Health Rockford. Therefore,  
18 UW/Swedes' census figures for births are much  
19 lower today than those detailed in their  
20 application, and UW/Swedes failed to note this  
21 change, a change that's a 37 percent drop in  
22 births. They did not note this to the Board, nor  
23 did it update its data in its CON application.

24 Crusader's decision to move care from

1 UW/Swedes was based on Mercy Health's exceptional  
2 pediatrics, OB hospitalists, and Level III NICU  
3 program as well as the high quality of facilities  
4 being built at Mercy Health's new I-90 facility,  
5 which was unanimously approved by this Board in  
6 November of 2015. And, additionally, Mercy Health  
7 will still keep a vibrant hospital on the west  
8 side of Rockford to meet the needs of the west  
9 side community.

10 Without a doubt, the 10-bed Level III NICU  
11 that UW/Swedes has proposed will pull from the  
12 same patient population we have served for  
13 decades. In doing so, again, it will dilute,  
14 divert, and misdirect Level III NICU services,  
15 harming the high level of care patients now  
16 receive.

17 This proposed NICU will also serve as a  
18 base to transfer babies to Wisconsin, up to  
19 two hours and 100 miles from their home, all when  
20 they could be cared for at Mercy Health's I-90  
21 Rockford facility.

22 I strongly urge the Board to deny  
23 UW/Swedes' application.

24 Thank you.

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1 CHAIRWOMAN OLSON: Thank you.

2 MS. MITCHELL: The next five that will be  
3 called will be speaking on Project No. 17-012,  
4 Meadowbrook Manor of Geneva, Jennifer Bebinger,  
5 Fred Berkovits, Daniel Weiss, Robert Kaplan, and  
6 Dr. Anis Rauf.

7 If you could, again, please state and  
8 spell your name at the beginning of your remarks  
9 for the court reporter. And if you have written  
10 comments, if you'd leave them at the side of the  
11 table.

12 Thank you.

13 CHAIRWOMAN OLSON: Are there five?

14 MS. MITCHELL: I called five names.

15 CHAIRWOMAN OLSON: Who are we missing?

16 MS. MITCHELL: Jennifer Bebinger,  
17 Fred Berkovits, Daniel Weiss, Robert Kaplan, and  
18 Dr. Anis Rauf.

19 I might be pronouncing that incorrectly.

20 CHAIRWOMAN OLSON: Going once, going  
21 twice.

22 Okay. Go ahead. Please, anybody can  
23 start.

24 MS. BEBINGER: Good morning. My name is



1 Jennifer Bebinger, J-e-n-n-i-f-e-r; B, as in  
2 "boy," -e-b, as in "boy," -i-n-g-e-r.

3 I am here to show my support for the  
4 Meadowbrook of Geneva project. My -- and to vote  
5 yes. I have known the managers and owners for at  
6 least 15 years and have 27 years of postacute  
7 health care management experience. I can speak to  
8 the abilities and the experience of these owners  
9 in developing and operating skilled nursing  
10 facilities like Meadowbrook Manor of Geneva.

11 Today's skilled health care market is  
12 changing, and as we -- and we, as health care  
13 providers, continue to adapt to the needs of the  
14 modern patients as well as the needs of our  
15 hospital acute care partners.

16 Meadowbrook, through their innovative  
17 state-of-the-art center, will bridge the gap  
18 between illness and recovery. The Meadowbrook  
19 Geneva experience promotes wellness in mind, body,  
20 and spirit through dedicated medical professionals  
21 that will support you in reaching your goals by  
22 providing individualized encouragement to guests,  
23 all within the comforts of home.

24 Meadowbrook Geneva is the future of health

1 care, and that is why I strongly encourage the  
2 Board to vote in favor of this innovative project.

3 Thank you.

4 CHAIRWOMAN OLSON: Thank you.

5 Next.

6 MR. KAPLAN: Hi. My name is Robert  
7 Kaplan, R-o-b-e-r-t; Kaplan, K-a-p-l-a-n. My  
8 family and I have been involved in the nursing  
9 home industry for over 30 years. I'm quite  
10 familiar with the business.

11 The nursing home industry today is being  
12 very careful in the type of care being provided.  
13 Long-term care and short-term rehab providers are  
14 forced to make financial choices of admission  
15 types. Because of this they are seeing the client  
16 inpatient days within the facility creating  
17 several empty beds.

18 These empty beds are now being repurposed,  
19 but they are not delicensing their beds. Because  
20 of this, occupancy rates have plummeted since the  
21 rates are calculated and based on the number of  
22 licensed beds. This is obvious -- this obviously  
23 gives the impression that beds are an abundant  
24 number within a geographic area for several -- for

1 nursing care admissions.

2 Many providers use this type of buffer for  
3 protection. This is not the case at all. I've  
4 heard that your own Long-Term Care Subcommittee to  
5 the Board have been exploring the possibility of  
6 creating a buy/sell program where providers could  
7 actually sell their unused or ghost beds or even  
8 use them to build new facilities in the area where  
9 they are not seeing a bed need.

10 The whole trend in the nursing home  
11 industry is changing rapidly. The baby boomers of  
12 today are asking for more living space, more  
13 social spaces, and amenities within a facility.  
14 Our old facilities built 30 and 40 years ago do  
15 not have the luxury of these additional areas. It  
16 is very difficult for an aged facility to create  
17 this much-needed space without undergoing a major  
18 capital improvement project.

19 Given the climate with the Medicaid  
20 reimbursement in the state being 49th in the  
21 country, providers are then forced to seek higher  
22 reimbursement challenges, such as caring for the  
23 mentally ill population or other severe medical  
24 conditions. Otherwise, these much-needed

1 improvements cannot be made. Therefore, providers  
2 find themselves with a facility that has several  
3 empty beds, institutional in appearance, limited  
4 amenities and activities where no one wants to go.

5 It is important that patients have choices  
6 of where to live. When you have several old  
7 facilities with no new innovative approach in  
8 living environments, the choices then become  
9 limited. The proposed project will offer  
10 residents of Kane County a new choice for  
11 long-term --

12 MR. ROATE: Two minutes.

13 MR. KAPLAN: -- and short-term care.

14 Thank you.

15 CHAIRWOMAN OLSON: Thank you.

16 Next.

17 MR. BERKOVITS: Good morning. My name is  
18 Fred Berkovits, B-e-r-k-o-v-i-t-s.

19 I'm the corporate compliance officer and  
20 regional director of operations for BRIA of  
21 Geneva. We're one of the facilities within the  
22 30-minute drive time to the proposed project.

23 According to this Board's most recent  
24 report, the applicant has failed to meet 6 of

1 20 criteria to justify the proposed CON project.

2 First and foremost, this Board stated  
3 there's no need for additional beds in this  
4 planning area. The State Board has calculated an  
5 excess of 108 long-term care beds in the  
6 Kane County long-term care planning area.

7 Secondly, there's no absence of long-term  
8 care services in the Kane County long-term care  
9 planning area or in the 30-minute drive radius  
10 surrounding the proposed project.

11 Third, this Board concluded that there are  
12 4,127 beds within 30 minutes of the proposed  
13 project that are collectively below the State  
14 target occupancy of 90 percent. In fact, the  
15 surrounding facilities are only operating at an  
16 average of 81 percent occupancy. Furthermore,  
17 current occupancy in the 27 Kane County facilities  
18 is only 64.5 percent.

19 Lastly, they have yet to demonstrate they  
20 even have the funds necessary to complete this  
21 project, which has now grown to beyond  
22 \$30 million.

23 As a facility that has been in Geneva for  
24 many years, we understand the needs of the

1 community. Simply put, there is no need for  
2 additional beds in this area. BRIA of Geneva is  
3 licensed for 107 beds, and we have never turned  
4 away an indigent patient for lack of beds.

5 In order to achieve the projected  
6 stabilized income shown in the applicant's  
7 submission, they would have to run their facility  
8 with a minimum of 30 percent or 45 Medicare  
9 patients. By allowing this applicant to move  
10 forward with this project and add at least another  
11 45 Medicare beds to an already oversaturated  
12 market, every other home in the area will be at  
13 risk of shutting down because the only source for  
14 those 45 patients is to siphon those patients away  
15 from the existing facilities.

16 For these reasons and the reasons set  
17 forth in our written comments submitted today,  
18 BRIA of Geneva objects to this project and asks  
19 the Board to deny the extension request as it has  
20 done so many times in the past.

21 Thank you.

22 CHAIRWOMAN OLSON: Thank you.

23 Next, please.

24 MR. WEISS: My name is Daniel Weiss,

1 D-a-n-i-e-l W-e-i-s-s. I'm here on behalf of my  
2 brother, Natan Weiss, who is down -- has the flu  
3 and could not make it.

4 "My name" -- I will be reading his  
5 statement.

6 "My name is Natan Weiss. I have been  
7 involved in the CON process on multiple occasions  
8 on both sides of the coin, to obtain a CON and to  
9 oppose a CON. Meadowbrook of Geneva was an  
10 unprecedented four extensions to their last CON.  
11 In all five instances they have attested to their  
12 ability to complete the project in the requested  
13 time. In none of those instances did the  
14 applicant begin construction, secure a mortgage,  
15 or actually start the project, let alone complete  
16 it, as they claimed that they would.

17 "Five times they obtained approval from  
18 this Board, and five times they did not build.  
19 Five times they had excuses why they couldn't  
20 proceed with that project. Why should they be  
21 given another bite at the apple? This Board  
22 correctly decided enough of the extension, enough  
23 chances. There's no need; therefore, no  
24 certificate of need.

1            "In 2008, when they first applied for a  
2        CON, there was a bed need. Today, 10 years later,  
3        there is no bed need. The region has an excess of  
4        108 skilled nursing beds according to the State  
5        report. Every facility in the area has excess  
6        empty beds. The building that was needed was  
7        completed by others, and the future need will be  
8        taken care of by those in the market with  
9        capacity. All of the nursing homes are under the  
10       State optimal occupancy percentage of 90 percent.

11           "Here we are today, once again, looking at  
12        the same applicant with higher costs, 30 percent  
13        higher than the application that was submitted  
14        just a few months ago. They're still using the  
15        same income as a total and the same per-patient  
16        day income of \$305 per day. These numbers don't  
17        jibe.

18           "They say that they want to fill it with  
19        Medicaid -- with the Medicaid population. The  
20        need doesn't exist, and they say they'll get \$305  
21        per day. That is a rate for Medicaid that does  
22        not exist in the state of Illinois.

23           "They don't have financing in place. They  
24        do not meet the State standards for referrals to



1 show a need. The State formula shows no need.  
2 What they have is a plot of land they purchased  
3 over 20 years ago as a real estate investment,  
4 over 10 years before their first CON application,  
5 and a claim that because they had a CON when there  
6 was a need, this Board should look at it as a  
7 placeholder and give them a sixth bite at the  
8 apple.

9 "There are no placeholders in this  
10 process. 10 years ago there was a need. Today  
11 there is no need. The suggestion by the applicant  
12 that they have a placeholder" --

13 MR. ROATE: Two minutes.

14 MR. WEISS: We strongly oppose this  
15 project.

16 CHAIRWOMAN OLSON: Thank you.

17 Next, Jeannie.

18 MS. MITCHELL: Again, speaking on  
19 Project 17-012, Meadowbrook Manor of Geneva, the  
20 next five are Tim Wilsey, Jennifer Moran,  
21 Dr. Kuljit Kapur, Patti Long, and Richard "Rick"  
22 Lynn.

23 Please state and spell your name at the  
24 beginning of your remarks and, again, written

1 comments, please leave them at the table.

2 MR. WILSEY: My name is Tim Wilsey, T-i-m  
3 W-i-l-s-e-y. To the members of the CON License  
4 Board, I am speaking to you today in favor of  
5 Meadowbrook Manor's Geneva application.

6 As a geriatric health care professional,  
7 I have over 20 years' working in operations,  
8 administration, business development, and the last  
9 10 years as a consultant for continuing care  
10 retirement communities, assisted living, geriatric  
11 physicians, and skilled nursing and rehab  
12 communities.

13 I speak from both a professional and  
14 personal viewpoint. As a consultant, my assisted-  
15 living clients would often have their residents on  
16 occasion end up in Meadowbrook Manor for short-  
17 term rehab following hospitalization. From the  
18 excellent care of nursing to the consistent  
19 follow-through with the therapy departments, down  
20 to the availability of not only administration but  
21 the accessibility of ownership regarding any  
22 questions on an operations level was simply  
23 stellar.

24 Any questions from the operation or

1 ownership of my client from Meadowbrook Manor's  
2 ownership and operations were addressed  
3 immediately. Their proactive approach to not only  
4 medical care needed for my clients' residents but  
5 also their education and consistent open  
6 communication for their family members was a  
7 breath of fresh air in today's world of confusing  
8 hospital systems.

9 On a personal level, I have had friends in  
10 and out of the health care industry have their own  
11 family members stay in both short-term and  
12 long-term care at the Bolingbrook and Naperville  
13 locations. The reports I always receive back from  
14 these friends were both positive and refreshing,  
15 considering what their family members have been  
16 through regarding their own medical diagnosis.

17 Meadowbrook Manor also provides the  
18 options of long-term care covered financially by  
19 public aid, which is extremely beneficial in this  
20 marketplace and often is not always provided by --  
21 readily -- by other skilled nursing facilities in  
22 that market.

23 I strongly urge the Board to approve  
24 Meadowbrook Manor for their Geneva license. This

1 family business has been so successful throughout  
2 the years in geriatric health care and would  
3 provide needed support to many seniors and their  
4 families in that area.

5 Thank you.

6 CHAIRWOMAN OLSON: Thank you.

7 Next.

8 DR. KAPUR: Hi. My name is Kuljit Kapur,  
9 Dr. Kuljit Kapur. K-u-l-j-i-t; last name, Kapur,  
10 K-a-p-u-r.

11 And I have served -- I would like to  
12 express my support for the Meadowbrook Manor's  
13 application for a certificate of need because I've  
14 been in the area practicing for 5 to 10 years as a  
15 medical director in Aurora of a nursing facility,  
16 a prominent nursing facility, as well as a hospice  
17 physician in the area, as well, at two different  
18 companies. Currently I'm the medical director at  
19 APEX Hospice and Palliative Care.

20 One of the reasons I'd like to support  
21 Meadowbrook is their staunch support of palliative  
22 care services, and I've had many good experiences  
23 in their building. I've been to all the buildings  
24 in the Geneva area, and it appears that the new

1 building would be quite integrated, upgraded  
2 private rooms, and rooms for healing. And for my  
3 population of patients -- I am a geriatric  
4 physician, internal medicine physician, and  
5 board certified also in hospice and palliative  
6 medicine -- I feel that it's a great opportunity  
7 to provide an integrative approach to patient care  
8 not only with dialysis, which is much needed in  
9 the area, however, several types of services  
10 offered to the elderly. Palliative care is an  
11 underutilized yet progressive area of medicine  
12 where we really need to be looking at offering  
13 earlier services in assistive facilities.

14 I am a SNFist, and I feel these facilities  
15 are where you can really make a difference when  
16 they come in from the hospital, when you start  
17 having those conversations with patients, when you  
18 start doing symptom management and setting their  
19 goals.

20 So I support Meadowbrook because I have  
21 had very good interactions in their buildings all  
22 over the area, and I feel that they would be the  
23 top.

24 Thank you.

Transcript of Full Meeting  
Conducted on February 27, 2018

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1 CHAIRWOMAN OLSON: Thank you.

2 Next.

3 MS. LONG: Good morning. My name is  
4 Patti Long, P-a-t-t-i L-o-n-g. I have been the  
5 administrator at BRIA of Geneva for the past  
6 three years.

7 I'm here today to state my opposition to  
8 Meadowbrook's project to build a skilled nursing  
9 facility in the Geneva/Fox Valley area. BRIA of  
10 Geneva is a 107-bed, dual-certified facility that  
11 was built in the 1980s located on the east side of  
12 Geneva. This means that we serve both Medicare  
13 and Medicaid recipients as well as those with  
14 private insurance or the ability to pay privately.

15 In my three years at BRIA of Geneva, we  
16 have never reached a hundred percent occupancy,  
17 not even 90 percent. On average, we have  
18 maintained an 80 to 89 percent occupancy rate and  
19 an average Medicaid occupancy of 88 to 92 percent.  
20 We have never turned away a Medicaid patient whose  
21 medical needs could be met at our location. We  
22 always have bed availability. Just ask our  
23 referring hospitals. Their demand never exceeds  
24 our capacity.

1           BRIA of Geneva has built one of the most  
2   robust on-site medical teams in the marketplace.  
3   We have 24-hour RN coverage, a full-time  
4   nurse-practitioner, and a medical director that  
5   rounds several days a week and is available 24/7.  
6   We have specialists that round weekly to provide  
7   comprehensive services, including cardiology,  
8   pulmonology, nephrology, gastroenterology, wound  
9   care, and psychiatric care. Our aging seniors  
10   often suffer from dementia and Alzheimer's  
11   disease, which are part of the care we provide at  
12   BRIA.

13           We also provide dental, optometry, and  
14   podiatry on-site. Our therapy department is  
15   active with our patients seven days a week with  
16   the traditional disciplines as well as the  
17   therapeutic modalities. Offering these services  
18   allows us to meet the need of our patients and  
19   serve our community.

20           I'm sure we're all in agreement that  
21   Meadowbrook is a well-established company with  
22   other facilities in the area and that a bright,  
23   new, shiny building would look pretty and nice,  
24   but what we need to think about is the bigger

1 picture, regardless of who is building the  
2 facility, and answer the following questions: Is  
3 another facility needed? Is the facility  
4 necessary? How will building another facility  
5 affect the area? And, more importantly, what  
6 that -- will that effect be positive?

7 I truly believe that another facility --

8 MR. ROATE: Two minutes.

9 MS. LONG: -- in the Geneva/Fox Valley --

10 CHAIRWOMAN OLSON: Please conclude.

11 MS. LONG: -- community is not necessary  
12 due to the abundance of available beds.

13 CHAIRWOMAN OLSON: Please conclude.

14 MS. LONG: In closing, I want to state  
15 that the quality of care in the Geneva/Fox Valley  
16 area will only be negatively affected --

17 CHAIRWOMAN OLSON: I need you to conclude.

18 MS. LONG: -- by building another facility.

19 Thank you.

20 MS. MORAN: Hello. My name is Jenny

21 Moran, J-e-n-n-y M-o-r-a-n. I'm the human  
22 resources director at BRIA of Geneva.

23 Recruiting staff is challenging and often  
24 a struggle to maintain the necessary levels of



1 staffing to provide optimal care. We often  
2 must utilize agency staff, which is costly to our  
3 bottom line but necessary to meet staffing  
4 requirements to provide our patients and residents  
5 with the care they deserve.

6 Our current efforts in staff recruitment  
7 include using resources such as Indeed,  
8 ZipRecruiter, Facebook, and CareerBuilder,  
9 combined with current staff referrals for  
10 applicants. We offer to fund interested  
11 applicants' education and enroll them into CNA  
12 classes with the stipulation that they remain a  
13 BRIA employee for a year. We also currently offer  
14 a sign-on bonus for new CNAs that join our team.  
15 Our retention program is equally robust.

16 If an additional skilled nursing facility  
17 is added in the Fox Valley area, it will make it  
18 more difficult to find new staff, take staff from  
19 existing facilities in the area, further straining  
20 efforts to maintain necessary staffing levels, and  
21 increase the use of agency staff, which puts an  
22 additional financial strain on our business  
23 viability.

24 Thank you.

1 CHAIRWOMAN OLSON: Thank you.

2 Next.

3 MR. LYNN: Good morning. My name is  
4 Richard Lynn, L-y-n-n, and I am in support of the  
5 Meadowbrook Manor application.

6 I work at a company called Marcus &  
7 Millichap, and we are investment sales brokers of  
8 senior housing, both in the state of Illinois and  
9 nationally. We help people to buy or sell  
10 independent-living, assisted-living, memory care,  
11 and skilled nursing facilities and CCRCs, which  
12 we're talking about here.

13 I have worked personally with the  
14 Meadowbrook Manor companies for over 20 years on  
15 both financing and real estate opportunities, and  
16 they have always performed excellently in  
17 completing the transaction and what they have said  
18 and done in a trustworthy and timely manner.

19 Meadowbrook Manor is a family business.  
20 It is local and it is midsize. Let me share with  
21 you what doesn't work in the state of Illinois:  
22 Small, single-site facilities in the state do not  
23 work. The people feel the pain, and I can share  
24 with you so many single-site owners that are

1 feeling the pain that need to get out, and they're  
2 asking us for that.

3 The others that do not work are large  
4 national corporations like between California and  
5 New York. They come here and try to provide the  
6 services. They cannot do it.

7 So what does work is a company just like  
8 Meadowbrook Manor. It's a family business,  
9 midsize, local, and locally focused. I would  
10 strongly encourage you to support their  
11 application for this CON. It will be a benefit to  
12 the community.

13 Thank you very much.

14 CHAIRWOMAN OLSON: Thank you, all.

15 Next five, please.

16 MS. MITCHELL: Next up, also from  
17 Meadowbrook Manor of Geneva, Project 17-01,  
18 Kelly McCallister, Amanda Pratt, Tiffany  
19 Singletary, Steven Valencia, and Scott Vavrinchik.

20 CHAIRWOMAN OLSON: Somebody can go ahead  
21 and start, please.

22 Anybody.

23 Thank you.

24 MR. VAVRINCHIK: Hi. Good morning. My

1 name is Scott Vavrinchik, S-c-o-t-t  
2 V-a-v-r-i-n-c-h-i-k.

3 I'm one of the owners of Affiliated  
4 Dialysis Centers. We provide on-site hemodialysis  
5 services in skilled care centers throughout  
6 Illinois, Ohio, California, and shortly in  
7 Indiana. We've had the privilege of partnering  
8 with the Meadowbrook corporation since 2011 at  
9 their La Grange, Naperville, and Bolingbrook  
10 locations.

11 After reviewing our treatment data, we've  
12 cared for 325-plus patients and provided over  
13 24,000 dialysis treatments over the past  
14 seven years. They have and continue to be an  
15 excellent partner, utilizing state-of-the-art  
16 equipment, thus providing cutting-edge daily  
17 dialysis therapy and realize the benefits,  
18 improved quality of life, excellent clinical  
19 outcomes for their patients.

20 The geography bordering on Carpentersville  
21 to the east, south to Channahon, west to Analana  
22 [phonetic], north to Mount Carroll, and back east  
23 to Carpentersville, there are a number of skilled  
24 care centers in that geography who accept renal

1 patients but send out those patients to an  
2 outpatient dialysis center. To our knowledge,  
3 there are not skilled care centers offering  
4 on-site hemodialysis in that area. The closest  
5 skilled care centers offering on-site dialysis are  
6 Naperville, Elgin, and Rockford.

7 Specific to the Meadowbrook corporation,  
8 their Naperville facility is filled with a waiting  
9 list for dialysis patients. The same holds true  
10 for La Grange. Their facility is filled, and they  
11 are -- we are seeing referrals from the area in  
12 question that I just mentioned.

13 We have had a -- as I said, we have an  
14 excellent working relationship with the  
15 Meadowbrook Butterfield corporation. And if we do  
16 have the privilege of doing dialysis at that  
17 location, we would employ the same type of daily  
18 dialysis treatment in their other buildings that  
19 we use.

20 Thank you.

21 CHAIRWOMAN OLSON: Thank you.

22 MS. PRATT: Hello. My name is Amanda  
23 Pratt, A-m-a-n-d-a P-r-a-t-t --

24 CHAIRWOMAN OLSON: Right into the mic,

1 please.

2 MS. PRATT: -- and I am here to represent  
3 Tower Hill Health Care Facility in South Elgin.  
4 I'm also here to oppose the construction of  
5 Meadowbrook Manor in Geneva.

6 My position at Tower Hill is primarily  
7 external, so we do nursing care analysis on a  
8 monthly basis, and I know that there's definitely  
9 no absence of Medicaid nor Medicare beds. I know  
10 the surrounding communities have available  
11 Medicare and Medicaid beds. As for my community,  
12 we have 30-plus open dually certified beds, and we  
13 have averaged this amount of availability for the  
14 last couple of years due to the already  
15 oversaturated area.

16 I think that this project is only going to  
17 hurt the existing markets. I don't see any  
18 benefit to this project while knowing the  
19 established nursing facilities in the area are not  
20 at full capacity. It will be a continued  
21 challenge for our county not only to staff  
22 properly but also the increase in money spent on  
23 agencies.

24 Thank you.

1 CHAIRWOMAN OLSON: Thank you.

2 Next, please.

3 MS. MC CALLISTER: Kelly McCallister,  
4 K-e-l-l-y M-c-C-a-l-l-i-s-t-e-r.

5 My name is Kelly McCallister. I'm the  
6 president of --

7 CHAIRWOMAN OLSON: Please speak into the  
8 microphone.

9 MS. MC CALLISTER: My name is Kelly  
10 McCallister. I'm the president of business  
11 development and marketing for Symphony Postacute  
12 Network. I'm here to express my concern regarding  
13 adding additional nursing home beds to an already  
14 saturated market.

15 According to the National Investment Care  
16 Center for Senior Housing and Care, NIC, skilled  
17 nursing occupancy nationwide fell to 81.8 percent  
18 in the fourth quarter of 2016. That's down  
19 .8 percent from the third quarter of 2016 and the  
20 lowest level skilled nursing occupancy has reached  
21 since NIC started collecting the data in 2011.  
22 Downward pressure on occupancy has been steady  
23 since May 2015, the last month that occupancy was  
24 85 percent or higher.

1           There are 27 nursing homes in Kane County.  
2           The three closest nursing homes to the proposed  
3           sites, average occupancy ranges from 69 to  
4           80 percent, and there is a hemodialysis skilled  
5           nursing facility in Aurora, which does reside in  
6           Kane County.

7           Northwestern Delnor Hospital, which would  
8           be the primary referral source for this location,  
9           only discharged 184 Medicare patients for the  
10          whole entire last reported quarter. All of the  
11          hospitals in Kane County for the last reported  
12          quarter only discharged 814 Medicare patients.  
13          Clearly, there is not enough Medicare business to  
14          reach the proposed number Meadowbrook states they  
15          need to be viable.

16          Private pay continues to decrease, as well  
17          as Medicaid. There are plenty of Medicare and  
18          Medicaid providers in the state. And although  
19          Medicaid is at its highest occupancy since it's  
20          been reported and tracked, we're still only at  
21          66.8 percent Medicaid occupancy.

22          Clearly, with the blurring lines between  
23          assisted living and SNFs, the multigenerational  
24          homes, and more options for seniors to stay at



1 home, there's plenty of readily available options  
2 for the seniors in Kane County, so that is why I'm  
3 here to say please leave our market alone. We  
4 continue to struggle already.

5 CHAIRWOMAN OLSON: Thank you.

6 Next, please.

7 MS. SINGLETARY: Hello. My name is  
8 Tiffany Singletary; T-i-f-f-a-n-y; Singletary,  
9 S-i-n-g-l-e-t-a-r-y.

10 I am the administrator and owner of  
11 Newsome Home Health Care, and I am here in support  
12 of the Meadowbrook Manor of Geneva extension.  
13 We've worked closely with Meadowbrook Manor of  
14 Bolingbrook and of Naperville for the last  
15 six years, and we feel that the patients and the  
16 care that they provide there is very good. When  
17 the patients go home, they are at a level where  
18 they're ready to be home. We feel that they help  
19 to continue their care and that they are  
20 discharging at the appropriate time.

21 Their mission to get them ready for home  
22 in order for them to be successful there we've  
23 found to be higher than a lot of the facilities  
24 that we work with. So I'm just here in support of

1 the project.

2 Thank you.

3 CHAIRWOMAN OLSON: Thank you.

4 Next, please.

5 MR. VALENCIA: Good morning. My name is  
6 Steve Valencia. I am a resident at Meadowbrook  
7 Manor.

8 We're not there by choice. We have to be  
9 there. I was at two other facilities before  
10 Meadowbrook Manor and they're disgusting. I can  
11 see why some of the places have empty beds.  
12 I would never stay there.

13 The staff demand -- excuse me.

14 The management at Meadowbrook Manor you  
15 can't beat. And I'm telling you it's like a home.  
16 They treat you good. From housekeeping to the  
17 owners, they care. They care a lot.

18 So when people say that they don't need  
19 another one, they need one that has some of the  
20 people that care. And that's the truth.

21 Thank you.

22 CHAIRWOMAN OLSON: Thank you, sir.

23 Five more.

24 There's three more for Meadowbrook, and

1 then we'll take a short break.

2 MS. MITCHELL: Again, for  
3 Meadowbrook Manor of Geneva, Project 17-012,  
4 Ruthanne Chesley, Craig Frank, Katherine  
5 Katsoyannis.

6 If there's anybody who signed up to speak  
7 on this project whose name was not called, please  
8 come up at this time.

9 CHAIRWOMAN OLSON: Somebody can go ahead.  
10 Please.

11 MR. FRANK: My name is Craig Frank and --  
12 C-r-a-i-g F-r-a-n-k.

13 I'm here representing Rosewood Care  
14 Centers, which has two facilities in the area  
15 representing 248 beds.

16 CHAIRWOMAN OLSON: Pull that close.

17 MR. FRANK: Sorry.

18 We currently have an occupancy less than  
19 80 percent, and our staffing needs are great. By  
20 opening a new facility, the staffing will probably  
21 be drawn out even more than it is today. The use  
22 of agency is astronomically high, and the dollars  
23 being spent to try to staff these buildings is --  
24 you know, continues to rise.

1           The patient flow that will come out of the  
2           hospitals here will, you know, slowly divide that  
3           by -- even further, causing a major financial  
4           strain on the current facilities in the area. So  
5           I'm here in opposition to the CON.

6           Thank you.

7           CHAIRWOMAN OLSON: Thank you.

8           Next, please.

9           MS. CHESLEY: Good morning.

10          My name is Ruthanne Chesley, R-u-t-h-a-n-n-e  
11          C-h-e-s-l-e-y.

12          I am proud to say that I am a lifelong  
13          resident of the city of Geneva, born and raised  
14          and still enjoying life in the Fox Valley. My  
15          parents were married at the United Methodist  
16          Church in Geneva in 1945, where they lived in  
17          their family home in Geneva until their deaths in  
18          2009 and 2014. My youngest sister and her family  
19          currently reside in that house.

20          I have also worked in the skilled nursing  
21          sector for the past 14 years. I am currently the  
22          activity director at BRIA of Geneva. Over  
23          the years I have had numerous friends and  
24          acquaintances whose family members have needed

1 placement in a skilled nursing facility. Not once  
2 did they need to look outside Geneva or the  
3 Fox Valley area for placement. This means there  
4 are sufficient choices already available to meet  
5 the needs of the residents of Geneva and the  
6 Fox Valley.

7 In my time at BRIA of Geneva, we have  
8 never been at capacity. A bed is always  
9 available. BRIA goes out of its way to ensure  
10 Geneva and the Fox Valley residents can stay  
11 local, regardless of their payer source. I am  
12 sure this is true with other local area providers,  
13 as well.

14 The bottom line, there is no need for any  
15 additional facilities in the area. The needs of  
16 Geneva and the Fox Valley area residents are  
17 clearly being met.

18 Thank you.

19 CHAIRWOMAN OLSON: Thank you.

20 Next, please.

21 DR. KATSOYANNIS: Good morning. I'm  
22 Katherine Katsoyannis, K-a-t-h-e-r-i-n-e  
23 K-a-t-s-o-y-a-n-n-i-s.

24 I am a board-certified geriatrician, and

1 I primarily practice in facilities. I've been  
2 affiliated with a Meadowbrook home, Lee Manor in  
3 Des Plaines, for almost 20 years, and I've been  
4 the medical director there for about 15 years.

5 I do practice in a lot of other  
6 facilities, obviously, in -- near my practice in  
7 Park Ridge, but I can tell you that there is a lot  
8 of difference between the quality of care  
9 provided, and I'm very proud to work at -- at  
10 Lee Manor and be part of a team, and we really do  
11 feel like it's a team.

12 I think I'm echoing a previous commentator  
13 in saying that it is family run and it feels  
14 family run. You can get answers to any questions  
15 or concerns very quickly. There's a lot of -- a  
16 lot of attention paid to details, to respect for  
17 patients, to providing the highest quality of care  
18 that can be.

19 And, again, I'm very proud to be part of  
20 that team and, in some cases, leading that team in  
21 addressing any issues that come up. There's a  
22 great deal of commitment to doing things well, and  
23 I think that the demographics -- yeah, there are a  
24 lot of nursing home beds empty right now, but by

1 the year 2030, about 20 percent of us will be over  
2 the age of 65, and we probably are going to need  
3 that type of care at some point.

4 Thank you.

5 CHAIRWOMAN OLSON: Thank you.

6 Next, please.

7 MR. LAFER: Good morning. My name is  
8 Evan Lafer, E-v-a-n L-a-f, as in "frank," -e-r.

9 I'm here in opposition to the Meadowbrook  
10 project. I am the business development director  
11 for BRIA Health Services.

12 Over the past six years I've become  
13 intimately familiar with the discharge trends at  
14 Delnor, Central DuPage, and other hospitals that  
15 service patients in the Fox Valley. The discharge  
16 data over this period supports my experience that  
17 the number of patients sent to skilled nursing  
18 locations has significantly decreased. The  
19 percentage of patients being discharged home has  
20 increased every year over the same period, which  
21 means the number of discharges to SNFs has  
22 decreased. As I am sure you are aware, this trend  
23 matches similar trends throughout Illinois and  
24 nationwide.

1           The hospitals caring for the Fox Valley  
2     patient base do not have enough discharges to SNFs  
3     to sustain the current market, as substantiated in  
4     State figures showing that the area is overbedded.  
5     Surely, another 150 beds is not needed.

6           BRIA of Geneva participates in the  
7     Northwestern preferred provider network. As a  
8     member of this network, we work with Delnor and  
9     Central DuPage Hospital to ensure all patients  
10    needing skilled nursing placement are  
11    accommodated. We are actually contractually  
12    obligated to ensure patients with Medicaid are  
13    equally considered and placed as we would a  
14    Medicare or private insurance patient.

15           Our census typically runs 85 to 90 percent  
16    public aid and public aid-pending patients, as  
17    well, and, yes, we regularly assist the hospitals  
18    in placing patients who are in the process of  
19    applying for public aid. The claim that the  
20    Medicaid population is underserved is a gross  
21    overstatement. We regularly take Medicare --  
22    Medicaid patients and will continue to do so.

23           The application lists physicians that  
24    purportedly will send referrals to support the



1 applicant. Physicians are not driving the  
2 majority of patient placement. This is driven by  
3 hospital preferred provider network -- networks --  
4 and criteria, insurance carrier networks that  
5 limit the number of contracts to any specific  
6 market area, and patient choice driven heavily by  
7 the hospital social workers and case managers.

8 With that said, I offer the following with  
9 regard to several physicians listed in the  
10 application: Dr. Jabban does not send or -- to us  
11 or anyone else other than the Edward Hospital  
12 postacute network. Dr. Popp has left Fox Valley  
13 Orthopedics and now resides in Florida.  
14 Dr. Hashemi, which is an infectious disease  
15 physician -- she rounded by us for over  
16 two years -- as a secondary specialist does not  
17 and is not in the position to place patients in  
18 SNFs.

19 On an annual basis Dr. Morawski and  
20 Dr. Petrucci do not send SNFs the volume listed in  
21 the application, even if you include all possible  
22 destinations within a 15-mile radius of Delnor  
23 Hospital. They do most of their surgeries at  
24 Valley Ambulatory Surgical Center on an outpatient

1 basis.

2 MR. ROATE: Two minutes.

3 MR. LAFER: In summary, we oppose this  
4 application.

5 CHAIRWOMAN OLSON: Thank you.

6 Okay. We're going to take a short break,  
7 15 minutes. We'll come back in 15 minutes.

8 (A recess was taken from 10:42 a.m. to  
9 10:51 a.m.)

10 CHAIRWOMAN OLSON: Okay. We'll continue  
11 with public participation.

12 Jeannie, could you call the next five.

13 MS. MITCHELL: Is there anyone here to  
14 speak on Project E-001-18, MacNeal Hospital,  
15 change of ownership?

16 (No response.)

17 MS. MITCHELL: Okay. Hearing none, next  
18 speakers will be speaking on Project 17-044,  
19 Smith Crossing.

20 Ron Nunziato, Michael Taylor, Roger  
21 Ellens, Wendy Janulis, and Evan Lafer.

22 MR. NUNZIATO: Good morning. My name is  
23 Ron Nunziato, N-u-n-z-i-a-t-o.

24 I'm the CEO for Extended Care Consulting,

1 a nursing home consulting company that provides  
2 services to 22 facilities based in Illinois and  
3 Indiana. We provide consultation services to  
4 several facilities in the HSA 9 area and  
5 several -- and several facilities in the  
6 contiguous HSA of 7E.

7 Our objections are based on the service  
8 needs in these areas. The area of 7E is clearly  
9 overbedded in excess of a thousand beds. This  
10 project would create more empty beds in an area  
11 that doesn't need them.

12 Our examples from HSA 9 and HSA 7E, for  
13 instance, are Lakewood Nursing & Rehab in the Will  
14 County area has 131 beds. It's in HSA 9 and ended  
15 its 2017 with an average census of 84 percent of  
16 capacity and a Medicare census of 26. Medicare is  
17 clearly the type of payer and people that Smith  
18 Crossing is particularly hoping to attract to this  
19 new proposed project.

20 The PARC at Joliet, 203 beds in Will  
21 County, HSA 9, and ended its 2017 year with an  
22 average census of 63 percent of capacity and a  
23 Medicare census of 20. Spring Creek in Will  
24 County, HSA 9, ended its 2017 year with an average

1 census of 50 percent and a Medicare census of 13.  
2 Lemont Nursing Center, which someone else will be  
3 speaking with here today, I'll skip.

4 Chateau Nursing in Willowbrook has  
5 150 beds, is in the contiguous HSA, ended its 2017  
6 with 21 Medicare residents and an average census  
7 of only 80 percent.

8 Smith Crossing's proposal includes  
9 statements of need that this project is addressing  
10 the unmet bed and corresponding deflected  
11 referrals that Smith Crossing cannot accept due to  
12 existing utilization. That's what the application  
13 reads. This statement is not true for the  
14 community at large within the HSA 9 and the  
15 contiguous HSA 7E.

16 Not only do we believe this proposal is  
17 unnecessary to serve the community from a resident  
18 or perspective -- patient perspective -- but we  
19 also contend that that area is incredibly --

20 MR. ROATE: Two minutes.

21 MR. NUNZIATO: -- short of staff, and we  
22 oppose this project.

23 Thank you.

24 CHAIRWOMAN OLSON: Thank you.

1           Next, please.

2           MR. LAFER:   Evan Lafer, E-v-a-n L-a-f-e-r,  
3           director of business development, BRIA Health  
4           Services. I'm here in opposition to the Smith  
5           Crossing project.

6           The STRIVE Center for Rehabilitation at  
7           BRIA of Palos Hills is where five-star luxury is  
8           only exceeded by the quality care we provide, as  
9           recognized by our Joint Commission accreditation.  
10          The future of short-term rehabilitation has  
11          arrived with our five-star amenities, lavish  
12          private suites, and 3,000-square-foot therapy gym  
13          complete with the world's most advanced aquatic  
14          therapy pool and spa. We are meeting the modern  
15          needs of patients and exceeding their expectations  
16          and the expectations of our hospital and physician  
17          partners.

18          Our rehabilitation center offers  
19          cutting-edge specialty programs and advanced  
20          equipment and therapeutic modalities developed  
21          around orthopedic, cardiac, pulmonary, and  
22          neurological medical conditions of aging adults.

23          The STRIVE Center boasts an easy access,  
24          no-stairs, no-lift aquatic therapy pool with

1 underwater treadmill, resistive jet therapy, and  
2 underwater cameras to monitor progress. This is  
3 an example of how we are delivering to our seniors  
4 the most advanced therapy solutions, only once  
5 afforded to multimillion-dollar athletes.

6 We provide a true home away from home  
7 while our patients get back on their feet and  
8 return to their active lifestyles and family. Our  
9 patient rooms provide flat screen TVs with cable,  
10 WiFi Internet access and iPads, private phone  
11 lines, high quality hotel linens and ample space  
12 for family members to sit and visit. The patients  
13 take full advantage of both community and private  
14 dining options, a spa room, ice cream parlor,  
15 beauty salon, family rooms, sitting areas with  
16 fireplaces, and our library.

17 We work tirelessly to strike the perfect  
18 balance between compassionate individual care and  
19 the latest advantages -- advances in  
20 rehabilitation and skilled nursing practice and  
21 technology in all the services we provide, while  
22 doing everything in our power to ensure our  
23 clients get everything they need.

24 The Smith Crossing project is not needed

1 because all the services required by residents in  
2 the project area are met by the STRIVE Center for  
3 Rehabilitation at BRIA of Palos Hills and other  
4 current service providers.

5 CHAIRWOMAN OLSON: Thank you.

6 Next, please.

7 MR. ELLENS: Hi. My name is Roger Ellens,  
8 R-o-g-e-r E-l-l-e-n-s. I'm the CFO of Peace  
9 Village. I've been there for over eight years,  
10 and I'm also a CPA.

11 We were started in 1989 by Peace Memorial  
12 Church, which is a member of the United Church of  
13 Christ. Since 1989 we've been serving older  
14 adults from that congregation as well as the  
15 surrounding area of Tinley Park, Palos Park, and  
16 Orland Park.

17 I chose to work at Peace Village because  
18 it values relationship care. It has a thoughtful  
19 approach to collaborating with other organizations  
20 to provide all the services and supports that our  
21 residents may need.

22 I've served as Peace Village's financial  
23 officer -- chief financial officer -- for  
24 almost -- for over eight years. For five years

1 I worked as the finance manager at Praxair  
2 Healthcare Services, and my experience in other  
3 fields as a controller informs my role at Peace  
4 Village.

5 More than 30 years ago, when Peace  
6 Village's founders envisioned how our community  
7 would serve seniors, they included partnering with  
8 other like-minded organizations to serve the  
9 residents there. Since its inception, Peace  
10 Village's focus remains on serving older adults  
11 who are independent or may need some assistance  
12 with daily living or memory care support.

13 Peace Village is a life plan community.  
14 This means we provide, at a discounted price,  
15 either directly or with a partner, future care at  
16 a higher level when a resident needs that care.  
17 Rehab services and programs are in this category,  
18 so Peace Village gives credit to residents to  
19 underwrite a portion of that care when they  
20 require rehab or skilled nursing care in another  
21 location.

22 Over the years Peace Village has  
23 considered building its own rehab facility, and at  
24 one time Peace Memorial Church did own a facility



1 for skilled care and rehab, but it was sold to  
2 another provider.

3 During the last three years of strategic  
4 planning, our board and executive team at Peace  
5 Village decided to leave rehab programs to the  
6 experts, including Smith Crossing. We want to  
7 stay true to our founders' vision, focused  
8 continual support for seniors and partnering with  
9 other organizations to provide those that we do  
10 not offer.

11 It's ideal when Peace Village residents go  
12 from their hospital stay to Smith Crossing for  
13 rehab and then back to living full-time in their  
14 residence at our community. Fortunately, Marie  
15 Murray was able to stay at Smith Crossing and  
16 everything went well. She just got back to Peace  
17 Village, and she's doing very well now as our  
18 self-coordinated queen of Peace Village.  
19 Unfortunately, this is the exception when one of  
20 our residents needs rehab --

21 MR. ROATE: Two minutes.

22 MR. ELLENS: -- and must go somewhere else  
23 other than Smith Crossing.

24 CHAIRWOMAN OLSON: Please conclude.

1           MR. ELLENS: We support Smith Crossing  
2 being given permission to add more rehab beds so  
3 our residents --

4           CHAIRWOMAN OLSON: Please conclude.

5           MR. ELLENS: -- can stay there.

6           CHAIRWOMAN OLSON: Thank you.

7           Next, please.

8           MR. TAYLOR: Good morning. My name is  
9 Mike Taylor, M-i-k-e T-a-y-l-o-r. I'm the head of  
10 health care lending for First Midwest Bank -- can  
11 you hear me?

12          CHAIRWOMAN OLSON: Pull it closer.

13          MR. TAYLOR: Can you hear me? Sorry.

14          Good morning. My name is Mike Taylor,  
15 M-i-k-e T-a-y-l-o-r. I'm the head of health care  
16 lending for First Midwest Bank, and I'm here in  
17 support of the Smith Crossing expansion.

18          I've been financing senior living  
19 facilities for the last 15 years and have worked  
20 closely with Smith Senior Living for the past  
21 10-plus years at both my prior institution,  
22 Ziegler Capital Markets, and since I joined  
23 First Midwest Bank here 5 years ago when we  
24 financed their expansion of their independent

1 living project on their existing campus.

2 Smith Crossing continues to be a high  
3 quality facility and continues to be a strong  
4 performer with occupancy across all of its levels  
5 of care in the mid-'90s, which speaks not only to  
6 the quality of the community but the desire for  
7 people to reside within it.

8 In addition, from a credit perspective,  
9 they continue to be a strong financial partner,  
10 have a very strong balance sheet and strong cash  
11 flows. In addition, behind them they also have  
12 the support of Smith Senior Living, their sponsor.

13 As for this project, we've been involved  
14 in the planning of it for the last number  
15 of months and are very supportive of the project.  
16 We're looking forward to starting the financing  
17 process once they receive all of their approvals.

18 In summary, First Midwest Bank has  
19 completed over a billion dollars worth of health  
20 care financing in the last five years. We're  
21 looking forward to continuing our partnership with  
22 Smith Crossing and financing this project for  
23 them.

24 CHAIRWOMAN OLSON: Thank you.

1 Next.

2 MS. MITCHELL: Niki Mehta --

3 CHAIRWOMAN OLSON: If you have comments,  
4 please leave them on the table for the court  
5 reporter, if you have written comments.

6 MS. MITCHELL: Also speaking on  
7 Project 17-044, Smith Crossing, Niki Mehta -- or  
8 Mehta -- Amanda Mauceri, Daniel Weiss, Gary  
9 Weintraub, and Fred Berkovits.

10 CHAIRWOMAN OLSON: Somebody please start.

11 MS. MEHTA: Hi. Niki Mehta, N-i-k-i  
12 M-e-h-t-a, administrator at Lemont Nursing & Rehab  
13 Center.

14 We are in opposition of this project.  
15 Lemont Nursing Center has 173 certified beds with  
16 HSA 7E and Smith Crossing. It should be noted  
17 that Lemont Center is only 12 miles from Smith  
18 Crossing. In 2017 we ended the year at an average  
19 monthly census of approximately 84 percent of  
20 capacity. Our Medicare average was 32 for 2017.

21 Thank you.

22 CHAIRWOMAN OLSON: Thank you.

23 Next, please.

24 MS. MAUCERI: Good morning. My name is

1 Amanda Mauceri, M-a-u-c-e-r-i. I'm the director  
2 of Evergreen Senior Living.

3 Evergreen is an assisted-living and memory  
4 care support located just a few blocks west of the  
5 Smith Crossing community. Currently we are  
6 serving 92 residents.

7 Two years ago our community was built with  
8 Smith Crossing in mind to be able to send our  
9 seniors who need rehab to that location;  
10 oftentimes there is no availability due to lack of  
11 beds. The Smith Crossing expansion will help  
12 placement of our seniors.

13 I am in favor of this project both  
14 personally and professionally. Personally,  
15 11 years of my career has been spent with the  
16 Smith communities. I know firsthand their  
17 commitment to the seniors with an outstanding  
18 reputation, excellence in leadership, and staff  
19 retention and the highest quality of care.

20 Professionally, there have been times that  
21 our residents were able to go to Smith Crossing  
22 rehab. They returned to their prior level of  
23 functioning, returned with better physical  
24 outcomes and improved mental health.

1           My community is serving nine residents  
2           that are currently out of the community, five of  
3           which are in hospitals and four of which are in  
4           other rehabs. Time and time again families and  
5           residents come to me asking if they can go to  
6           Smith Crossing as their first choice but  
7           oftentimes have to go to other rehabs, and quite  
8           often I am counseling with these family members  
9           that have stayed in other rehabs that it's not  
10          going well and they want to come back home. They  
11          want to come back home "due to poor quality, staff  
12          turnover, subpar therapists," are things that  
13          I hear. Smith Crossing leadership and care is  
14          above the rest.

15          Orland Park needs this project. Our  
16          current marketplace of seniors also need this as  
17          well as our future seniors.

18          For this I support the Smith Crossing  
19          expansion and hope, with your support, it is  
20          approved.

21          Thank you.

22          CHAIRWOMAN OLSON: Thank you.

23          Next, please.

24          MR. BERKOVITS: Good morning. My name is

1 Fred Berkovits, B-e-r-k-o-v-i-t-s.

2 I'm the corporate compliance officer for  
3 BRIA Health Services, and we operate two  
4 facilities within the 30-minute drive time to the  
5 proposed project, and I am here to oppose the  
6 project.

7 According to this Board's recent report,  
8 the applicant has failed to meet at least 4 of  
9 16 criteria to justify the proposed project.  
10 First and foremost, the applicant failed to show a  
11 need for additional beds. Second, applicant  
12 failed to show availability of funds to complete  
13 the project. Third, the applicant failed to  
14 demonstrate financial viability. And, fourth,  
15 they have failed to justify the reasonableness of  
16 the project costs.

17 As to bed availability, the applicant  
18 states and I quote, "Garnering additional referral  
19 volume will mean taking market share from other  
20 skilled nursing providers in the market." It's  
21 important to note that it's already garnering  
22 87 percent of its new admissions from HSA 7E, an  
23 area that is already overbedded.

24 Failure to meet these four criteria speaks

1 volumes as to the applicant's true intent, and  
2 that is to build a bigger building at an  
3 unreasonably high cost with money it doesn't have  
4 and to fill that building with patients garnered  
5 from surrounding nursing facilities, 87 percent of  
6 which historically have come from an adjacent  
7 planning area.

8 In short, there's no real bed need on the  
9 northern border of HSA 9, which is adjacent to  
10 HSA 7E, and this project will result in a gross  
11 maldistribution of services that will negatively  
12 impact the surrounding facilities, primarily those  
13 in HSA 7E, a factor which this Board should not  
14 ignore.

15 And for these reasons and those reasons  
16 set forth in our written comments submitted today,  
17 BRIA Health Services objects to the project and  
18 asks the Board to deny the request.

19 Thank you.

20 MR. WEISS: My name is Daniel Weiss,  
21 D-a-n-i-e-l W-e-i-s-s. I'm the CEO of BRIA Health  
22 Services.

23 I'm here to oppose the Smith Crossing  
24 project and the addition of 46 new SNF beds. This



1 addition is a 100 percent increase from their  
2 current licensure.

3 Smith Crossing's application is inaccurate  
4 and not reflective of the whole picture as it  
5 relates to several points as reflected in its  
6 submissions and testimony. One of the points they  
7 have made is that they're the only ones who can --  
8 can and do provide the quality services needed for  
9 the additional population they are seeking to  
10 serve. This is simply not the reality.

11 Our facility, BRIA of Palos Hills, as  
12 Mr. Lafer explained in prior testimony, is a  
13 state-of-the-art SNF providing short-term  
14 rehabilitation to the exact patients Smith  
15 Crossing suggests have no place to go. Our  
16 readmission rate in 2016 and '17 was at 16 and  
17 17 percent as compared to Smith Crossing's  
18 17.3 percent reported -- that was their reported  
19 readmission rate to this Board on their  
20 application.

21 Our length of stay is comparable to that  
22 of Smith Crossing. They show an 18-day length of  
23 stay and return to home. We have a 19-day length  
24 of stay and return to home since we opened in

1 2016.

2 Since opening, we have more than  
3 quadrupled our admissions from Palos Community  
4 Hospital, Silver Cross, and Christ Hospitals from  
5 147 in 2015 to 677 in 2017 on a path to a thousand  
6 in 2018. Not only is BRIA of Palos Hills and  
7 other facilities like ours filling the need that  
8 Smith Crossing erroneously says exists, we all  
9 have empty beds, putting us below the occupancy  
10 standards set by the State for the area and can  
11 accept any patients that Smith Crossing would like  
12 to accept that are discharging from hospitals.

13 At the end of the day, Smith Crossing and  
14 their representation have not painted a complete  
15 picture to this Board. Smith Crossing was built  
16 for the affluent, and they now want to build the  
17 most expensive per-bed facility that has ever been  
18 requested in Illinois to drain more of the premium  
19 pay sources away from the facilities that provide  
20 care to everyone regardless of pay sources.  
21 Patient needs with all types of payer sources are  
22 being met by qualified and quality skilled nursing  
23 facilities in the area.

24 I would ask the Board to recognize Smith

1 Crossing's application for what it is, which is  
2 simply an attempt to take a larger number of  
3 patients with premium pay sources away from  
4 current providers in the HSA, Which will lower the  
5 utilization below occupancy standards for the  
6 facilities in the area. This will result in a  
7 negative impact on these facilities.

8 I ask the Board to deny Smith Crossing's  
9 application. Thank you.

10 CHAIRWOMAN OLSON: Thank you.

11 Next.

12 MR. WEINTRAUB: Good morning. My name is  
13 Gary Weintraub, W-e-i-n-t-r-a-u-b, representing  
14 Objector BRIA Health Services in opposition to  
15 this request.

16 The address of the Smith Crossing facility  
17 is 10501 Emilie Lane in Orland Park. Virtually  
18 all of Orland Park is in Cook County HSA 7 except  
19 a very small area at the southern edge of  
20 Orland Park, which extends into Will County,  
21 HSA 9. Smith Crossing is located in that small  
22 sliver.

23 The Village of Orland Park has a  
24 population of approximately 58,800 as of 2016

1 census data. Virtually all of the residents of  
2 the village of Orland Park live in the Cook County  
3 portion of the village. In fact, all of the  
4 residents of Orland Park except those that reside  
5 at Smith Crossing live in Cook County.

6 The applicant here states that its  
7 resident source for referral base is split 50/50  
8 between Will County, HSA 9, and Cook County,  
9 HSA 7; however, the data which it has submitted  
10 contradicts this. See Table 4.

11 The applicant initially submitted  
12 historical admission data for an 18-month period  
13 from 1/1/16 through 6/30 of '17 which showed that  
14 83 percent of its referral sources for skilled  
15 nursing population came from Cook County zip  
16 codes. The applicant subsequently submitted an  
17 additional six months of data, which indicated  
18 that 87 percent of new admissions come from  
19 Cook County, not Will County.

20 Cook County, HSA 7, is significantly  
21 overbedded by 202,409 beds, according to the  
22 Board's 9/1/17 inventory. Of the five subareas in  
23 HSA 7, Planning Area 7E, which contains Orland's  
24 township, is the most overbedded, with

1 1,132 excess beds. Far less than 50 percent of  
2 Smith Crossing's admissions come from HSA 9.  
3 Since only 13 to 17 percent of its admissions have  
4 been from HSA 9, we respectfully submit that  
5 Criteria 1125.530(b) --

6 MR. ROATE: Two minutes.

7 MR. WEINTRAUB: Thank you.

8 We oppose this request and ask that it be  
9 denied.

10 CHAIRWOMAN OLSON: Thank you.

11 Next five, please.

12 MS. MITCHELL: Emily [sic] Byerley on  
13 Smith Crossing, Project 17-044.

14 Is there anybody here who has not been  
15 called who signed up to speak on Smith Crossing?

16 (No response.)

17 MS. MITCHELL: Okay. Also, Project 17-052,  
18 Dialysis Care Center Beverly, Mark Mielnicki.

19 And for Valley Ambulatory Surgery Center,  
20 Project 17-057, Patrick Griffin and Sam Vinson.

21 MS. BYERLEY: Eva Byerley, E-v-a  
22 B-y-e-r-l-e-y.

23 My name is Eva Byerley, and I represent  
24 Generations Healthcare Network. I'm here today to

1 speak against the Smith Crossing project.

2 I have many objections to this project  
3 that are discussed more fully in a previously  
4 submitted letter. Today, I really want to address  
5 two concerns.

6 Ultimately, the area of this project has  
7 an excess of beds. I represent five facilities in  
8 the Cook County area that can be directly affected  
9 by this project. Each facility accepts patients  
10 regardless of payer source and serves a large  
11 indigent population. Each of these facilities has  
12 a strong history of reinvesting in improvements  
13 that directly affect the patient experience and  
14 care. That is made possible by the mixed payer  
15 sources.

16 The addition of 46 beds in an area that is  
17 so competitive and overbedded diverts patients  
18 and, ultimately, resources away from area  
19 facilities who are already serving this population  
20 and community. It can also negatively affect the  
21 services that are available to the residents  
22 already in the area.

23 I also have family and loved ones in rural  
24 Will County. I fear that the concentration of the

1 available Will County beds on or near the Cook  
2 County border will mean that, when they need such  
3 services, they will find that they have to travel  
4 far from home to get that care.

5 And, again, I request that you vote  
6 against this.

7 CHAIRWOMAN OLSON: Thank you.

8 Next, please.

9 MR. MIELNICKI: Good morning, Board.

10 My name is Mark, M-a-r-k; Mielnicki,  
11 M-i-e-l-n-i-c-k-i.

12 I'm here to discuss Dialysis Care Center  
13 Beverly. I'm with First in Realty Executives, a  
14 commercial real estate firm representing ownership  
15 in the transaction. I'm here to express strong  
16 support for Dialysis Care Center Beverly in  
17 Chicago for a certificate of need project and  
18 clarify the Board's concerns regarding the  
19 construction costs.

20 Ownership of the 28,000-square-foot  
21 medical office development shall provide a turnkey  
22 build-out pursuant to the plans and specifications  
23 including all labor, material, and equipment. The  
24 23,000 -- I'm sorry.

1           The 28,000-square-foot building, the  
2     tenant shall occupy approximately 23 percent of  
3     the building and 46 percent of the main floor  
4     area. The center is conveniently located on  
5     Western Avenue, Chicago's primary north and south  
6     thoroughfare, with easy access to public  
7     transportation, major thoroughfares, and  
8     sufficient parking with handicapped stalls located  
9     in front of Dialysis Care Center Beverly's  
10    premises, offering great circulation with easy  
11    drop-off and pickup access.

12           We feel Dialysis Care Center Beverly will  
13    be a long-term valuable asset to the development  
14    and the community on the south and southwest area  
15    of the city.

16           Thank you.

17           CHAIRWOMAN OLSON: Thank you.

18           Next, please.

19           Either direction.

20           MR. VINSON: Madam Chairman, I just want  
21    to make sure that I'm speaking at the right time  
22    because these folks are -- talked about a  
23    different project.

24           CHAIRWOMAN OLSON: Yeah. Just make sure



1       you clarify.

2               MR. VINSON:   And I'm here on Docket H-08,  
3       Project 17-057.

4               CHAIRWOMAN OLSON:   That's fine.

5               MR. VINSON:   Am I appropriate?

6               CHAIRWOMAN OLSON:   Yes, you're  
7       appropriate.

8               MR. VINSON:   Thank you.

9               Thank you, ladies and gentlemen of the  
10       Board.   My name is Sam Vinson.   I represent VMBC,  
11       Valley Medical Building Corporation, the landlord  
12       of Valley Ambulatory Surgical Center in  
13       St. Charles.

14               I recognize your rules and I'm going to  
15       speak very quickly and --

16               CHAIRWOMAN OLSON:   We appreciate that.

17               MR. VINSON:   -- not repeat anything that  
18       I previously have provided the Board with in  
19       documents.

20               CHAIRWOMAN OLSON:   Thank you.

21               MR. VINSON:   The Planning Board has -- the  
22       Planning Act has two primary purposes in its  
23       "Purpose" section at the beginning.   It talks  
24       about the need to avoid duplicative facilities, to

1     avoid high costs, to try to hold down costs, and,  
2     secondly, it deals with the need to make health  
3     care available to the medically underserved and to  
4     the poor.

5             The report you have before you on this  
6     particular project does a very good job of dealing  
7     with the duplicative facility, the extra  
8     construction that is proposed, and the lack of  
9     need and the extra beds, the extra operating rooms  
10    that would be proposed in this procedure.

11            The State report inadequately deals with  
12    one aspect, and that is the fact that 5.4 of the  
13    Planning Act imposes on the Board and on every  
14    applicant that comes before you a duty to deal  
15    with a safety net impact statement, and that  
16    safety net impact statement is supposed to, among  
17    other things, fully analyze the project's impact  
18    on the ability of other applicants, of other  
19    facilities, to serve the poor, to provide safety  
20    net facilities.

21            There is not a single word in the  
22    application that deals with that issue. I go  
23    beyond that, and I point out that the State agency  
24    report, in fact, does not deal with that issue,

1 either.

2 If you turn to page 10 of the State agency  
3 report, you'll find one line which simply says  
4 that the applicant filed a safety net impact  
5 statement, and then it says, "Turn to the end of  
6 the report to see it."

7 MR. ROATE: Two minutes.

8 MR. VINSON: If you turn to the end of the  
9 report, you will find --

10 CHAIRWOMAN OLSON: I need you to conclude.

11 MR. VINSON: -- there's nothing there  
12 at all on that subject.

13 Now --

14 CHAIRWOMAN OLSON: Thank you.

15 MR. VINSON: -- the point of --

16 CHAIRWOMAN OLSON: Sir, your two minutes  
17 are up.

18 MR. VINSON: Excuse me?

19 CHAIRWOMAN OLSON: Your two minutes are  
20 up. I need you to stop.

21 Thank you.

22 MR. VINSON: I would just urge that the  
23 Board insist that the rules that apply be applied  
24 and that it not pass a project --

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1 CHAIRWOMAN OLSON: Thank you.

2 MR. VINSON: -- which does not respect the  
3 Board and the law.

4 Thank you.

5 CHAIRWOMAN OLSON: Thank you.

6 Finally, please.

7 MR. GRIFFIN: My name is Patrick Griffin,  
8 P-a-t-r-i-c-k G-r-i-f-f-i-n. I'm a  
9 preconstruction specialist in health care  
10 construction at Ryan Companies, here in support of  
11 Project 17-057.

12 Ryan Companies has executed over  
13 150 million in health care construction over the  
14 last three years, including multiple ambulatory  
15 surgical centers and health care renovation  
16 projects. Valley Ambulatory Surgery Center asked  
17 Ryan to review a cost estimate and construction  
18 phasing narrative prepared by DLA Architects on  
19 behalf of the building's landlord. Based on the  
20 magnitude and scope of the needed renovations,  
21 we determined that the work could not be  
22 completed using weekends and off-hour shifts, as  
23 DLA Architects had asserted.

24 CHAIRWOMAN OLSON: Can you move your mic a

1 little closer?

2 MR. GRIFFIN: We proceeded to price a  
3 phased schedule that would allow Valley Ambulatory  
4 Surgery Center to remain partially operational  
5 during the renovations. We prepared an estimate  
6 that included the original scope per  
7 DLA Architects, additional scope per the Valley  
8 Ambulatory Surgery Center, revised general  
9 conditions for the phased construction schedule,  
10 and the operational and revenue impact on the  
11 Valley Ambulatory Surgery Center.

12 DLA Architects estimated approximately  
13 \$3.7 million in costs to renovate the existing  
14 site with no operational cost impacts to the  
15 center or the recommended renovations to the  
16 connected Valley Medical Inn.

17 Including all necessary repairs, Ryan  
18 estimated construction costs exceeding \$6 million,  
19 \$3.7 million in new medical equipment, and  
20 approximately \$14 million in operational expenses  
21 and lost revenue during the 11-month renovation  
22 process. The total projected costs of renovating  
23 in place is about \$24 million, more than  
24 \$7 million higher than the cost of constructing a

1 new building.

2 I urge you to vote yes in support of this  
3 project. Thank you.

4 CHAIRWOMAN OLSON: Thank you.

5 That concludes the public participation  
6 hearing of the agenda.

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1 CHAIRWOMAN OLSON: I would like to go to  
2 the approval of the agenda, and I'm going to make  
3 one amendment -- two amendments.

4 And Courtney will tell you what they are.

5 MS. AVERY: Okay. We would make a  
6 motion -- may I have a motion to move Item C-01 to  
7 be heard after Item H-08.

8 VICE CHAIRMAN SEWELL: So moved.

9 CHAIRWOMAN OLSON: Second.

10 MS. AVERY: The second amendment to the  
11 agenda will be to remove MacNeal --

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

13 CHAIRWOMAN OLSON: So there's a motion on  
14 the floor to move Item C-01 to be heard after  
15 H-08. I have a motion and a second.

16 May I have a vote, please. All those in  
17 favor?

18 (Ayes heard.)

19 CHAIRWOMAN OLSON: Opposed?

20 (No response.)

21 CHAIRWOMAN OLSON: Motion passes.

22 MS. AVERY: Okay. The second change to  
23 the agenda will be to request to remove Item C-02,  
24 Exemption E-001-18, MacNeal Hospital.

1           So may I have a motion to remove  
2       Exemption E-001-18, MacNeal Hospital.

3           MEMBER MURPHY:   Motion.

4           VICE CHAIRMAN SEWELL:   Second.

5           CHAIRWOMAN OLSON:   All those in favor?

6           (Ayes heard.)

7           CHAIRWOMAN OLSON:   The motion is approved  
8       as amended for those two items.

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1 CHAIRWOMAN OLSON: Next, we have items  
2 approved by the Chairwoman.

3 Mr. Constantino.

4 MR. CONSTANTINO: Thank you, Madam  
5 Chairwoman.

6 The Board Chair has approved the following  
7 items: Permit Renewal 14-017, Skokie Hospital,  
8 six-month renewal; Permit Renewal No. 17-047,  
9 Vascular Access Centers of Illinois, six-month  
10 renewal; Permit Renewal No. 15-048, DaVita Park  
11 Manor Dialysis, six-month renewal; Permit  
12 Renewal 15-049, DaVita Huntley Dialysis, six-month  
13 renewal; Permit Renewal 15-021, OSF St. Anthony  
14 Medical Center in Rockford, six-month permit  
15 renewal; Exemption No. E-052-17, AMITA Alexian  
16 Brothers Medical Center, discontinuation of  
17 pediatric category of service; Exemption  
18 No. E-018-16, Justice Medical Center, doing  
19 business as Forest Medical Surgical Center,  
20 relinquishment of exemption; Exemption  
21 No. E-080-17, Eye Surgery Center of Hinsdale,  
22 change of ownership; Exemption No. E-081-17, Alton  
23 Memorial Hospital, distinction of 28-bed long-term  
24 care service; Exemption No. E-053-17 through

1 E-064-17, Presence Health Network and Ascension  
2 Health, change of ownership; Exemption  
3 No. E-065-17 through E-079-17, Advocate Health  
4 Network and Aurora Health Care, Inc., change of  
5 ownership.

6 Thank you, Madam Chair.

7 CHAIRWOMAN OLSON: Thank you, Mike.

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1 CHAIRWOMAN OLSON: Next, we have permit  
2 renewal requests and there are none.

3 Extension requests, there are none.

4 The exemption request will be moved on the  
5 agenda as noted.

6 There are no alteration requests, no  
7 declaratory rulings or other business.

8 Nothing for Health Care Worker  
9 Self-Referral Act, and no status reports on  
10 conditional/contingent permits.

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1 CHAIRWOMAN OLSON: The next order of  
2 business is applications subsequent to initial  
3 review.

4 I would call to the table Project 17-012,  
5 Meadowbrook Manor of Geneva.

6 May I have a motion to approve  
7 Project 17-012, Meadowbrook Manor of Geneva, to  
8 establish a 150-bed long-term care facility.

9 A motion, please.

10 VICE CHAIRMAN SEWELL: So moved.

11 CHAIRWOMAN OLSON: And a second.

12 MEMBER MURPHY: Second.

13 CHAIRWOMAN OLSON: The Applicant will sign  
14 in and be sworn in.

15 Do you want to swear them in?

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

17 THE COURT REPORTER: Would you raise your  
18 right hands, please.

19 (Seven witnesses sworn.)

20 THE COURT REPORTER: Thank you.

21 CHAIRWOMAN OLSON: Mr. Constantino, your  
22 report.

23 MR. CONSTANTINO: Thank you, Madam Chair.

24 The Applicants are proposing to establish

1 a 150-bed skilled nursing facility in Geneva,  
2 Illinois. The cost of the project is  
3 approximately \$30 million. The expected  
4 completion date is March 31st, 2021.

5 There was a public hearing on this  
6 project; it was included in your packet of  
7 information. There was opposition and there were  
8 findings on this report.

9 Thank you, Madam Chair.

10 CHAIRWOMAN OLSON: Thank you,  
11 Mr. Constantino.

12 Applicants, when you speak, would you  
13 introduce yourselves -- when you're speaking,  
14 please introduce yourself for the court reporter.

15 MR. FOLEY: Yes, ma'am.

16 Needless to say, I'm very nervous. My  
17 name is Charles Foley, F-o-l-e-y.

18 CHAIRWOMAN OLSON: It is not your first  
19 rodeo, Mr. Foley.

20 MR. FOLEY: Well, it's been 8 to 10 years  
21 since I gave a presentation before the Board, but  
22 I have sat before this Board at the table.

23 CHAIRWOMAN OLSON: You'll be fine.

24 MR. FOLEY: But this project, obviously,

1 is very important to me.

2 First of all, I'd like to -- I think I'd  
3 like to congratulate our two new Board members,  
4 Mrs. Hemme and Mr. McNeil. I hope you find this  
5 endeavor that you're undertaking here very  
6 rewarding, as I have over the years.

7 I'd like to take this opportunity, if I  
8 can, to basically thank Mike and George both for  
9 the opportunity of meeting with us a few months  
10 back and for the review of this application.

11 As you are aware, this project was  
12 originally approved by the Board, but since the  
13 time line had lapsed, the permit expired in  
14 July of 2016, and with that we had turned around  
15 and filed this new application that's before you  
16 today.

17 A public hearing that was conducted was  
18 overwhelmingly positive with 18 people supporting  
19 the project, alluding at some point that this  
20 project is, in fact, needed. In addition, in the  
21 application you will find several letters of  
22 support supporting this project, as well. There  
23 were only three oppositions at that public  
24 hearing.

1           For the benefit of the new Board members,  
2       I'm sure you're aware that the public hearing that  
3       was held plus the public comment period that you  
4       heard this morning are two different processes, so  
5       it does give everybody the opportunity to come  
6       forward and to speak and to give their --  
7       obviously -- their point of view.

8           I'd like to take this opportunity, if  
9       I may, to introduce the Applicant. This is a  
10      family-owned business, as you heard before. It's  
11      not only a family-run business but it's also a  
12      community project, as well.

13          To my immediate left I have Mr. Chris  
14      Vangel, and to his left is his father, Mr. Nick  
15      Vangel, and to Nick's left is their partner,  
16      Mr. Robert Jafari.

17          In order to give you a summary of the new  
18      project as well as an explanation of what happened  
19      in the old project, which I think you deserve to  
20      hear about a little bit, I'd like to introduce, if  
21      I may, Mr. Nick Vangel.

22          MR. NICK VANGEL: Thank you very much,  
23      Charles.

24          I might correct Charles. I am not Chris

1 Vangel. I am Chris' dad. Thank you very much.

2 MR. FOLEY: I did that on purpose.

3 MR. NICK VANGEL: I know you did.

4 My name is Nick Vangel, N-i-c-k  
5 V-a-n-g-e-l.

6 This project is for the establishment of a  
7 150-bed skilled nursing facility in Geneva,  
8 Illinois. Meadowbrook -- pardon me. There will  
9 be 26 private rooms, 62 semiprivate rooms. The  
10 facility will be certified for both Medicaid and  
11 Medicare. Meadowbrook has a track record of  
12 caring for Medicaid beneficiaries. Our four  
13 existing facilities currently have a resident  
14 census that is 71 percent Medicaid.

15 The proposed location of our Geneva  
16 facility will be part of the health care hub, so  
17 to speak, which includes Northwestern Delnor-  
18 Community Hospital, Tri-Cities Surgical Center,  
19 medical office buildings, as well as the Crossings  
20 at Geneva, which is an independent living  
21 facility.

22 Our property where this project would be  
23 constructed literally shares a property line with  
24 Northwestern Delnor-Community Hospital. The



1 project has significant community support,  
2 including the Geneva Chamber of Commerce. It will  
3 bring 150 new jobs to the community.

4 The history of our project: As you are  
5 aware, we had a CON for this project and have  
6 already invested in excess of 3 million; however,  
7 we had some issues with the local government  
8 approvals. The City's zoning department wanted  
9 the entrance to our project to be located off of  
10 the hospital access road, which required us to  
11 negotiate an easement with the hospital. This  
12 proved to be very difficult due to the fact that  
13 there were three different ownership structures  
14 that the hospital has had over the last -- or past  
15 eight years.

16 I know we have rehashed this many times in  
17 the past, so I will not do it again now, but,  
18 should you have any additional questions on this,  
19 we have brought with us our construction manager  
20 Mr. John Maze.

21 MR. FOLEY: We would now like to turn our  
22 attention, if we can, to the findings of the staff  
23 report.

24 Planning area need. The Board's

1 calculation does, in fact, show, as you had heard,  
2 an excess of 108 beds in the State's current  
3 inventory, the latest one being January 2018. The  
4 opposition have pointed out that this project is  
5 not needed because there has been new project  
6 development in Kane County; however, one such  
7 development that they are referring to is the  
8 Park Point South Elgin project. That permit was  
9 approved back in December of 2010 for 120 skilled  
10 nursing beds. According to their latest annual  
11 progress report, which was received by the State  
12 on January 17th of 2017, it was stated that  
13 construction has not yet started.

14 As this Board is aware, an annual progress  
15 report is required to be filed 30 days before or  
16 30 days after the anniversary date of the issuance  
17 of the permit, which was received by that facility  
18 back in December of 2010.

19 Please note, also, that their last report  
20 that was filed just over 13 months ago with no  
21 report being filed for the current year and their  
22 permit does, in fact, expire this May; as a matter  
23 of fact, it's May 31st of 2018.

24 We did, in fact, submit pictures to the

1 State back in October of 2017 that show that no  
2 development whatsoever had commenced on this  
3 property site. If Park Point Elgin beds should be  
4 placed back into the inventory, there will be  
5 additional need for beds in the Kane County  
6 planning area.

7 Please note that our project's first  
8 full year of target utilization is not until 2022.  
9 The need for beds went from an excess of 359 beds  
10 back in 2015 down to an excess of only 108 beds  
11 with the current inventory. Kane County  
12 population is projected to show consistent  
13 6 percent growth from 2015 through 2025.

14 The real issue is that the 65-plus age  
15 cohort is projected to grow an average -- an  
16 average -- of 25 percent for each five-year period  
17 from 2015 all the way through 2025 according to  
18 the State's demographic study. This represents a  
19 continued and unprecedented growth rate.

20 As an average, Illinois has one nursing  
21 home bed for every 129.7 people. Kane County  
22 itself has only one nursing bed for only  
23 198.3 persons. This project will only bring that  
24 number to one bed for every 185.8 persons, a rate

1 nowhere near the state as a whole.

2 Meadowbrook did turn around and commission  
3 Laurel Research Associates to conduct a marketing  
4 study for a skilled nursing facility in Geneva.  
5 The study showed a projected need for additional  
6 beds by 2021. This accurately projects that the  
7 project is, in fact, in line with the State  
8 Board's 2020 bed need; therefore, the methodology  
9 employed by Laurel Research appears to be in  
10 line with the State's methodology and shows that  
11 the excess of beds dissipates by 2020 and an  
12 outstanding need for additional beds will be  
13 needed in 2021.

14 Based on the State's demographics, the  
15 need will continue to grow through 2025, as I  
16 indicated. Presuming that the South Elgin beds  
17 are returned from the inventory, there will be  
18 a need ranging from -- anywhere from 221 to  
19 284 additional beds in 2021.

20 Long-term care providers are in a very  
21 precarious position in that their low utilization  
22 rates are not due to the lack of available  
23 residents but primarily because several providers  
24 in the state choose not to upgrade facilities to

1 be more attractive to the consumers. In reviewing  
2 the facility data taken from the State's latest  
3 Medicare cost reports, it was noted that an  
4 average age of the facility within a 20-minute  
5 drive time of this project is over 32 years old,  
6 and they have approximately 328 gross square feet  
7 per bed, which is well, well under the State's  
8 standard range, which ranges up to 713 gross  
9 square feet per bed. This, within itself, is not  
10 acceptable to the public.

11 I put down a pause here because I'm saying  
12 today's baby boomers, of which I am one of them --  
13 and I think I'm the only one here speaking that is  
14 at that age group -- would prefer larger  
15 facilities with extra amenities that are most --  
16 that we, as baby boomers, are most accustomed to  
17 and that most facilities cannot provide because of  
18 space limitations within the facility.

19 Occupancy rates. Occupancy rates are  
20 affected by the fact that several facilities share  
21 bathrooms and showers with very little, if any,  
22 private room accommodations. As I'm sure that  
23 most of you have heard in the previous  
24 presentations today, there is also the issue of

1 ghost beds, which are existing licensed beds but  
2 are utilized for other purposes, such as the  
3 conversion of multiprivate rooms -- multirooms to  
4 private rooms or even to luxury suites. They're  
5 converting rooms to meeting rooms, to physical  
6 therapy rooms, to offices, but they are not giving  
7 up those licensed beds, and this kind of more or  
8 less skews the occupancy rate.

9 When you hear occupancy rates are low at  
10 70 percent, 80 percent, it's not because the  
11 bodies are not there. It's not because -- the  
12 beds are there but they're not being -- they're  
13 not being properly utilized, and this is -- this,  
14 obviously, affects our utilization rate.

15 This facility would be licensed for  
16 skilled care and will be dually certified for both  
17 Medicare and Medicaid. There are facilities in  
18 the area that are not licensed for skilled care  
19 but, rather, intermediate care, making these beds  
20 not available or accessible to our planning area  
21 residents.

22 Under the Department of Public Health  
23 regulations, a skilled facility cannot --  
24 cannot admit an intermediate care patient -- I'll

1 rephrase that if I may. A skilled facility can  
2 admit an intermediate care resident, but a bed  
3 licensed for intermediate care cannot accommodate  
4 a skilled patient.

5 So for benefit of the new Board members,  
6 we have what is called skilled level of care, we  
7 have what is called intermediate level of care,  
8 and those combine -- according to the Board's  
9 inventory, they call those nursing beds.

10 To give you an example, there's a facility  
11 called North Aurora Care Center, which is licensed  
12 for 129 beds. These beds are all licensed for  
13 intermediate care beds, meaning that a skilled  
14 patient cannot be admitted to these beds. The  
15 population in this facility is primarily mentally  
16 ill. They have currently like 111 patients out of  
17 112 residents that are mentally ill.

18 Another facility, called the West Chicago  
19 Terrace Nursing Home, is licensed for  
20 120 intermediate care beds, thereby making these  
21 beds not available to our -- or accessible to our  
22 planning area skilled population or the Medicare  
23 population. And they are also accommodating the  
24 mentally ill population, and you can see this on

1 page 105 of the application.

2 With these two facilities there are  
3 249 beds that are not available to the general  
4 geriatric skilled Medicaid and Medicare  
5 population.

6 Now, we're going to talk about service  
7 demand, and I'll turn this over to Mr. Chris  
8 Vangel.

9 MR. CHRIS VANGEL: Good afternoon. Chris  
10 Vangel, C-h-r-i-s V-a-n-g-e-l.

11 We received letters from physicians  
12 projecting to admit at least 40 patients per month  
13 during the first 24-month -- the 24 months after  
14 the project completes. Our referrals came from  
15 five area physicians that practice from within  
16 20 miles of Northwestern's Delnor Hospital, right  
17 in our market area, making 480 to 528 annual  
18 referrals.

19 We also received seven additional referral  
20 letters from area physicians supporting the  
21 project that were not included within the  
22 40 monthly patient referrals because the  
23 physicians could not identify the specific  
24 zip code in which the patient would come from.



1       Regardless, we believe that there is overwhelming  
2       support for this project from clinicians.

3               One point of care that we found lacking in  
4       this area is dialysis. As you heard this morning  
5       from public comments, if approved, our facility  
6       would be the only in-house dialysis nursing  
7       facility to offer bedside dialysis treatments in  
8       our planning area.

9               Presently in the area nursing home  
10       residents must leave the facility for  
11       several hours to have dialysis. Transferring out  
12       for treatment can interfere with daily therapies,  
13       clinical programs, and patients' overall quality  
14       of life.

15               Two of our current facilities provide the  
16       same dialysis treatments and have been successful.  
17       Two -- both of them are full -- at full occupancy  
18       for our dialysis program.

19               MR. FOLEY: If I may address the --  
20       another criterion called service accessibility.  
21       And, again, as you heard, there's many reasons why  
22       the existing facilities have accessibility  
23       limitations.

24               Some of those are, as I had said

1 previously, 40 percent of our existing residents  
2 are classified as mentally ill, nearly 300 beds in  
3 a 20-mile radius, 772 MI residents or beds in  
4 30 minutes. There's -- 388 beds within 20 minutes  
5 are classified as intermediary. These beds are  
6 typically in smaller facilities caring for a less  
7 acuity resident, and these beds, as I said  
8 previously, cannot be Medicare certified or -- nor  
9 can they be used for skilled care.

10 Then there's the criterion that's called  
11 unnecessary duplication of services. There  
12 appears to be a wide disparity between the State's  
13 data of empty beds in the planning area and what  
14 is actually available. The State's data is taken  
15 directly from the facility's annual profiles,  
16 which is the actual number of licensed beds versus  
17 their reported patient days, whereby the actual  
18 occupancy rates are kind of skewed by many  
19 different factors, alluding that beds might, in  
20 fact, be available.

21 However, at the heart of this criterion is  
22 the ratio of beds to population. We previously  
23 discussed this ratio in terms of beds to total  
24 population, but it may be more meaningful looking

1 at the beds compared to the over-age 65 -- the  
2 65-age cohort. In this market area there are  
3 25.4 people over 65 for every nursing bed, whereas  
4 the State has one bed for over 20 people. The  
5 service area has 21.3 percent less beds per  
6 population.

7 Chris, if you would continue.

8 MR. CHRIS VANGEL: In preparation for the  
9 CON with Mr. Foley, we kept running up against the  
10 issue of no available empty beds where the State's  
11 inventory kept saying there should be.

12 To attempt to get a measure of real data,  
13 we conducted an unbiased telephone survey on three  
14 different dates. The results were very  
15 intriguing. The results are contained on page 139  
16 of the application. There were only 9 out of the  
17 31 facilities that indicated that they would  
18 accept a Medicaid patient. Of those nine, only  
19 one indicated that they actually had an available  
20 Medicaid bed.

21 We also found in this area there's a high  
22 concentration of CCRC providers. These facilities  
23 offer preferred admissions to those residents  
24 within the campus. This is indicative of an

1 access issue to those facilities that provide a  
2 continuum of care environment; that is, either  
3 restricting admissions to those residents already  
4 residing in the campus or giving priority to --  
5 admissions to campus residents before those  
6 outside of the campus.

7 There are five facilities that fall under  
8 this category with a total of 433 beds that may  
9 not be fully available or accessible to planning  
10 area Medicaid residents.

11 MR. NICK VANGEL: Thank you, Chris.

12 If I may, I would like to speak in --  
13 regarding the availability of funds. Finally, I'd  
14 like to address you for the negative finding, the  
15 availability of funds.

16 As you have heard, we operate facilities  
17 in Bolingbrook, La Grange, Naperville, and  
18 Des Plaines. We have successfully obtained  
19 financing for all these projects. In fact, we  
20 just finished a \$30 million renovation and partial  
21 replacement building for Meadowbrook of La Grange.  
22 This project is awaiting final IDPH inspection  
23 and, God willing, should be fully licensed and  
24 operational in a few weeks.

1           And in conclusion, we urge you to approve  
2     our project again. We ask that you look at our  
3     history. We are a very small, family-owned-and-  
4     operated business that has been operating four  
5     nursing homes for 40 years.

6           My son is the third generation, I am the  
7     second, and my father-in-law was the first. I can  
8     also share with you that my partner, Robert  
9     Jafari, and his father, who's a surgeon, is very  
10    actively involved. Unfortunately, he couldn't be  
11    here today, but he is our medical director that  
12    oversees our medical directors as a whole.

13          Through the ups and downs of this industry  
14    that we have seen, we have continued to be  
15    successful with a high utilization at our existing  
16    facilities, which you have just heard includes a  
17    substantial percentage of Medicaid residents, as  
18    I stated earlier, of 71 percent.

19          We have stayed the course of providing  
20    traditional nursing care services over the years  
21    with a heavy emphasis on all types of  
22    rehabilitation, dialysis, and long-term care  
23    before it was in fashion to do so.

24          We again urge you to approve our project

1 and would be most happy to answer any questions  
2 that you may have.

3 Thank you so much.

4 CHAIRWOMAN OLSON: Thank you.

5 Questions from Board members?

6 Mr. Sewell.

7 VICE CHAIRMAN SEWELL: Yes. I wanted to  
8 get a little more of your interpretation of the  
9 State agency findings on availability of funds.

10 It sounds like no one is under any  
11 obligation or -- or at least you're not ready yet  
12 to qualify for financing. That's my  
13 interpretation of this, so straighten me out on  
14 that.

15 MR. NICK VANGEL: I'd like to refer to my  
16 partner, Robert Jafari, who has been -- his focus  
17 has been on financing.

18 And we just completed -- we are  
19 completed -- of a \$30 million project that we  
20 had HUD -- had gotten HUD financing. We are in  
21 contact and have made a number of interviews  
22 and -- with a company called Greystone. Robert  
23 can elaborate on that. They are very much  
24 interested in our project.

1 Robert.

2 MR. JAFARI: Robert Jafari, J-a-f-a-r-i.

3 We submitted to the State a letter from  
4 Greystone providing that they would give financing  
5 under conditional terms. Since that letter we've  
6 received a new letter from Greystone that we have  
7 with us today that provides the financing as a  
8 firm commitment.

9 Chris and I have also flown out to  
10 New York City. We met with the owner of  
11 Greystone, Steve Rosenberg, who -- in addition to  
12 providing HUD financing, he has a billion-dollar  
13 side fund that he offers financing in the event  
14 that HUD does not give financing. And Steve said  
15 that he would provide that money if there was any  
16 issue, but we have no issues.

17 All four of the buildings that we have  
18 right now we built ourselves. All four of the  
19 buildings that we built we got HUD financing.  
20 This Geneva project, we did have HUD financing  
21 before the permit was not renewed. There's  
22 absolutely no issue with financing.

23 VICE CHAIRMAN SEWELL: I wanted to ask,  
24 then, Mr. Constantino, if you've seen the more

1 recent Greystone letter.

2 MR. CONSTANTINO: No.

3 VICE CHAIRMAN SEWELL: Okay. The other  
4 thing I wanted to ask you about is this financial  
5 ratio that you don't meet, which is the percent of  
6 debt to total capitalization.

7 Answer, from your perspective, the "So  
8 what?" question about that.

9 MR. FOLEY: Robert, you're the financial  
10 guy.

11 We have to refer to Mr. Kniery.

12 MR. KNIERY: Sorry.

13 I was sworn in with the group. John  
14 Kniery, K-n-i-e-r-y.

15 The ratio that you see that you were  
16 asking about that's coming in at -- what? --  
17 58 percent, 60 percent debt to equity?

18 VICE CHAIRMAN SEWELL: 60.88 percent.

19 MR. KNIERY: Traditionally long-term care  
20 projects have come in at 80 percent or less, is  
21 what the industry has looked at.

22 So just as a -- I understand that for --  
23 in the rules not-for-profits can -- are shown up  
24 against the 80 percent debt-to-equity ratio.



1 Not -- for-profits come in at 50 percent according  
2 to your rules.

3 So respecting the rules, what I'm trying  
4 to explain is, industrywide, lending -- lenders  
5 look at an 80 percent debt-to-equity, and we are  
6 well beneath that.

7 VICE CHAIRMAN SEWELL: But our standard is  
8 less than 50 percent.

9 MR. CONSTANTINO: That's correct, for this  
10 for-profit.

11 VICE CHAIRMAN SEWELL: It relates to  
12 for-profit.

13 MR. CONSTANTINO: That's right.  
14 80 percent is not-for-profit.

15 VICE CHAIRMAN SEWELL: Okay.

16 MR. KNIERY: And just one additional  
17 point: This Applicant did receive financing on  
18 the first project, full HUD financing, not just  
19 the originator but full HUD financing. I really  
20 don't think Nick and Chris and Robert, that -- you  
21 know, that they have -- they have not felt any  
22 issue with -- that this particular issue is going  
23 to be a problem moving forward.

24 CHAIRWOMAN OLSON: Other questions?

1 MEMBER MC GLASSON: Yes.

2 CHAIRWOMAN OLSON: Marianne and then  
3 Mr. McGlasson.

4 MEMBER MURPHY: Thank you.

5 I have a question about this zip code  
6 information under the service demand finding.

7 According to the State Board staff report,  
8 it sounds like there were no zip codes provided.  
9 Is that correct?

10 MR. CONSTANTINO: That's correct.

11 MEMBER MURPHY: But then your testimony  
12 today makes it sound like there were some  
13 zip codes provided. Could you elaborate?

14 MR. KNIERY: Yes.

15 Initially the letters that were submitted  
16 with the application as it was filed, the -- there  
17 were no zip codes. We provided subsequent letters  
18 that -- the doctors asked the referral sources to  
19 go back and provide us a little bit better  
20 information, and what they were able to provide us  
21 was a percentage of their patients that are  
22 within -- I don't have it in front of me -- within  
23 the market area.

24 So they were able to qualify the number of

1 patients that were -- are within the Delnor-  
2 Community Hospital service area, within --  
3 I believe it was 20 minutes.

4 And they were able to say that 90 --  
5 I believe one was 80 but most of them were  
6 90-plus percent of their patients are coming from  
7 within the zip code area of the Delnor community,  
8 which is -- you know, we're on that site, market  
9 area.

10 MEMBER MURPHY: But they didn't provide  
11 the zip codes? They just said they're there?

12 MR. KNIERY: Correct.

13 MEMBER MURPHY: Okay. Thank you.

14 MR. KNIERY: They provided zip codes and  
15 said that, you know, "These are the zip codes that  
16 90 percent of our patients come from."

17 MEMBER MURPHY: Thank you.

18 MR. KNIERY: Yes.

19 CHAIRWOMAN OLSON: Mr. McGlasson.

20 MEMBER MC GLASSON: Yeah. I have  
21 two questions and -- excuse me.

22 I have two questions and then, I think,  
23 one for staff and counsel.

24 Isn't the ratio of semiprivate rooms to

1 private rooms a little bit higher than what we've  
2 been presented with recently?

3 MR. KNIERY: I'll keep going.

4 MR. FOLEY: He's doing good.

5 MR. KNIERY: Yes, it is. The State -- the  
6 minimum standards put forth by IDPH only require  
7 3 percent of the beds to meet -- to be private.  
8 And private bath. This does far exceed that.

9 MEMBER MC GLASSON: Do you have a  
10 timetable in mind for how this is going to  
11 progress?

12 MR. NICK VANGEL: I'm not sure  
13 I understand the question. But if I could go back  
14 to --

15 MEMBER MC GLASSON: I mean financing,  
16 breaking ground --

17 MR. NICK VANGEL: I would think it would  
18 take -- for the application to -- for HUD and  
19 breaking ground, it would take a year.

20 MEMBER MC GLASSON: Well, I have great  
21 sympathy for your competition in that this has  
22 been held in abeyance for so long. If I were, you  
23 know, a competing home, I would be loathe to do  
24 improvements and plans with this hanging in

1 abeyance.

2 My question for staff and counsel is, do  
3 we have the ability to put a timetable along with  
4 our approval?

5 MS. MITCHELL: A timetable for project  
6 completion?

7 MEMBER MC GLASSON: Uh-huh.

8 MS. MITCHELL: You can put a condition,  
9 but they have a completion date already that  
10 they're providing.

11 MEMBER MC GLASSON: I understand. But  
12 we're giving them in excess of three years further  
13 abeyance if we don't have some assurance --

14 MS. MITCHELL: There could be a condition  
15 placed on the application should it not be  
16 completed within a certain amount of time that  
17 maybe --

18 THE COURT REPORTER: I'm sorry.

19 MS. MITCHELL: I said, "perhaps they come  
20 back before the Board."

21 THE COURT REPORTER: Thank you.

22 MR. KNIERY: There are -- if I can add a  
23 little bit of response to that -- I know it's for  
24 staff.

1           There are a couple things in place already  
2   in terms of the obligation. It has to commence  
3   within 18 months. But I think that I speak for  
4   Nick. I think a condition to break ground would  
5   be amenable to the Applicant.

6           MR. NICK VANGEL: Absolutely.

7           Absolutely. We are -- certainly understand  
8   the delay that has occurred, and we are very  
9   much -- would agree with any -- with any  
10   requirements that you wish for -- within reason --  
11   to break ground in a reasonable amount of time.

12           We do have, once again, our construction  
13   manager, John Maze, here, who could answer that  
14   for you.

15           And I'd like to go back to one question  
16   you asked. You know, we're becoming more  
17   sophisticated, and I think all of us that are in  
18   the baby boomer age are -- as -- thank you for  
19   including me -- I think I'm a little older but --  
20   the private rooms are not necessarily going to be  
21   earmarked for private residents or Medicare or --  
22   it's -- the availability will be open, as well, to  
23   the Medicaid population.

24           But we need the mix because the success of

1 all the facilities nowadays are a blend of  
2 insurance, private, Medicare, and Medicaid. So  
3 many of the facilities that we are experiencing --  
4 with our facility, say, in Des Plaines -- is we're  
5 finding that, when the availability for the  
6 admission is to be under Medicare or private  
7 insurance, et cetera, they're -- they pick some  
8 other facilities that are more accepting of that.

9 But these other facilities are not all  
10 licensed, as Charles made reference to, and they  
11 have a limited amount of beds that are Medicaid.  
12 Once they exhaust their eligibility for Medicare  
13 or exhaust their funds for private, they discharge  
14 them. Then they -- we cannot discharge because  
15 all our beds are Medicare and Medicaid licensed,  
16 but they can do so because they limit the number  
17 of Medicaid beds they have so they're asked to  
18 leave.

19 It's a sad situation but many families are  
20 finding themselves facing "In two weeks you must  
21 be discharged because you've run out of money and  
22 we don't have the availability of the Medicaid,"  
23 and we take them. We have taken them.

24 CHAIRWOMAN OLSON: Mr. Burzynski and

1 then --

2 MEMBER BURZYNSKI: Thank you.

3 These are just questions for points of  
4 clarification.

5 First of all, for those of you at the  
6 table, so then you have cleared up your access to  
7 the property situation with the City of Geneva and  
8 Delnor or Northwestern?

9 MR. NICK VANGEL: We have. We have.

10 MEMBER BURZYNSKI: Okay.

11 MR. NICK VANGEL: But we have now an  
12 immediate -- it's hard to describe but -- behind  
13 the facility, which would be facing the hospital  
14 itself -- prior to that, they were requiring us to  
15 leave -- go out to Keslinger, exit that way, which  
16 really was an endangerment to many of the family  
17 members that would be visiting our facility, as  
18 well as the ambulances, et cetera, and then have  
19 to enter the main entrance, as far as the drive,  
20 and come in to the hospital.

21 Now we have access. You could literally  
22 walk also -- you know, not that that's what we  
23 would do, but you could literally do that.

24 MEMBER BURZYNSKI: Okay. Thank you.



1           Mike, I'm just curious. If they have a  
2 new letter from Greystone indicating that they  
3 have the financing, you have not seen that yet?

4           MR. CONSTANTINO: No, not yet.

5           MEMBER BURZYNSKI: Okay. Do you have that  
6 with you today?

7           MR. KNIERY: Yes.

8           MEMBER BURZYNSKI: It would seem to me  
9 that would be very important if I were the  
10 Applicant.

11          MR. KNIERY: Well, we do have it. We were  
12 hesitant about bringing it up because of the rule  
13 that Mike hasn't reviewed it, State staff hasn't  
14 reviewed it. We can definitely have as -- we did  
15 that before on another project -- a condition of  
16 the permit to get that to Mike.

17          MEMBER BURZYNSKI: And then, also, the zip  
18 code information which you, obviously, haven't had  
19 access to either.

20          MR. CONSTANTINO: No. What we usually see  
21 is individual zip codes -- number of patient by  
22 individual zip code.

23          CHAIRWOMAN OLSON: Other questions?

24          VICE CHAIRMAN SEWELL: This is for Mike,

1 also.

2 So the fact that you said the criteria on  
3 planning area need was not met means that you  
4 don't -- we don't project completion and then  
5 project either use rates or broke and elderly  
6 population to see what the bed need would be after  
7 the project was completed?

8 MR. CONSTANTINO: We use --

9 VICE CHAIRMAN SEWELL: We do it for right  
10 now?

11 MR. CONSTANTINO: That's correct, yes.  
12 We're using a calculated need or excess published  
13 in 2017 for five years, from 2015 to 2020, using  
14 the historical utilization of 2015. And we use  
15 the State demographer to estimate the population  
16 for those five years.

17 VICE CHAIRMAN SEWELL: And --

18 MR. CONSTANTINO: When this project was  
19 originally approved, we were using a 10-year  
20 forecast and not a 5-year. We got that changed to  
21 a five-year forecast.

22 VICE CHAIRMAN SEWELL: So this Applicant  
23 has stated that they would meet the bed need by  
24 2022; they would be in compliance.

Transcript of Full Meeting  
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1 MR. CONSTANTINO: Yeah. What --

2 VICE CHAIRMAN SEWELL: Now, even though we  
3 don't -- that's not our practice to do it that  
4 way, do we verify their projections?

5 MR. CONSTANTINO: No. We relied upon what  
6 we had done and what we're required by rule to do.

7 And what we're saying to the Board is  
8 we're estimating -- the State Board is estimating  
9 there will be 108 beds in excess. If -- by 2020.  
10 We did not verify the numbers that they gave us.

11 VICE CHAIRMAN SEWELL: These 120 beds that  
12 they mentioned that are not yet under construction  
13 by one of the competitors, even if they were, that  
14 would just be a need for -- for 12 beds; right?

15 MR. CONSTANTINO: That's correct.

16 VICE CHAIRMAN SEWELL: Okay. Not 150?

17 MR. CONSTANTINO: Not 150, that's correct.

18 VICE CHAIRMAN SEWELL: All right.

19 MR. CONSTANTINO: I would like to make one  
20 other point.

21 Courtney and Jeannie and Nelson at the  
22 time -- we did try to do some work with active --  
23 looking for active long-term care beds. The  
24 Long-Term Care Subcommittee tried to put together

1 a process where we could determine that, and we  
2 couldn't get it done. It's still in the statute;  
3 it still sits there. We're required to get it  
4 done, but we couldn't get any cooperation from the  
5 associations, how they wanted that done.

6 CHAIRWOMAN OLSON: Which sort of brings up  
7 my point. And I know I probably have said this  
8 way too many times.

9 I believe the nursing home industry has  
10 created their own dilemma here. I mean, if you've  
11 got -- we're talking about ghost beds, we're  
12 talking about intermediate beds that are being  
13 used as MI beds instead of skilled beds, licensed  
14 in different ways.

15 I mean, I guess, in my mind, the onus is  
16 on the industry to clean this up so that we can  
17 move on projects that -- because it seems to me  
18 that what you're saying makes sense, that there  
19 really is a bed need there. But we're tied to  
20 our criteria and, according to our criteria,  
21 there's not.

22 And I do think -- when you talk about the  
23 facility that hasn't started to break ground yet,  
24 I think it's important to note that, because of

1 your dilemma -- which I understand was out of your  
2 control -- you had beds tied up for a number  
3 of years, as well, so -- I mean it's hard to --

4 MR. KNIERY: And to your suggestion, you  
5 know, we had to go back and -- and I think it was  
6 a good exercise -- and reapply, readdress all the  
7 criteria.

8 I think it's very important to note  
9 your -- to add to your point, the four facilities  
10 that this Applicant owns have been traditionally  
11 and remain highly utilized. They're on the larger  
12 side of facilities, and that allows them to  
13 provide that patient mix that Mr. Vangel was  
14 talking about. But that's unheard of in this  
15 state, to have larger facilities that are able to  
16 remain very positively utilized.

17 CHAIRWOMAN OLSON: So what you're saying  
18 is that every one of your beds will be dually  
19 Medicare and Medicaid certified so that, if I'm  
20 in that --

21 MR. NICK VANGEL: Yes, that is correct.

22 CHAIRWOMAN OLSON: -- Medicare bed and my  
23 Medicare is no longer -- I can no longer use my  
24 Medicare, I have to go to Medicaid, you're not

1 going to throw me in the street and tell me to  
2 find someplace else?

3 MR. NICK VANGEL: I can't think of the  
4 right word, but they would be -- I would be  
5 Medicaid or Medicare. They're licensed both ways,  
6 dual licensure. So the availability of those beds  
7 for Medicaid or Medicare, insurance, whatever,  
8 they would certainly be available to that.

9 CHAIRWOMAN OLSON: Okay.

10 MR. NICK VANGEL: We have done that; we'll  
11 continue to do that. And if we took a survey  
12 today, you would find that we have a number of  
13 beds that are occupied that -- even that are  
14 private -- that are occupied by residents that are  
15 Medicaid or dialysis Medicaid.

16 CHAIRWOMAN OLSON: And that's unusual in  
17 the industry?

18 MR. NICK VANGEL: Pardon me?

19 CHAIRWOMAN OLSON: That's unusual in the  
20 industry --

21 MR. CHRIS VANGEL: Yes.

22 CHAIRWOMAN OLSON: -- that high of a  
23 percentage of beds that are both Medicare and  
24 Medicaid?

1 MR. NICK VANGEL: It's -- I think it's  
2 unusual, yes in the industry.

3 You know, I have a -- I don't know if it's  
4 applicable here but -- a number in my head that we  
5 have 43 million people or 50 million people that  
6 are over the age of 65.

7 In the year 2040, which it seems like a  
8 long way away but -- we're going to have  
9 80-some million, 84 million. So those numbers --  
10 every year will change, I believe. We can take  
11 surveys and look at what's going to happen in  
12 five years, but you can't get away from the fact  
13 that we have an aging population, as you see --  
14 witness all the assisted living. There are niche  
15 facilities for memory care, short-term memory  
16 care, MI. I mean, they're just becoming more and  
17 more specialized.

18 And the growth in that industry in  
19 long-term care is far behind some of the other  
20 increases that you've seen in structures like the  
21 assisted living. I think anyone that's on the  
22 Board or as well as is here this evening -- or  
23 this afternoon -- is a witness to all the new  
24 buildings that are going up that are accommodating

1 memory care, and they don't take -- they're all  
2 private. 90 percent of them are private.

3 CHAIRWOMAN OLSON: And while that niche  
4 market is a good thing, I think -- from a patient  
5 perspective -- it makes our job more difficult  
6 because now you're not comparing apples to apples  
7 anymore because you talked about facilities that  
8 are basically MI, but we still have the same set  
9 of rules.

10 Other questions from Board members? Oh,  
11 I'm sorry. I forgot the doctor. He was -- and  
12 then I'll go to you, Barbara.

13 Dr. Goyal, please go ahead.

14 MEMBER GOYAL: Thank you, Madam Chair.

15 MR. FOLEY: Technical difficulties.

16 MEMBER GOYAL: The mic is coming from the  
17 Senator; it better work.

18 My name is Arvind Goyal. I represent  
19 Medicaid on this Board as an ex officio, so  
20 I don't vote.

21 I have a question for you and it digs a  
22 little bit deeper into your dedication to  
23 Medicare and Medicaid.

24 The question has to do with everybody



1 around you -- and we hear it every day -- that  
2 "Medicaid rates are too low; we cannot survive on  
3 Medicaid rates." Here, we have a proposal from  
4 you with 71 percent projected Medicaid occupancy.

5 Did I hear you correctly?

6 MR. NICK VANGEL: That's correct.

7 MEMBER GOYAL: Right. So what do you  
8 think it solves? How are you planning to survive?

9 MR. NICK VANGEL: Well, as was shared  
10 by -- or earlier, because of the size of our  
11 facilities -- you know, a number of facilities are  
12 being constructed more recently -- 90-bed, 80-bed,  
13 70-bed -- that are niche facilities that are only  
14 going to accommodate Medicare or insurance.

15 We believe, with the mix that we can  
16 accommodate -- it may not always be 70 percent;  
17 there may be months that it changes. But,  
18 overall, at the end of the year, we expect that we  
19 could -- and I pray that the State will not be the  
20 48th or 47th in the future with Medicaid  
21 reimbursement.

22 MEMBER GOYAL: If you can find a secret  
23 sauce for growing a money tree, we'll make sure  
24 that you get paid more.

1 MR. NICK VANGEL: We can discuss that in  
2 private.

3 CHAIRWOMAN OLSON: Barbara.

4 MEMBER HEMME: My question relates to  
5 your days' cash on hand and your comment that you  
6 want to have 70 percent Medicaid.

7 75 days does not seem like a long enough  
8 period of time when, often, Medicare and Medicaid  
9 are -- can be up to six, seven, eight months.

10 How do you propose -- with your percent-  
11 to-debt and total capitalization ratio on top of  
12 that, how do you propose to pay your bills?

13 MR. NICK VANGEL: Well, first of all, if  
14 I heard you correctly -- and I, unfortunately, am  
15 sitting next to Charles. I have a hearing aid,  
16 and he's like put it out of commission.

17 I'll defer to Robert.

18 MR. JAFARI: I can address that.

19 So we have an accounts receivable line of  
20 credit with the banks, and they provide us with  
21 the money until we get paid by Medicaid.

22 MEMBER HEMME: And how large is that line  
23 of credit?

24 MR. JAFARI: For every facility it's

1 different, but they would provide us for --  
2 80 percent of whatever the receivables are up  
3 until -- as long as the State goes.

4 In my experience, the State has gone as  
5 long as 13 months back in the early '90s.  
6 Currently, you know, 90 to 120 days. The banks  
7 are flexible. When the State changes the payment,  
8 they change the lines.

9 MR. NICK VANGEL: And you may have  
10 mentioned Medicare, as well. Or just Medicaid?

11 MEMBER HEMME: Well, both Medicare and  
12 Medicaid.

13 MR. NICK VANGEL: Medicare pays in  
14 45 days. They're 45 days. So there's a balance.

15 To say there wouldn't need to be a blend  
16 would not be honest. There has to be a blend.  
17 Private insurance and private pay, also, those are  
18 certainly much more current.

19 And now I know the State has the MCOs that  
20 provide a better -- and working on that  
21 continually -- to provide better responses as far  
22 as payment, and it's shortening that gap. As  
23 Robert alluded to or said before, in the '90s it  
24 was a long period of time, but we haven't

1 experienced that and it's gotten to be better.  
2 I think there's some pressure on whomever in  
3 Springfield, and we're seeing a little better  
4 response for that.

5 It's not regular but intermittently we get  
6 bumps, which has helped. And, again, the  
7 financing and the relationship with banks is also  
8 what carries us. Otherwise, we wouldn't have  
9 enough money to continue in this industry, not  
10 only us but everybody else.

11 CHAIRWOMAN OLSON: Yes.

12 MEMBER MC NEIL: From an organizational  
13 standpoint, is each unit independently  
14 incorporated and financially by itself? Or is it  
15 a corporate overlay where monies transfer back and  
16 forth?

17 MR. JAFARI: Each facility stands on its  
18 own as a separate LLC, separate legal entity, with  
19 separate financing.

20 MEMBER MC NEIL: So if payments don't come  
21 to one but to another, it's still independent?

22 MR. JAFARI: Yes.

23 CHAIRWOMAN OLSON: Other questions from  
24 the Board?

1 MEMBER MC GLASSON: It's not a question.

2 I -- I would like to offer an amendment to  
3 the motion to accept that financing be secured --  
4 not promised, secured -- by March 31st of 2019.

5 CHAIRWOMAN OLSON: So is there a second to  
6 the amendment to the motion on the table?

7 MEMBER HEMME: I'll second.

8 CHAIRWOMAN OLSON: All those in favor  
9 say aye.

10 (Ayes heard.)

11 CHAIRWOMAN OLSON: Opposed, like sign.

12 (No response.)

13 CHAIRWOMAN OLSON: Okay. The motion is  
14 amended.

15 Is that -- are you guys okay with that?

16 MR. JAFARI: Yeah, that's acceptable.

17 MR. NICK VANGEL: That is acceptable.

18 CHAIRWOMAN OLSON: All right. Thank you.

19 All right. Seeing no other further  
20 questions or comments, I would ask for a roll call  
21 vote.

22 MR. ROATE: Thank you, Madam Chair.

23 Motion made by Mr. Sewell; seconded by  
24 Ms. Murphy.

1 Senator Burzynski.

2 MEMBER BURZYNSKI: I have to be honest.  
3 I'm really struggling with this.

4 But I think this is one of the better  
5 discussions that we've had relative to any of the  
6 applicants that have appeared in front of us in  
7 quite some time.

8 I think, based on the amended motion, the  
9 information that we've received, I'm going to  
10 support the Applicant at this point in time so  
11 I vote yes.

12 MR. ROATE: Thank you.

13 Ms. Hemme.

14 MEMBER HEMME: I'm voting yes, as well,  
15 due to the amendment.

16 MR. ROATE: Thank you.

17 Mr. McGlasson.

18 MEMBER MC GLASSON: Yes, based on the  
19 amendment and reasons stated by the Senator.

20 MR. ROATE: Thank you.

21 Mr. McNeil.

22 MEMBER MC NEIL: I vote yes because you  
23 met the criteria. Coming in, I would have said  
24 something different, but you did explain it and

1 address the issues and that's extremely important.

2 MR. ROATE: Thank you.

3 Ms. Murphy.

4 MEMBER MURPHY: I'm going to vote yes  
5 based on the answers to our questions today, the  
6 assurances we've been given, and the amendment.

7 MR. ROATE: Thank you.

8 Mr. Sewell.

9 VICE CHAIRMAN SEWELL: I vote no.

10 The project still fails to meet pretty  
11 critical criteria.

12 MR. ROATE: Thank you.

13 Madam Chair.

14 CHAIRWOMAN OLSON: I'm going to vote no,  
15 as well, with the encouragement of the long-term  
16 care industry to clean up this bed situation so  
17 that we can approve these kinds of projects.

18 I do think it's a good project and I'm  
19 glad that it passed, but I'm going to vote no.

20 MR. ROATE: Thank you, Madam Chair.

21 That's 5 votes in the affirmative, 2 votes  
22 in the negative.

23 May I clarify the motion? The motion for  
24 financing being secured by March 2019?

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1 CHAIRWOMAN OLSON: That's correct -- no,  
2 no --

3 MS. AVERY: March 31st.

4 CHAIRWOMAN OLSON: -- '18.

5 MS. MITCHELL: '19.

6 MEMBER MC GLASSON: '19.

7 CHAIRWOMAN OLSON: Oh, '19? Okay.

8 MR. ROATE: March 31st, 2019?

9 MEMBER MC NEIL: Yes.

10 MR. ROATE: Very good.

11 Thank you.

12 CHAIRWOMAN OLSON: Okay. The motion  
13 passes.

14 Congratulations.

15 MR. KNIERY: Thank you.

16 MR. FOLEY: Thank you very much.

17 MR. NICK VANGEL: Thank you very much.

18 CHAIRWOMAN OLSON: It is almost 12:15.

19 We'll break for lunch for one hour -- oh, until  
20 one o'clock. I'm sorry.

21 We'll break for lunch until one o'clock.

22 (A recess was taken from 12:13 p.m. to  
23 1:02 p.m.)

24 - - -



1 CHAIRWOMAN OLSON: It is one o'clock. We  
2 are back in session.

3 Next, I'll call Project 17-044, Smith  
4 Crossing.

5 May I have a motion to approve  
6 Project 17-044, Smith Crossing, for a  
7 modernization/expansion project at its existing  
8 long-term care facility.

9 A motion, please.

10 MEMBER MURPHY: Motion.

11 CHAIRWOMAN OLSON: May I have a second.

12 VICE CHAIRMAN SEWELL: Second.

13 MEMBER BURZYNSKI: Second.

14 MR. CONSTANTINO: Madam Chair, before we  
15 get started, can I -- I need to make an addition  
16 to what I read as to what you approved. Our  
17 lovely court reporter noticed this.

18 CHAIRWOMAN OLSON: Okay.

19 MR. CONSTANTINO: Relinquishment of  
20 Exemptions E-038-16 through E-056-16, 19 exemptions,  
21 from Advocate NorthShore.

22 CHAIRWOMAN OLSON: Okay.

23 MR. CONSTANTINO: I apologize.

24 MS. AVERY: Thank you.

1 CHAIRWOMAN OLSON: Thank you.

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

3 CHAIRWOMAN OLSON: If you can't hear in  
4 the back of the room, wave at me or throw  
5 something.

6 The Applicant will be sworn in.

7 THE COURT REPORTER: Would you raise your  
8 right hands, please.

9 (Five witnesses sworn.)

10 THE COURT REPORTER: Thank you.

11 CHAIRWOMAN OLSON: Mr. Constantino, your  
12 report, please.

13 MR. CONSTANTINO: Thank you, Madam Chair.

14 The Applicants are proposing a 46-bed  
15 expansion project at an existing 46-bed long-term  
16 care facility located on the campus of Smith  
17 Crossing, an Illinois not-for-profit retirement  
18 community in Orland Park.

19 The cost of the project is approximately  
20 \$22.2 million. The expected completion date is  
21 December 31st, 2020.

22 There was a public hearing on this  
23 project, there was opposition, and we do have  
24 findings related to this project.

1 CHAIRWOMAN OLSON: Thank you, Mike.

2 MR. CONSTANTINO: Thank you, Madam Chair.

3 CHAIRWOMAN OLSON: Comments for the Board?

4 MR. KNIERY: Thank you, Chair.

5 Thank you, Mike and George, for your  
6 assistance through the process.

7 I'd like to introduce the presenters on  
8 behalf of Smith Crossing and its sponsored  
9 organization, Smith Senior Living.

10 With us today are Kevin McGee, Smith  
11 Senior Living CEO and president for the last  
12 five years. He's worked with Smith for 20 years  
13 and started with Smith Crossing as their first  
14 administrator in 2003, before the project was  
15 built.

16 To my immediate left is Mr. Ray Marneris,  
17 a CPA, and he has served as the CFO for Smith  
18 Senior Living for six years.

19 With us also is Frank Guajardo, who just  
20 celebrated his tenth anniversary as Smith  
21 Crossing's administrator.

22 So there's some longevity in this group,  
23 and they're going to demonstrate the need and the  
24 fact that Smith Crossing has the capacity and

1 support for this project.

2 With us also are Charles Foley of Foley &  
3 Associates, Juan Morado of Benesch, Ann D'Acquisto  
4 of AG Architecture, Daniel Collins of Eventus  
5 Partners, and Peter Worthington of Weis Builders.  
6 They're here as part of our team to answer any  
7 questions should there be any.

8 So not only is this Applicant unique but  
9 so is the project. I'll briefly address the  
10 State's findings under need, and then I'd like the  
11 Applicant to tell their story, which will address  
12 the remaining findings.

13 So there's a single finding, only a single  
14 finding, under the need portion of this project.  
15 That is the referral letters did not provide the  
16 patient origin for those referrals. And while  
17 that's technically correct, I'd like to point out  
18 that the Applicant, not the referral sources,  
19 provided the historical referral origin  
20 information to those letters.

21 This is one particular way this project is  
22 unique. Usually, applicants provide referral  
23 letters, typically from physicians for nursing  
24 home projects, which provide a total number of

1 referrals sent out; however, as an existing  
2 preferred provider, this Applicant received  
3 hospital referral letters that only quantified  
4 those referrals that were sent to Smith Crossing;  
5 and in this light, this project addresses its  
6 existing underserved. Moreover, the Applicant has  
7 been -- was able to provide better and more  
8 reliable patient origin than typical nursing home  
9 projects receive.

10 Specifically addressing this item, the  
11 Applicant provided 25 pages of documentation,  
12 which can be found in the application from  
13 pages 71 through 95. It identified each referral  
14 by day received, sourced by hospital, and if it  
15 turned into an admission or not. It also provided  
16 the internal numbers, the internal bed hold days  
17 for Smith Crossing residents' anticipated needs,  
18 and the total census.

19 This data showed that only 11 --  
20 I'm sorry -- 13.3 percent of the referrals could  
21 be admitted because Smith Crossing's high  
22 occupancy -- 2,494 -- sought care from Smith  
23 Crossing but were not able to be admitted.

24 And I've been doing this a long time, and

1 the data just doesn't get more accurate and  
2 reliable than it was provided here. Additionally,  
3 the rules are written to address just these kinds  
4 of projects that lie in one planning area but  
5 adjacent to another.

6 This project merely addresses 11 percent  
7 of the outstanding needs for additional beds.  
8 Approval of the project will still leave an  
9 outstanding need for 228 additional nursing beds  
10 in the planning area.

11 We're prepared for a full presentation to  
12 continue, but in light of the Board's time, if you  
13 just want to open it up to questions -- however  
14 you want to proceed.

15 CHAIRWOMAN OLSON: That's fine.

16 Questions -- actually, you -- am I not  
17 seeing something right? You said there was only  
18 one finding. What about all of the financial  
19 findings?

20 MR. KNIERY: That was on the need side.  
21 There's only one finding under the need portion.

22 Yeah, let's just continue and we'll  
23 address all those.

24 CHAIRWOMAN OLSON: Yeah. I think you need

1 to address those, yes.

2 MR. KNIERY: I'd like Mr. McGee,  
3 Mr. Marneris, and Mr. Guajardo to address the  
4 Applicant's strengths and backgrounds to shed  
5 light on the financial findings.

6 MR. MC GEE: Good afternoon. My name is  
7 Kevin McGee, M-c-G-e-e.

8 Our not-for-profit senior living community  
9 was founded in 1924 by local citizens, including  
10 business and civic leaders, because they saw the  
11 need to honor the lives of older adults by  
12 providing a better way for them to live.

13 Today, our board of trustees continues our  
14 mission into its ninth decade legacy by  
15 volunteering their professional expertise to  
16 provide a variety of services, programs, and  
17 living arrangements to enhance the quality of life  
18 for Smith residents.

19 Serving the surrounding community is built  
20 into the DNA of Smith Senior Living. Today, for  
21 instance, Smith Crossing in Orland Park and Smith  
22 Village on Chicago's southwest side serve our  
23 neighbors in a number of ways, including we offer  
24 our neighbors who are caregivers of family members

1 with memory loss monthly support meetings to help  
2 them cope. Smith holds special programs to  
3 support veterans, especially those who served in  
4 World War II, the Korean War, and, most recently,  
5 Vietnam.

6 Both our communities provide meaningful  
7 ways for individuals and groups to volunteer more  
8 than 70,000 hours in the last seven years in  
9 support of older adults who live near or on our  
10 campuses. We invest our staff time and resources  
11 by offering clinical training opportunities for  
12 colleges to educate future CNAs and registered  
13 nurses.

14 Currently Smith Crossing has 46 skilled  
15 beds, of which only 16 are dedicated to short-term  
16 rehab and 30 for long-term care, and our Smith  
17 Village campus has a hundred skilled beds which,  
18 on the average, provide 15 to 20 percent for  
19 rehab.

20 Even though our not-for-profit  
21 organization has served older adults since 1924,  
22 Smith Crossing is not your typical nursing home.  
23 Smith Crossing is a continuing care retirement  
24 community, often referred to as a CCRC. When



1 people move into a retirement community like Smith  
2 Crossing as independent living residents, they pay  
3 an entrance fee, which is 90 percent refundable to  
4 their estate or if they leave. With this fee,  
5 independent living residents receive a life care  
6 contract which gives a discount on future health  
7 care services.

8 As a CCRC, residents in all settings live  
9 under one roof to make our continuum of care  
10 easily accessible for spouses and friends should a  
11 resident move to a higher level of care.

12 MR. MARNERIS: My name is Ray Marneris.  
13 I'm the CFO of Smith Senior Living.  
14 M-a-r-n-e-r-i-s.

15 On behalf of Smith Crossing, I would like  
16 to thank Mike Constantino and his staff for  
17 meeting with John Kniery, Juan Morado, and me. We  
18 found the time they spent with us very helpful,  
19 and we appreciate the generosity.

20 Like other not-for-profit continuing care  
21 retirement communities, Smith Crossing uses the  
22 entrance fees from independent living residents to  
23 help pay for construction costs and to manage its  
24 annual debt obligation. Accounting standards

1 require carrying entrance fees as a liability on  
2 the Smith Crossing's balance sheet and not part of  
3 net assets.

4 On June 30th, 2017, Smith Crossing's  
5 balance sheet showed \$44 million in refundable  
6 entrance fees and \$3.6 million in deferred revenue  
7 from those fees shown as liabilities.

8 Due to how a CCRC is structured, Smith  
9 Crossing does not meet some of the State Board  
10 financial ratios, which I'll address in a minute.  
11 We thought, however, you'd appreciate knowing, as  
12 1 of only 10 CARF-accredited continuing care  
13 retirement communities in the state of Illinois,  
14 Smith Crossing uses and meets all of CARF's  
15 17 ratios that analyzes trends, strengths, and  
16 weaknesses. We review these ratios every quarter  
17 with our board of trustees and report them  
18 annually to this accrediting agency.

19 As we have discussed with Mr. Constantino,  
20 we agree with the State Board's findings about  
21 Smith Crossing not complying on four financial  
22 ratios based on the State's definition of those  
23 ratios, but we underscore that Smith Crossing is  
24 not a typical nursing home.

1           First, analyzing the State formula for the  
2           current ratio does not take into account Smith  
3           Crossing's investment account, which is shown  
4           under other assets on the Smith Crossing balance  
5           sheet. If the investment account was used in the  
6           formula, the current ratio would have been 1.96 in  
7           fiscal year 2014, 2.57 in '15, and 3.85 in fiscal  
8           year '16, more than meeting the State standard  
9           of 1.5.

10           Second, analyzing the State formula for  
11           the net margin ratio, the State divided net income  
12           by patient revenue. For Smith Crossing, however,  
13           these numbers include both independent living and  
14           assisted-living revenue and expenses for people  
15           who do not receive skilled nursing care.

16           27 percent of our operating expense are in  
17           depreciation and interest and only 9 percent of  
18           the depreciation and interest expense is allocated  
19           or attributable to our skilled nursing unit. This  
20           is another accounting factor considered because  
21           Smith Crossing is a continuing care retirement  
22           community, not a traditional nursing home.

23           Third, the long-term-debt-to-  
24           capitalization ratio is below the State standards.

1 As we discussed with Mr. Constantino and his  
2 staff, most CCRCs -- or continuing care retirement  
3 communities -- could never meet this ratio. For a  
4 continuing care retirement community or life plan  
5 community like Smith Crossing, values in excess of  
6 a hundred percent for this ratio are caused by net  
7 deficits and they're common because of the  
8 reliance on the cash from the entrance fees, which  
9 are treated on the balance sheet as a liability.

10 And, finally, we acknowledge Smith  
11 Crossing did not make the cushion ratio -- or meet  
12 the cushion ratio -- in fiscal year 2014 and 2015.  
13 As part of our refinancing of Smith Crossing in  
14 fiscal year 2014, Smith Crossing paid off  
15 \$17 million in principal on its construction loan.  
16 Smith Crossing would have met this cushion ratio  
17 if not for these loan principal payments in  
18 November of 2013.

19 Here's a top-line summary of why we have  
20 confidence in Smith Crossing's strong financial  
21 position: Smith Crossing generates more than  
22 \$2 million a year in cash from current operations,  
23 which can be used to support the additional debt  
24 service and continue to maintain more than

1 nine months of days' cash on hand.

2 Since 2003 Smith Crossing has successfully  
3 negotiated \$76 million in loan and has repaid  
4 \$43.3 million of that debt. As of today, Smith  
5 Crossing's total loan outstanding is 32.7 million.  
6 In November of 2013, when the refinancing was  
7 completed, Smith Crossing was appraised at  
8 \$75 million.

9 I'm happy to report that three banks have  
10 expressed their interest in working with Smith  
11 Crossing on this new opportunity before you today,  
12 and that is to add more rehab beds in the  
13 underserved area of Will County.

14 The three banks have stated they are  
15 willing to lend up to 70 percent of the appraised  
16 value of Smith Crossing, which equals a borrowing  
17 capacity of 27.3 million. Once this project is  
18 approved, Smith Crossing will be issuing an RFP to  
19 banks to secure the best available financing.

20 Smith Crossing can only provide a letter  
21 from a bank confirming a loan has been approved by  
22 signing the bank term sheet and paying a \$20,000  
23 application fee at the time of signing in order  
24 for it to go in front of their credit committee.

1 That is why we have gone this approach until after  
2 the project has been approved, to put it out to  
3 bid to get the best financing available.

4 MR. GUAJARDO: Good afternoon, ladies and  
5 gentlemen of the Board. My name is Frank  
6 Guajardo, administrator of Smith Crossing.  
7 G-u-a-j-a-r-d-o.

8 I'm here today to inform you that Smith  
9 Crossing cannot meet the current demand for  
10 short-term rehab stays within our area. Between  
11 January 2016 through June 2017, Smith Crossing  
12 received 2,494 referrals for inpatient short-term  
13 rehab and could only accept 170 patients during  
14 those 18 months.

15 This adds up to turning away 87 percent of  
16 older adults who are asking for Smith Crossing to  
17 help them return to a life of independence. Can  
18 you imagine what it's like to turn away 150 older  
19 adults each month?

20 It is especially difficult because nearby  
21 hospital discharge planners continue to call, but,  
22 again, we are not able to accommodate due to lack  
23 of beds, but it doesn't stop there.

24 Many times after our admissions director

1 denies a patient, I will personally receive a  
2 phone call from a family member, trustee, or even  
3 our own residents who are asking us to reconsider  
4 the person that we've just turned away; however,  
5 we are not able to accommodate due to lack of  
6 beds.

7 Since 2013 Smith Crossing has successfully  
8 partnered with Silver Cross Hospital in its  
9 bundled care program and entered into a similar  
10 agreement with Palos Community Hospital to improve  
11 on the continuity of care between hospital and  
12 skilled nursing facility.

13 If you approve of this project, Smith  
14 Crossing will also have more room to offer more  
15 rehab for medically complex older adults suffering  
16 from dementia, COPD, congestive heart failure,  
17 diabetes, and other chronic diseases when they  
18 have surgery or another major health event.

19 So why do so many people ask for Smith  
20 Crossing? Word of mouth. We don't spend  
21 advertising money on our short-term rehab unit,  
22 yet many ask for Smith Crossing as a preferred  
23 placement due to our high quality of care and  
24 services. Our five-star CMS rating. And of the

1 15 facilities in our area, Smith Crossing has the  
2 shortest length of stay of 17 days. That is less  
3 than those set by Illinois and national standards.

4 We are privileged to play a key role in  
5 returning senior citizens to their life of  
6 independence quicker and with confidence to  
7 continue to heal.

8 MR. MC GEE: I would like to address the  
9 three areas relating to the reasonableness of  
10 project costs that appear high when compared to  
11 State standards: Site preparation, new  
12 construction, and equipment costs.

13 The design we presented for Smith Crossing  
14 supports our continuum model. In this new rehab  
15 wing, for example, dining rooms for rehab patients  
16 as well as their visiting family and friends  
17 provide a more home-like experience.

18 To achieve this continuity of access to  
19 space, Smith Crossing must take significant site  
20 preparation changes in some exteriors, as well.  
21 Key factors affect Smith Crossing's construction  
22 costs because the new wing and the common areas  
23 are connected to our existing wings, and the  
24 Village of Orland Park, where Smith Crossing is



1 located, has building codes more stringent than  
2 the State of Illinois.

3 For this project Orland Park requires  
4 Smith Crossing to move our existing campus  
5 entrance, to reroute campus traffic, and to  
6 underwrite major modifications to the public road  
7 leading into our main entrance on its south side.

8 Orland Park also mandates erecting a  
9 structure with full masonry exterior, driving the  
10 design to block-and-plank construction instead of  
11 the more economical gage metal frame; building a  
12 roof that exceeds IDPH standards, so it is taller  
13 and more complicated than the typical construction  
14 and allows for higher ceilings in the therapy gym  
15 and other common areas.

16 MR. GUAJARDO: I would also like to add  
17 that the Mokena Fire Department that services  
18 Smith Crossing has required us to add a separate  
19 fire lane on the south side of the building.  
20 Smith Crossing was also required to reroute its  
21 utilities and access lines.

22 MR. MORADO: Members of the Board, as  
23 simply as I can put it, your rules work. When the  
24 Board considers a project, it does so at various

1 levels, each one focusing on the need for and the  
2 impact of a project: The health service area,  
3 which reflects the 11 larger geographic areas into  
4 which the state is divided; the planning area,  
5 which is a more specific region, allowing for more  
6 specific collection of data and evaluation for  
7 responsible planning; and then the actual service  
8 area, which is where the patients are actually  
9 coming from.

10 This multilayered approach is necessary to  
11 perform a meaningful evaluation. Patients don't  
12 know which side of an HSA or planning area they  
13 live in. They do know where they want to receive  
14 care, and they know where they want their loved  
15 ones to be cared for. That's why, at every level  
16 of assessment, it's important when you evaluate  
17 your project.

18 And here, regardless of how close the  
19 facility is to the border, it's clear that more  
20 people want to be cared for at the CMS five-star-  
21 rated Smith Crossing facility than it can  
22 currently accommodate. This Board, however, can  
23 make that continued dream into a reality by  
24 approving this project.

1           At every level of need that this Board  
2 focuses on, there is a strong basis to approve  
3 this project. Your rules are designed to allow  
4 for it. Your rules work and approving this  
5 project would be the perfect example of that.

6           MR. MC GEE: We think it is essential to  
7 act now because Will County is one of the  
8 100 quickest growing counties in the country, and  
9 it has an increasingly aging demographic.

10           Now I'd like to summarize why we are  
11 confident that Smith Crossing can support an  
12 additional 46 nursing beds.

13           During our last fiscal year on June 30th,  
14 Smith Crossing and Smith Village, combined, served  
15 a total of 1,170 older adults. On any given day  
16 both Smith campuses are home to close to  
17 600 residents.

18           Smith communities currently employ  
19 500 people who live on the southwest sector of  
20 Chicago and its suburbs. As a not-for-profit  
21 established in 1924, Smith Senior Living  
22 demonstrates our commitment to the care of older  
23 adults through our charity care program, which  
24 means we never ask a resident to leave our campus

1       should they outlive their means.

2               Between July 2009 and June 2017, Smith  
3       underwrote the cost of providing 54,673 days of  
4       charity care, costing close to \$6.2 million. And  
5       please know we do not consider Medicaid to be  
6       charity care.

7               The trustees of Smith Crossing and Smith  
8       Senior Living stand willing, ready, and able to  
9       take on these additional responsibilities of  
10      building a new rehab of 46 skilled beds. A  
11      sustained five-star CMS rating for both of our  
12      CCRCs validates we fulfill our goal in providing  
13      the highest quality care.

14              On behalf of Smith Crossing, we  
15      respectfully ask you to allocate 11 percent of  
16      the additionally needed beds in Will County to  
17      Smith Crossing.

18              Thank you.

19              CHAIRWOMAN OLSON: Thank you.

20              Questions or comments from Board members?

21              Mr. Sewell.

22              VICE CHAIRMAN SEWELL: Yeah.

23              I wanted to ask Mr. Constantino -- this  
24      Applicant said that they had their referral volume

1 in their application.

2 MR. CONSTANTINO: Yes, from hospitals.

3 VICE CHAIRMAN SEWELL: But you require  
4 letters from the entity making the referral?

5 MR. CONSTANTINO: Yeah.

6 VICE CHAIRMAN SEWELL: So I guess I would  
7 ask, why didn't you include the letters from those  
8 individuals or organizations that plan to make the  
9 referrals?

10 MR. KNIERY: The difficulty of getting the  
11 referral sources to spend the time in doing that  
12 when we have that information. I mean, we could  
13 have given it back to them, but it still wouldn't  
14 have been their data. It's our data.

15 But they have -- I'd kind of like to have  
16 Frank walk through the process that they have in  
17 collecting the data. There is -- when they  
18 have -- get a call, they document it better than  
19 I've seen almost anyone document. I just feel  
20 that this information is probably better  
21 information than what we have typically received  
22 on projects.

23 Frank, would you add to that --

24 VICE CHAIRMAN SEWELL: Respectfully,

1 I don't really -- you've answered the question as  
2 to why --

3 MR. KNIERY: Yeah.

4 VICE CHAIRMAN SEWELL: -- the letters  
5 weren't sent in.

6 Okay. Now, under "Availability of Funds,"  
7 we have this sort of chicken-and-egg situation.  
8 You want to wait until you get approval, and then  
9 you'll show that approval to a bank or a financing  
10 entity, then they'll give you a letter. And in  
11 our process we're asking for evidence that the  
12 funds are available as a part of the process.

13 Am I describing that correctly?

14 MR. MARNERIS: Yes, you are.

15 Mr. Constantino and his staff did describe  
16 that and the reasons why the State has that when  
17 we met with them last month.

18 We felt that, instead of trying to do an  
19 RFP with the banks before we had a project and  
20 then paying a \$20,000 fee if the project didn't go  
21 through, we'd be better served -- let's get the  
22 project approved and then let's go out and get the  
23 financing.

24 We have worked with three banks

1 continually throughout this process. Besides  
2 First Midwest Bank, which spoke this morning in  
3 support of the project, we've also worked with  
4 Huntington Bank and Byline Bank, and they all want  
5 to be part of this project.

6 VICE CHAIRMAN SEWELL: Okay.

7 CHAIRWOMAN OLSON: Other questions?

8 (No response.)

9 CHAIRWOMAN OLSON: So I just want to make  
10 sure I have these numbers right.

11 Was it last year that you had  
12 2,494 referrals, of which you were only able to  
13 accommodate about 14 percent?

14 MR. GUAJARDO: So we started taking in our  
15 information on January 1st of 2016, and it ended  
16 on June 30th, 2017, so it's a span of 18 months.

17 CHAIRWOMAN OLSON: Okay. But that is the  
18 correct number? 2,494 referrals, of which you  
19 were only able to accommodate about 13 percent of  
20 them?

21 MR. GUAJARDO: That's correct.

22 MR. MORADO: Yes.

23 CHAIRWOMAN OLSON: Other questions?

24 (No response.)

1 CHAIRWOMAN OLSON: Seeing none, I would  
2 ask for a roll call vote.

3 MR. ROATE: Thank you, Madam Chair.

4 Motion made by Ms. Murphy; seconded by  
5 Senator Burzynski.

6 Senator Burzynski.

7 MEMBER BURZYNSKI: Again, this is one  
8 I struggle a little bit with.

9 I understand, in particular, the financing  
10 aspect of this and your concern of spending  
11 \$20,000 and whatever, but I would suggest -- or  
12 I would guess that you've already spent a  
13 tremendous amount of money on architectural and  
14 those kinds of things. I don't know that. Or  
15 even purchase of the property or looking at your  
16 property.

17 But, anyway, having said that, I think  
18 you've addressed a lot of the issues that are here  
19 today, and I will support the project.

20 I vote yes.

21 MR. ROATE: Thank you.

22 Ms. Hemme.

23 MEMBER HEMME: I vote yes for the same  
24 reason.



1 I think you've addressed all of the  
2 financial concerns that I had with this.

3 MR. ROATE: Thank you.

4 Mr. McGlasson.

5 MEMBER MC GLASSON: I vote yes for reasons  
6 stated.

7 MR. ROATE: Thank you.

8 Mr. McNeil.

9 MEMBER MC NEIL: Yes. You've met the  
10 criteria and by updating with the messages here.

11 MR. ROATE: Thank you.

12 Ms. Murphy.

13 MEMBER MURPHY: I'm going to vote yes  
14 based on the testimony here today.

15 MR. ROATE: Thank you.

16 Mr. Sewell.

17 VICE CHAIRMAN SEWELL: I'm going to  
18 vote no.

19 There are too many of the financial ratios  
20 that are not met. I didn't think the explanation  
21 was satisfactory.

22 MR. ROATE: Thank you.

23 Madam Chair.

24 CHAIRWOMAN OLSON: I'm going to vote yes,

1 based on the fact that there's a 274-bed need in  
2 this HSA, and I believe that, if they meet all  
3 the CARF ratios --

4 THE COURT REPORTER: I'm sorry.

5 CHAIRWOMAN OLSON: I believe, if CARF  
6 feels they meet all the appropriate ratios, that  
7 we're probably pretty secure in the financial  
8 information we received.

9 THE COURT REPORTER: Thank you.

10 MR. ROATE: That's 6 votes in the  
11 affirmative, 1 in the negative.

12 CHAIRWOMAN OLSON: The motion passes.

13 MR. KNIERY: Thank you.

14 CHAIRWOMAN OLSON: Congratulations.

15 MR. MARNERIS: Thank you.

16 MR. MC GEE: Thank you.

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1 CHAIRWOMAN OLSON: Next, I would call to  
2 the table Project 17-052, Dialysis Center Beverly.

3 May I have a motion to approve  
4 Project 17-052, Dialysis Center Beverly, to  
5 establish a 14-station ESRD facility.

6 I'm sorry -- Dialysis Care Center Beverly.  
7 May I have a motion.

8 MEMBER MURPHY: Motion.

9 CHAIRWOMAN OLSON: May I have a second,  
10 please.

11 MEMBER BURZYNSKI: Second.

12 CHAIRWOMAN OLSON: The Applicant will be  
13 sworn in, please.

14 THE COURT REPORTER: Would you raise your  
15 right hands, please.

16 (Five witnesses sworn.)

17 THE COURT REPORTER: Thank you.

18 CHAIRWOMAN OLSON: Mr. Constantino, your  
19 report.

20 MR. CONSTANTINO: Thank you, Madam Chair.

21 The Applicants propose to establish a  
22 14-station ESRD facility in 6,313 gross square  
23 feet of leased space at a cost of approximately  
24 \$1.6 million. The expected completion date is

1       October 31st, 2019.

2               We did receive a comment on the State  
3       Board staff report. I placed it in -- the hard  
4       copy in front of you this morning. It was sent by  
5       email last week.

6               CHAIRWOMAN OLSON: Thank you,  
7       Mr. Constantino.

8               Am I okay now?

9               MR. ROATE: Is it better?

10              CHAIRWOMAN OLSON: I can hear myself. I'm  
11       not worried about me hearing myself. I'm worried  
12       about everybody else.

13              No?

14              UNIDENTIFIED MALE: No, we can't hear you.

15              CHAIRWOMAN OLSON: Comments for the Board?

16              DR. SALAKO: Good afternoon, Board.

17       Thank you for allowing us to speak.

18              I am Babajide Salako, Dr. Salako,  
19       B-a-b-a-j-i-d-e; Salako, S-a-l-a-k-o. I am the  
20       CEO of the Dialysis Care Center. I am represented  
21       here today with my team.

22              To my extreme left is Ms. Kristin  
23       Paoletti, who is my senior director of clinical  
24       services. Next to her is Ms. Melissa Smith, who

1 is my area administrator and head of my home  
2 program, my home dialysis program.

3 Next to her is Mr. Asim Shazzad, who is my  
4 chief operating officer, and right next to me here  
5 is Dr. Sarika Chopra, who is an associate  
6 nephrologist that works in the dialysis care  
7 center.

8 I have a few comments, and then we will be  
9 available for questions.

10 CHAIRWOMAN OLSON: Please.

11 DR. SALAKO: On October 25th, 2016, I had  
12 the benefit of appearing here before the Board.  
13 And if you'll recall -- I'm sure you see many  
14 providers -- we asked for CONs for our two  
15 clinics, DCC Oak Lawn and DCC Olympia Fields.

16 And at that time we requested for the CON,  
17 we were -- these were four sort of in-centers in  
18 the state of Illinois, and we requested those CONs  
19 because we felt -- this was a physician-owned  
20 dialysis provider, physician-managed dialysis  
21 provider.

22 We were very heavy in the home dialysis  
23 sphere, and we were looking for a way to have a  
24 continuum of care for our dialysis patients as

1       they transitioned out of home therapies into  
2       in-center therapies. And we felt that, by staying  
3       within our network of providers, we could continue  
4       to, A, manage those patients, give them the  
5       quality of care that we needed, and, B, continue  
6       to encourage those patients to get back into the  
7       home program.

8               Well, I'm very happy to report that, since  
9       those two clinics are open, they are -- they were  
10      certified without any deficiencies by CMS. As of  
11      today, February 27th, they are 50 percent  
12      occupancy.

13             What we saw during the trend of walls  
14      construction and openness of those two clinics  
15      were, for the first time in the areas where we  
16      were serving, we were now providing patients with  
17      options. Several patients were driving up,  
18      knocking on the doors of the clinics, telling our  
19      contractors that -- "When are these clinics going  
20      to open? We want to switch from DaVita or  
21      Fresenius to the clinics."

22             And in the weeks since our clinics have  
23      opened, just the rapid admissions we've been able  
24      to get into our clinics shows that there's a need

1 out there for other providers to come into the  
2 dialysis sphere to provide good dialysis care for  
3 patients. So that's the first thing I want to  
4 clearly state to the Board.

5 Other things we've been able to fully  
6 ascertain is -- as we have an open-door policy,  
7 we've been able to admit several patients,  
8 indigent patients, patients without insurances,  
9 patients waiting to get their Medicaid. You know,  
10 so we have an open-door policy. And several  
11 patients have come to us saying, you know, "I was  
12 rejected by, you know, the program at Christ  
13 Hospital. We can't place this patient in a  
14 Fresenius or DaVita. Will you take this patient?"

15 And we've said yes because we feel that  
16 we're providing a service to the community, and we  
17 believe that, with the expert care of my  
18 physicians and my nursing staff, we would rather  
19 admit the patient than deprive the patient of  
20 dialysis care based on their lack of or  
21 undesirable insurance.

22 Those are the two main things I want to  
23 get across.

24 Now, fast-forward to this project. Once

1 again, our nephrology practice continues to grow.  
2 We have more physicians working with us, and our  
3 physicians, once again, are saying, "We have all  
4 these patients on dialysis, on home therapies, in  
5 this particular part of town. We want to be able  
6 to have our own dialysis clinic that will ensure  
7 that, without losing those patients -- they go to  
8 Fresenius or DaVita -- and all of a sudden, hey,  
9 they place them on a home hemodialysis, they don't  
10 come back to PED."

11 That is something that we would like to  
12 really avoid and one of the reasons why we believe  
13 that we should go ahead and cater to those  
14 patients.

15 I'll let my medical director, Dr. Chopra,  
16 say a few words and the rest of my team.

17 DR. CHOPRA: Good afternoon. Can you  
18 hear me?

19 So I'm a nephrologist in the area where  
20 this dialysis unit would potentially open. In  
21 this area is where I take care of a large number  
22 of local patients with chronic kidney disease.  
23 And as the State Board survey tells us, there is a  
24 need for 75 dialysis chairs in this area alone.



1           Based on the number of CKD patients that  
2   I see in clinic and that my partners see in  
3   clinic, we certainly see a need for these chairs  
4   on the horizon. Given the expected care need,  
5   I believe this unit would provide a huge local  
6   service, one that also allows for flexibility and  
7   options for our patients.

8           The proposed center is close to acute care  
9   hospitals where our patients get quick access to  
10   inpatient care. They also wouldn't have to choose  
11   between keeping their nephrologist or traveling  
12   30, 40 minutes before and after each dialysis  
13   session three times a week. Being able to retain  
14   one's physician is a huge part of patient comfort  
15   and continuity of care, which we know is very  
16   beneficial for our patients.

17          Also, I'd be able to provide more  
18   oversight and have more control over my patient  
19   care, and, as Dr. Salako discussed, this would  
20   help me continue my patient care plans to  
21   transition them back to home dialysis and even to  
22   transplant.

23          So based on the State Board's survey  
24   recommendations and what I see in my own CKD

1 clinic in this area, I think that this unit would  
2 serve my patients very well.

3 MS. SMITH: My name is Melissa Smith.  
4 I am an area manager for --

5 CHAIRWOMAN OLSON: Closer.

6 MS. SMITH: My name is Melissa Smith.  
7 I am an area manager for the company and also a  
8 hope therapies nurse. I come as an advocate for  
9 the patients, both current and future, that would  
10 be in use of this facility.

11 I can speak from personal experience with  
12 the patients out in the area where the approved  
13 McHenry DCC is going to be opening for the  
14 patients that are currently on home therapies in  
15 that program.

16 They're excited to see that, in the event  
17 that their dialysis catheter fails, that they have  
18 an option to remain within our program in a  
19 facility that is going to have the same quality of  
20 care and values that we carry currently with our  
21 patients and we're not going to have to transfer  
22 them out to different companies where they're  
23 going to lose their care team, potentially have to  
24 switch nephrologists, and items like that that

1 would have them have to restart their whole  
2 process with forming the relationships with their  
3 care team.

4 So the appropriate facility within this  
5 area would -- at the Beverly DCC -- would provide  
6 the current and future patients with that same  
7 opportunity. It is very important to have that  
8 continuity of care because it increases patient  
9 likelihood to come and be compliant.

10 Noncompliance is a huge issue in the  
11 dialysis world. But when you have that strong  
12 relationship with your care team, patients are  
13 more likely to come when they're supposed to come,  
14 receive their medications, really want to be  
15 involved in their care. So this facility would  
16 give them the opportunity to continue that care  
17 with their nephrologist and their care team.

18 MS. PAOLETTI: Hello. Sorry. Can you  
19 hear me?

20 My name is Kristin Paoletti. I'm the  
21 senior director --

22 CHAIRWOMAN OLSON: Pull it closer.

23 MS. PAOLETTI: My name is Kristin  
24 Paoletti. I'm the senior director of clinical

1 operations with Dialysis Care Centers.

2 I just want to wrap up by saying that  
3 continuing care is very important for quality. In  
4 order to continue to keep our patients on track  
5 for a transplant, just to continue better care,  
6 the continuity of care coming from our home  
7 programs to our in-centers is pretty vital, to  
8 make sure that these patients transition well.

9 Thank you.

10 CHAIRWOMAN OLSON: Thank you.

11 Questions from Board members?

12 Mr. Sewell.

13 VICE CHAIRMAN SEWELL: Yes.

14 I want to talk about a couple of the items  
15 in the State agency report that I don't think your  
16 letter of February 15 addresses.

17 Start with the financial viability. Why  
18 didn't you submit the financial ratios?

19 DR. SALAKO: Well, regarding financial  
20 viability, we are a company where we -- we have a  
21 trust. As you can see, we have a letter from a  
22 bank saying we have over \$10 million in capital  
23 development money. That was shown as evidence.  
24 The letter was submitted to the State Board.

1           The way we -- we don't keep our funding --  
2           we don't keep our funding cash in our ongoing  
3           capital -- in our ongoing current account, so what  
4           we do is we have a capital investment fund. And  
5           at the time when needed, we supply the letter to  
6           the State agency saying, "Hey, we have  
7           \$10.1 million readily available for this project."  
8           This project is going to cost us \$1.6 million. We  
9           are well funded for this project and for any other  
10          expansion of our business.

11          VICE CHAIRMAN SEWELL: Why didn't you  
12          submit the financial ratios?

13          That's an interesting statement but it's  
14          not the answer to my question.

15          MR. SHAZZAD: I think it was -- the  
16          financial ratios were included.

17          VICE CHAIRMAN SEWELL: I'm sorry?

18          MR. SHAZZAD: I believe they were included  
19          in that --

20          DR. SALAKO: In the initial application.

21          VICE CHAIRMAN SEWELL: Well, according to  
22          the State agency report, you know, you didn't  
23          qualify for the waiver, which means you wouldn't  
24          have to submit them --

1 MR. SHAZZAD: Correct.

2 VICE CHAIRMAN SEWELL: -- but you didn't  
3 provide the ratios and supporting information for  
4 those ratios as a comparison between the State  
5 standard and an analysis of your financial  
6 statements --

7 MR. SHAZZAD: We did.

8 VICE CHAIRMAN SEWELL: -- to show where  
9 you fit.

10 Mr. Constantino, are there financial  
11 ratios?

12 MR. SHAZZAD: We provided a pro forma.

13 MR. CONSTANTINO: They provided a  
14 pro forma income statement.

15 VICE CHAIRMAN SEWELL: But no ratios?

16 MR. CONSTANTINO: No ratios.

17 VICE CHAIRMAN SEWELL: I just want to know  
18 why you didn't do it. I have my students do that  
19 just as an exercise. It's not a big deal.

20 MR. SHAZZAD: I'm sorry. We'll do it next  
21 time.

22 VICE CHAIRMAN SEWELL: The other thing is  
23 on the planning area need. Again, I'm trying to  
24 see if your letter of February 15 really addresses

1     this issue, and I guess I don't understand. It  
2     doesn't appear that you have been specific with  
3     respect to the referrals that you would receive.

4             And I'm trying to understand -- it doesn't  
5     look like this letter really addresses the concern  
6     in the State agency report.

7             MR. CONSTANTINO: Yes. What we require --  
8     what they provided was their population identified  
9     by CKD 3, 4, and 5.

10            VICE CHAIRMAN SEWELL: Okay.

11            MR. CONSTANTINO: And it appeared to me,  
12     when I reviewed it, that this was similar to the  
13     letter they provided for the applications that  
14     were approved for the facility 20 minutes from  
15     this one. Okay?

16            And it appears there -- it means --  
17     there's duplicates of what they provided.  
18     I wanted them to identify each individual that  
19     would be utilizing the proposed new facility, this  
20     facility. And that wasn't provided, no.

21            VICE CHAIRMAN SEWELL: Okay.

22            MR. SHAZZAD: And -- I'm sorry. Can I  
23     answer that?

24            We reviewed the data that was provided.

1       There were some duplications; however, I would  
2       like to point out there were an additional  
3       219 patients on the newer updated data that was  
4       provided with the application.

5               So there was additional data.

6               VICE CHAIRMAN SEWELL: But not referral  
7       letters?

8               MR. SHAZZAD: No, with referral letters.

9               VICE CHAIRMAN SEWELL: Were there referral  
10      letters?

11              MR. CONSTANTINO: The nephrologist  
12      provided a referral letter, but the information  
13      they provided us was their total population for  
14      CKD 3, 4, and 5 and not individual patients that  
15      would be utilizing the proposed facility --

16              VICE CHAIRMAN SEWELL: Yeah.

17              MR. CONSTANTINO: -- and that's what we  
18      needed or that's what we wanted here.

19              And they had one other -- I want to back  
20      up a minute.

21              They were approved -- the Board approved  
22      them for two facilities, one in Oak Lawn and one  
23      in Olympia Fields. Both have been certified for  
24      Medicare. We got that information last week.



1           So they have been certified, and they're  
2 up and running.

3           VICE CHAIRMAN SEWELL: Uh-huh.

4           MR. CONSTANTINO: My concern -- and  
5 I expressed this on the other applications they  
6 submitted -- is the cost of these facilities.  
7 I can't understand why they can do it so much  
8 cheaper than DaVita and Fresenius, the two largest  
9 opera- -- dialysis operators in the world.

10          That's my biggest concern. I don't  
11 believe we're getting all of the capital costs  
12 that are required by the Board.

13          VICE CHAIRMAN SEWELL: Okay.

14          DR. SALAKO: Can I answer that? I'll  
15 answer the cost question.

16          First of all, lucky for us, we have --  
17 we're a small company. Our overhead is very  
18 minimal -- our overhead is very minimal. Unlike  
19 the CEO of DaVita, I don't have a Gulfstream IV  
20 jet that I have to put in the cost of the project,  
21 so our projects are coming -- I wish I did. But  
22 our projects are coming in honestly at the square  
23 footage.

24          Going back, the rate for the square

1       footage, we did 110 to \$150 per square feet. Our  
2       overhead cost as a business, as a company, is so  
3       much smaller than a company with 50,000 employees  
4       with a huge corporate headquarters.

5               So these are the relative -- we have  
6       direct construction costs. And one of the things  
7       we did today was have the builder, landlord, talk  
8       in the public comment this morning. He came in  
9       and said he's going to do a turnkey project for  
10      us. These are ways in which we're very, very  
11      nimble and very, very creative in how to get our  
12      costs much lower.

13             By getting our costs much lower, our  
14      overhead is much smaller. That's why we're able  
15      to -- we're very flexible, and, unlike the big  
16      providers, we can now accept patients that, you  
17      know, pay little or sometimes nothing because we  
18      really try to -- we really try to offer a service  
19      here and try to offer an alternative to the LDLs.  
20      If we're going to build a clinic for 3- or  
21      \$4 million, I think it becomes extremely --  
22      extremely difficult for anybody to run a  
23      profitable business that way.

24             So we start by cost-cutting, we start by

1 being reasonable, and we always continue with that  
2 kind of mind-set in our organization.

3 CHAIRWOMAN OLSON: Other questions or  
4 comments?

5 Dr. Goyal.

6 MEMBER GOYAL: Thank you, Madam Chair.

7 I can -- George, did you fix it?

8 MR. ROATE: It should be on.

9 CHAIRWOMAN OLSON: Put your mouth closer  
10 to it. It's on.

11 MS. AVERY: It's on.

12 MEMBER GOYAL: If you say so.

13 Can you hear me?

14 MR. SHAZZAD: Yes.

15 MEMBER GOYAL: My name is Arvind Goyal,  
16 and I represent Medicaid.

17 Would you explain to me one item on page 6  
18 of your application that says your Medicaid  
19 percentage is 2 percent. That's surprising.  
20 Could you talk about that a little bit?

21 DR. SALAKO: You know, just  
22 straightforward Medicaid. But, remember, in  
23 Illinois now almost everybody has some kind of  
24 Medicaid provider plan, so you're going to have

1 another type of Medicaid plan but -- not exactly  
2 for Medicaid but you're looking at, as of today,  
3 you know, Medicare managed plans,  
4 Medicare/Medicaid plans so --

5 MEMBER GOYAL: So that's not Medicaid?

6 MR. SHAZZAD: No, that's not.

7 DR. SALAKO: No, no, no.

8 MEMBER GOYAL: Should you or could you?  
9 Because that is Medicaid.

10 DR. SALAKO: If you put the whole group  
11 together, then we're looking at almost 30,  
12 40 percent of our patients will be Medicaid as of  
13 today.

14 MEMBER GOYAL: Okay.

15 So I will ask Mr. Constantino, do you  
16 remember getting that impression, what percentage  
17 is Medicaid --

18 MR. CONSTANTINO: I --

19 MEMBER GOYAL: -- total?

20 Or is it -- is this the number?

21 MR. CONSTANTINO: That's the information  
22 that was provided to us by the Applicants, yes,  
23 Doctor.

24 MEMBER GOYAL: All right.

1 MR. CONSTANTINO: I don't -- that's the  
2 only number we have, is what is in that report,  
3 yes.

4 MEMBER GOYAL: So "Medicaid managed care"  
5 is Medicaid?

6 DR. SALAKO: Yes. So for all intents --

7 THE COURT REPORTER: Wait. You need your  
8 microphone, please.

9 DR. SALAKO: For all intents and purposes,  
10 we segregate that out. But if we include the  
11 Medicaid managed plans into it, then our numbers  
12 probably could be as high as 30 or 40 percent.

13 MEMBER GOYAL: Okay.

14 I have one other question, Madam Chair, if  
15 I may.

16 CHAIRWOMAN OLSON: Yes.

17 MEMBER GOYAL: And that is, could you tell  
18 the Board what your procedures might be when you  
19 get a new dialysis patient.

20 How do you sort out what kind of  
21 documentation you perform to determine if this  
22 patient is suitable for home dialysis? Plus, what  
23 procedures do you use to make sure the patient is  
24 appropriate or not appropriate for

1 transplantation?

2 DR. SALAKO: First of all, it's about  
3 patient choice, and it starts with patient  
4 education. An educated patient makes an educated  
5 choice.

6 So depending on where the patient is seen.  
7 As I say, is the patient seen by the physician in  
8 the clinic? Or is the patient seen by the  
9 physician in the hospital?

10 At whatever point, if the patient is seen  
11 pre-ESRD, we have a very robust patient education  
12 plan where we provide treatment options for the  
13 patient and we tell the patient, "These are the  
14 modalities that are available to you, these are  
15 the kinds of support you will get," and those  
16 alternatives in terms of treatment options would  
17 include transplant, obviously.

18 So we painstakingly educate the patients  
19 along what is available to them. You'll be very  
20 surprised the number of patients on dialysis who  
21 have transferred to us from other providers who  
22 will tell you things like "I never knew there was  
23 something called peritoneal dialysis" and they've  
24 been on dialysis for two or three years. Okay?

1           So we painstakingly educate our patients  
2     to make an informed choice. Once we work with the  
3     patients, family members, their support team, we  
4     really say, "Listen. If -- based on where we --  
5     what you would like to do, we will give you all  
6     the care and support that you need."

7           And invariably, when the patients are  
8     educated, the percentage of patients that will  
9     take a home therapy increases tremendously, you  
10    know, as compared to the uneducated patient. You  
11    know, patients tell you things like, "Oh, I can't  
12    do home dialysis -- home therapy because" -- for  
13    instance -- "I don't have a caregiver." Well --  
14    you know, or "My house is too small," all sorts of  
15    different reasons.

16          And you work with the patients. You work  
17    with them to educate them. You look at their  
18    operational or situational contingencies, and you  
19    really try to provide for them what both you  
20    and -- both the physicians and the nursing team  
21    and the care team and the patients feel is the  
22    best therapy for them.

23          And once you do that, a happy patient --  
24    your patient's first -- is a successful patient.

1     Their outcomes are better. It's bad enough being  
2     on dialysis. But if you have a care team that  
3     really works with the patient, you'd be amazed  
4     about how well you can get a patient to do.

5             One other thing: In terms of transplants,  
6     every patient gets educated on transplant. And,  
7     you know, every patient gets -- we sign the  
8     patients up with transplant centers at Loyola,  
9     Christ Hospital, all across the state, and the  
10    patients get the required education. They get on  
11    the transplant list. They get transplant triaged.  
12    And once they get transplant triaged as needed, a  
13    healthy percentage of our patients do get  
14    transplanted, and we're really happy for them when  
15    they do get transplanted.

16            MEMBER GOYAL: Could you -- that's a great  
17    answer, and I appreciate the education.

18            Could you estimate what percentage of your  
19    new chronic kidney disease patients end up getting  
20    a transplant versus dialysis?

21            DR. SALAKO: I don't have the data for  
22    2017, but I believe our data for 2016 is about  
23    6.5 to 7 percent. But, you know, I'll have to get  
24    back with you with the exact numbers.



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1 MEMBER GOYAL: Thank you.

2 CHAIRWOMAN OLSON: Other questions?

3 Comments?

4 (No response.)

5 CHAIRWOMAN OLSON: Seeing none, I would  
6 ask for a roll call vote.

7 MR. ROATE: Thank you, Madam Chair.

8 Pardon my question. Can you remind me who  
9 made the motion and who seconded?

10 CHAIRWOMAN OLSON: Didn't you make the  
11 motion, Marianne?

12 MEMBER MURPHY: I did.

13 CHAIRWOMAN OLSON: And who down here  
14 seconded?

15 MEMBER BURZYNSKI: (Indicating.)

16 MR. ROATE: Thank you.

17 Motion made by Ms. Murphy; seconded by  
18 Senator Burzynski.

19 Senator Burzynski.

20 MEMBER BURZYNSKI: Based on the  
21 information we've received this afternoon, I will  
22 support the proposal. Aye.

23 MR. ROATE: Thank you.

24 Ms. Hemme.

1           MEMBER HEMME: I don't feel that the  
2 financial information was sufficient enough, and  
3 so I vote no.

4           MR. ROATE: Thank you.

5           Mr. McGlasson.

6           MEMBER MC GLASSON: I agree that -- with  
7 some hesitancy on the financial information, but  
8 I don't know what the downside is of -- they're  
9 not serving patients right now in a facility if we  
10 deny it. If they ultimately have financial  
11 problems, then they don't serve patients then,  
12 either.

13           So I think I like the idea that they are  
14 trying to break new ground and I'll support that.

15           MR. ROATE: Thank you.

16           Mr. McNeil.

17           MEMBER MC NEIL: I will vote yes because  
18 you did explain your financials. You have, what,  
19 \$10.1 million in the bank? This is a \$1.3-million  
20 project. Therefore, you have cash on hand.

21           MR. ROATE: Thank you.

22           Ms. Murphy.

23           MEMBER MURPHY: I'm going to vote yes for  
24 the reasons just stated.

1 MR. ROATE: Thank you.

2 Mr. Sewell.

3 VICE CHAIRMAN SEWELL: I vote no.

4 This is an application that could receive  
5 my support if they had answered the questions  
6 asked by the State agency.

7 If you -- if we request referral letters,  
8 give us referral letters. If we ask for financial  
9 ratios, give us financial ratios. They didn't do  
10 that.

11 So I vote no.

12 MR. ROATE: Thank you.

13 Madam Chair.

14 CHAIRWOMAN OLSON: With a little bit of  
15 trepidation, I'm going to vote yes here because I  
16 do believe that this is a model that offers an  
17 alternative patient choice, increased access.  
18 There is a 75-station need, and there was no  
19 opposition to the project.

20 So I vote yes.

21 MR. ROATE: Thank you, Madam Chair.

22 That's 5 votes in the affirmative, 2 in  
23 the negative.

24 CHAIRWOMAN OLSON: The motion passes.

1       Congratulations.

2       MR. SHAZZAD:   Thank you.

3       DR. CHOPRA:    Thank you.

4       DR. SALAKO:    Thank you.

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1 CHAIRWOMAN OLSON: Next, we have  
2 Project 17-053, DaVita Ford City Dialysis.

3 May I have a motion to approve  
4 Project 17-053, DaVita Ford City Dialysis, to  
5 establish a 12-station ESRD facility.

6 MEMBER BURZYNSKI: So moved.

7 CHAIRWOMAN OLSON: Second, please.

8 MEMBER MURPHY: Second.

9 CHAIRWOMAN OLSON: The Applicant will be  
10 sworn in, please.

11 THE COURT REPORTER: Would you raise your  
12 right hands, please.

13 (Three witnesses sworn.)

14 THE COURT REPORTER: Thank you. And  
15 please print your names on the sheet.

16 CHAIRWOMAN OLSON: Mr. Constantino.

17 MR. CONSTANTINO: Thank you, Madam Chair.

18 The Applicants propose to establish a  
19 12-station ESRD facility in 7,000 gross square  
20 feet of leased space at a cost of \$3 1/2 million.

21 The expected completion date is  
22 August 31st, 2019. There was no opposition, no  
23 public hearing, and no findings.

24 CHAIRWOMAN OLSON: Thank you,

1 Mr. Constantino.

2 In light of that report, would you like  
3 to -- do you have some comments? Please.

4 MR. BHATTACHARYYA: Yes. I just wanted to  
5 introduce myself. I'm the new division vice  
6 president at DaVita, so I wanted to introduce  
7 myself to the Board.

8 CHAIRWOMAN OLSON: A new table -- a new  
9 face at the table.

10 MR. BHATTACHARYYA: That's right.

11 And given the fully positive State agency  
12 report, I'll keep my comments brief.

13 But I just want to give just a brief  
14 overview of the dialysis market here in Chicago,  
15 especially for the new members here.

16 As you-all know, kidney disease is a major  
17 health burden in the United States. About  
18 30 percent are -- excuse me -- 30 million, about  
19 15 percent of US adults, are afflicted with that  
20 disease, and this often progresses to end stage  
21 renal disease where these patients need treatment  
22 three times a week, 52 weeks a year to stay alive.  
23 And the name of my company, DaVita, actually means  
24 "to give life," which is what our men and women in

1 our clinics do every single day.

2 And so because of the frequency of that  
3 treatment, the way we approach the market is to  
4 try and ask for a small number of stations across  
5 a wide geography in the city so that it's easily  
6 accessible for patients in those local markets.

7 And from a clinical perspective, DaVita  
8 is -- both nationally and in Chicago -- the  
9 clinical leader in terms of clinical outcomes, as  
10 verified by CMS through the five-star program and  
11 other programs.

12 So, again, I just wanted to introduce  
13 myself, and we'll be happy to take any questions.

14 CHAIRWOMAN OLSON: Thank you.

15 Questions from Board members?

16 (No response.)

17 CHAIRWOMAN OLSON: Seeing none, I'd ask  
18 for a roll call vote.

19 MR. ROATE: Thank you, Madam Chair.

20 Motion made by Senator Burzynski; seconded  
21 by Ms. Murphy.

22 Senator Burzynski.

23 MEMBER BURZYNSKI: Based on the staff  
24 reports, I vote yes.

1 MR. ROATE: Thank you.

2 Ms. Hemme.

3 MEMBER HEMME: Based on the staff reports,  
4 I vote yes.

5 MR. ROATE: Thank you.

6 Mr. McGlasson.

7 MEMBER MC GLASSON: Based on staff  
8 reports, I vote yes.

9 MR. ROATE: Thank you.

10 Mr. McNeil.

11 MEMBER MC NEIL: Based on staff reports  
12 and meeting criteria, I vote yes.

13 MR. ROATE: Thank you.

14 Ms. Murphy.

15 MEMBER MURPHY: Based on the staff report,  
16 I also vote yes.

17 MR. ROATE: Thank you.

18 Mr. Sewell.

19 VICE CHAIRMAN SEWELL: I vote yes; no  
20 findings.

21 MR. ROATE: Thank you.

22 Madam Chair.

23 CHAIRWOMAN OLSON: Yes, for reasons  
24 stated.



1 MR. ROATE: Thank you.

2 7 votes in the affirmative.

3 CHAIRWOMAN OLSON: The motion passes.

4 Congratulations.

5 And thanks for introducing yourself.

6 MS. FRIEDMAN: I'd like to think we could  
7 get a vote even if we had negative findings, so  
8 we're going to work on that.

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1 CHAIRWOMAN OLSON: Project 17-054, Lurie  
2 Children's Hospital.

3 May I have a motion to approve  
4 Project 17-054, Lurie Children's Hospital, for an  
5 expansion project in its oncology ICU department.

6 A motion, please.

7 MEMBER MURPHY: Moved.

8 CHAIRWOMAN OLSON: May I have a second.

9 VICE CHAIRMAN SEWELL: Second.

10 THE COURT REPORTER: Would you raise your  
11 right hands, please.

12 (Five witnesses sworn.)

13 THE COURT REPORTER: Thank you.

14 CHAIRWOMAN OLSON: Mr. Constantino, your  
15 report.

16 MR. CONSTANTINO: Thank you, Madam Chair.

17 The Applicants are proposing to expand  
18 inpatient hematology and oncology service with the  
19 addition of a 24-bed ICU unit adjacent to the  
20 existing 24-bed pediatric medical/surgical unit.

21 The anticipated completion date for the  
22 project is September 30th, 2020. The project cost  
23 is approximately \$27.2 million. There was no  
24 opposition to this project, no public hearing, and

1 we did have one finding related to the cost of the  
2 project.

3 Thank you, Madam Chair.

4 CHAIRWOMAN OLSON: Comments for the Board?

5 MR. MAGOON: Good morning. My name is  
6 Patrick Magoon. I have the privilege of serving  
7 as the president and chief executive officer of  
8 Ann and Robert H. Lurie Children's Hospital in  
9 Chicago.

10 With me here this afternoon is Dr. Stewart  
11 Goldman to my immediate left. Dr. Goldman is the  
12 division chief of hematology, oncology,  
13 neuro-oncology, and stem cell transplant. To his  
14 left is Mr. Eric Hoffman, senior director of  
15 facility services.

16 To my immediate right is Mr. Ralph Weber,  
17 our CON consultant, and to his right is  
18 Dr. Michelle Stephenson, our executive vice  
19 president and chief operating officer.

20 The project before you today proposes to  
21 add 24 intensive care beds dedicated to cancer  
22 care on the 17th floor of Lurie Children's  
23 Hospital. If approved, this unit will be adjacent  
24 to the existing 24-bed hematology/oncology

1 medical/surgical unit. Colocating the ICU with  
2 the existing medical/surgical units on the same  
3 floor enhances the coordination of care for cancer  
4 patients on both units, and it greatly facilitates  
5 the work of our teams, of our hematology and  
6 oncology specialists.

7           This bed expansion project addresses the  
8 need for additional ICU beds. Lurie Children's  
9 ICU patient volumes have increased by an average  
10 of 14.2 percent per year over the last  
11 seven years. Last year in May you approved our  
12 project to add 44 ICU beds on the 22nd floor to  
13 address a portion of this need.

14           In the "Alternative" section of the permit  
15 application, we referenced this 24-bed hem/onc  
16 ICU project on the 17th floor as an expanded  
17 project with the 44 ICU beds on the 22nd floor;  
18 however, we had not advanced our planning of the  
19 17th-floor project sufficiently to have included  
20 it at that time and went forward with the  
21 22nd-floor project, so here we are today  
22 requesting your approval for the beds to support  
23 the specific hematology/ oncology needs.

24           Similar to the ICU total growth, the

1 growth in our hematology/oncology medical/surgical  
2 service has increased significantly, and it has  
3 implications for the proposed ICU project.

4 Let me highlight just a few of the numbers  
5 from the application that we've submitted.

6 First, our medical/surgical hem/onc  
7 volumes have increased on average of 10.5 percent  
8 per year for the past four years. Last year we  
9 had approximately 9,500 med/surg hem/onc  
10 patient days. Over 7500 patient days were served  
11 in the 24-bed unit for an occupancy level of  
12 86 percent. As a result of the high occupancy  
13 level, over 8900 -- or pardon me -- 1,900 days  
14 spilled over to other med/surg units.

15 About 30 percent or over 2800 of these  
16 individual med/surgical patient days were ICU  
17 eligible. At this rate of growth, over 6500 ICU-  
18 eligible medical/surgical patient days are  
19 forecast for the year 2022, the second year after  
20 the project is to be completed.

21 This is an average daily census of 18 ICU  
22 patients or 75 percent occupancy over the 24 ICU  
23 beds, which exceeds the State standard of  
24 60 percent.

1           The ICU project is continued evidence of  
2           the growth that we've seen since we've moved from  
3           our Lincoln Park campus to that of our academic  
4           partner, the Feinberg School of Medicine.

5           For the past 20 years, Lurie Children's  
6           has established partner relationships with  
7           16 hospitals across northeastern Illinois. Over  
8           half or nine of these partner hospital  
9           relationships have been sustained since the  
10          Review Board approved our new hospital in  
11          February of 2008.

12          These collaborative relationships have  
13          both enhanced patient care locally -- we're able  
14          to keep children in their local community, where  
15          it's more convenient and it's more accessible, and  
16          it also provides us the opportunity to provide  
17          complex care to those children who need the  
18          tertiary referral center that we have downtown.

19          Furthermore and most importantly, the  
20          ongoing recruitment of pediatric subspecialists at  
21          Lurie Children's has provided an important  
22          referral source for physicians throughout the  
23          region.

24          Dr. Goldman will now discuss developments

1 in hematology/oncology and the need clinically for  
2 the ICU unit.

3 Dr. Goldman.

4 DR. GOLDMAN: Thank you.

5 I am really pleased and honored to be here  
6 with you today to represent our hematology/  
7 oncology staff, our patients, and families. These  
8 children, adolescents, and young adults and their  
9 families fight courageous battles.

10 The good news is that, through research  
11 and our clinical trials, that we're now having  
12 increasing chances for these children and young  
13 adults to survive. I want to talk to you just  
14 about a few of the accomplishments and exciting  
15 things that we're doing at this time.

16 I start with our trial of using the human  
17 IL 12 gene that's put in through an adenovirus,  
18 the common cold virus, done surgically for  
19 patients with high-risk brain tumors that have no  
20 operative or other curative intent.

21 As I can explain to you, the IL 12 has  
22 been like the gas pedal on our immune system, and  
23 we've tried to harness this for many years.  
24 Unfortunately, when you turn the immune system on

1 without a way to control it, the side effects of  
2 turning the immune system on outweigh the benefit  
3 of cancer-fighting therapies.

4 We now are able to regulate IL 12 by  
5 taking a pill called veledimex, which is a ligand.  
6 Without this ligand the gene will not be turned  
7 on. Lurie Children's is the first institution in  
8 the country of the planned three institutions --  
9 the other two being Dana-Farber Cancer Institute  
10 at Harvard and UC-San Francisco Children's  
11 Hospital -- to provide this therapy.

12 And when we speak about brain tumors, we  
13 think about the 8 million people in the  
14 Chicagoland area. If 18 percent of those are  
15 children, looking at our incidence of CNS tumors,  
16 we would expect about 80 patients in the  
17 Chicagoland area diagnosed a year.

18 New patients to our institution, those  
19 that are newly diagnosed or come to us after a  
20 diagnosis of brain tumor, either recurrence or for  
21 treatment, last year was between 160 to 170 new  
22 patients, so the need continues to grow for the  
23 therapies we provide.

24 Stem cell transplantation and cellular



1 therapy are areas that we have tremendous growth.  
2 We are now embarking on the world of chimeric  
3 antigen receptor T cells where we can, again,  
4 harness the body's cells to fight cancer.

5 I'm very proud to tell you that a  
6 New England Journal article will be coming out in  
7 the next few weeks led by one of our physicians,  
8 Dr. Thompson, who -- we've been able to take  
9 patients with thalassemia and, through  
10 manipulating a gene, have now made them  
11 transfusion independent and, basically, taken away  
12 from the need of constantly being near their  
13 hospitals.

14 This Bluebird trial we're now extending to  
15 young adults and soon to children with sickle cell  
16 anemia to keep them away from being transfusion  
17 dependent. We also perform bone marrow  
18 transplantation for patients who have matched  
19 donors with sickle cell anemia and  
20 transplantation.

21 Our bone marrow transplantation program  
22 has grown at a tremendous rate. This year, in  
23 this first financial quarter of 2018, we're doing  
24 approximately 25 of these procedures.

1           Last but not least -- again, our growth is  
2   important, but our ability to make sure we care  
3   for each individual child and their family with  
4   the best possible care requires a team approach.  
5   Having our unit with our specialized physicians,  
6   nurses, child life specialists, and staff is  
7   essential to delivering the very finest possible  
8   quality we can for the children we serve.

9           Thank you.

10          MR. MAGOON: So our specialty programs,  
11   such as hematology and oncology and stem cell  
12   transplant, have resulted in Lurie Children's  
13   ranking as a top children's hospital in Illinois  
14   and ranking number seventh in the country by  
15   US News and World Report. Lurie Children's is the  
16   only children's hospital in Illinois to be on the  
17   Best Children's Hospital Honor Roll for six  
18   consecutive years.

19          And as you know, we're the primary  
20   teaching site for Northwestern University's  
21   Feinberg School of Medicine, training over a  
22   hundred fellows and a hundred pediatric residents  
23   each year.

24          As you know from previous applications,

1 Lurie Children's has a special commitment to  
2 serving all of Illinois' children, including those  
3 insured by the Medicaid program. In fiscal year  
4 2017, 56 percent of our inpatient days and  
5 46 percent of our outpatient services were  
6 provided to patients covered by Medicaid or a  
7 Medicaid managed care plan.

8 This is -- as you may know, there was only  
9 one negative finding in the State report. Our  
10 \$620 cost per square foot is about \$139 above the  
11 State standard of \$481 for this project. We  
12 appreciate that the State staff report on our  
13 project includes the documentation we provided for  
14 the several reasons explaining the higher capital  
15 costs that are not found in a typical project.

16 These include construction in a high-rise  
17 building requiring dedicated elevators and  
18 maintaining positive airflow pressure to prevent  
19 pathogens from the work area from entering the  
20 adjacent medical/surgical unit serving  
21 immunocompromised hematology and oncology patients  
22 on that unit.

23 Plumbing installation needed to support  
24 the 17th floor causes description to the ceilings

1 and the finishes on the 16th floor below.  
2 Extended phasing of the project is needed to  
3 minimize disruption on the 16th floor below, our  
4 pediatric intensive care unit, and to the  
5 specialized care on the 18th floor above, which is  
6 our infusion therapy unit.

7 Eric Hoffman is here, who can offer  
8 further information regarding the details if you'd  
9 like. But, collectively, our justification  
10 explains more than the \$139 per square foot in  
11 spending above the State standard.

12 In closing, I want to thank the Illinois  
13 Health Facilities staff and Board for their  
14 excellent partnership in reviewing this project  
15 and their technical assistance, and we thank you  
16 on behalf of those that we serve for your  
17 consideration of this project.

18 CHAIRWOMAN OLSON: Thank you.

19 Are there questions from Board members?

20 (No response.)

21 CHAIRWOMAN OLSON: Seeing none, I would  
22 ask for a roll call vote.

23 MR. ROATE: Thank you, Madam Chair.

24 Motion made by Ms. Murphy; seconded by

1 Mr. Sewell.

2 Senator Burzynski.

3 MEMBER BURZYNSKI: I vote yes based on the  
4 testimony we've heard today.

5 MR. ROATE: Thank you.

6 Ms. Hemme.

7 MEMBER HEMME: Yes, based on the testimony  
8 we've heard today.

9 MR. ROATE: Thank you.

10 Mr. McGlasson.

11 MEMBER MC GLASSON: Yes, based on the  
12 testimony we've heard today.

13 MR. ROATE: Thank you.

14 Mr. McNeil.

15 MEMBER MC NEIL: Yes, based on the report  
16 and the testimony.

17 MR. ROATE: Thank you.

18 Ms. Murphy.

19 MEMBER MURPHY: Yes, based on the  
20 explanations given today for the one staff  
21 finding.

22 MR. ROATE: Thank you.

23 Mr. Sewell.

24 VICE CHAIRMAN SEWELL: Yes, for reasons

1       stated by Ms. Murphy.

2               MR. ROATE: Thank you.

3               Madam Chair.

4               CHAIRWOMAN OLSON: Yes, as well, for  
5 reasons stated by Ms. Murphy.

6               MR. ROATE: Thank you.

7               That's 7 votes in the affirmative.

8               CHAIRWOMAN OLSON: The motion passes.

9               Congratulations. Thank you for your  
10 presentation.

11              MR. MAGOON: Thank you.

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1 CHAIRWOMAN OLSON: Next, we have 17-056,  
2 Fresenius Kidney Care Galesburg.

3 May I have a motion to approve  
4 Project 17-056, Fresenius Kidney Care Galesburg,  
5 to relocate an existing 14-station ESRD facility.

6 A motion?

7 MEMBER BURZYNSKI: So moved.

8 CHAIRWOMAN OLSON: Thank you.

9 A second?

10 MEMBER HEMME: Second.

11 CHAIRWOMAN OLSON: Thank you.

12 VICE CHAIRMAN SEWELL: Did you get a  
13 second?

14 CHAIRWOMAN OLSON: Yes.

15 Please be sworn in.

16 THE COURT REPORTER: If you could ask them  
17 to leave their documents, even the later ones.

18 Would you raise your right hands, please.

19 (Two witnesses sworn.)

20 THE COURT REPORTER: Thank you.

21 CHAIRWOMAN OLSON: Mr. Constantino.

22 MR. CONSTANTINO: Thank you, Madam Chair.

23 The Applicants are proposing to  
24 discontinue an existing 14-station ESRD facility

1 in Galesburg, Illinois, and establish a 14-station  
2 replacement facility in Galesburg.

3 The cost of the project is approximately  
4 \$6.9 million, and the expected completion date is  
5 December 31st, 2019. We had one finding related  
6 to this project. There was no opposition and no  
7 public hearing.

8 Thank you, Madam Chair.

9 CHAIRWOMAN OLSON: Thank you,  
10 Mr. Constantino.

11 Comments?

12 MS. CONNOR: Yes. Thank you.

13 My name is Clare Connor, C-o-n-n-o-r,  
14 and with me is Lori Wright, W-r-i-g-h-t. I'm  
15 CON counsel to Fresenius, and Lori is the  
16 CON specialist.

17 As always, thank you to Mr. Constantino  
18 and Mr. Roate for their assistance and thank you  
19 to the Board for your time and to the new Board  
20 members for agreeing to serve on the Board.

21 As Mike said, there is no opposition.  
22 This application is simply to relocate an existing  
23 14-station facility in Galesburg, Illinois, to  
24 another location which will provide more space.



1 That is important for patient care and quality as  
2 well as staff satisfaction because our current  
3 space is quite cramped.

4 Also, we have a 24-patient home program at  
5 this location. As you've heard from a prior  
6 presentation, home therapy is a very good form of  
7 therapy for patients. It typically is associated  
8 with better outcomes and lower cost.

9 Although it's not necessarily appropriate  
10 for all patients, we do have a very busy home  
11 program, and we would like to expand it. There  
12 are patients who want to get into it, but we  
13 cannot due to the limited space for our current  
14 location.

15 The one finding that we had was on cost of  
16 the project. And Mike can correct me if I'm  
17 wrong, but that cost relates to the modernization  
18 cost. This is a new construction building that we  
19 will be leasing space in if you approve our  
20 project and we are able to relocate to it, and our  
21 modernization costs, which are the build-out costs  
22 for the space, exceeded your standard by  
23 2.6 percent.

24 Typically Fresenius projects always come

1 under what we estimate, but, nonetheless, we were  
2 over based upon the standard that is calculated to  
3 a midpoint of construction, and the standard that  
4 was used for -- or the time frame was 2018.

5 If you use 2019, we would meet your  
6 standard. And because this is new construction  
7 space, we probably will not get that space turned  
8 over to us for modernization until latter 2018,  
9 which means the midpoint of construction would be  
10 in 2019, and then we would have met your standard,  
11 although, even not meeting it, we're only  
12 2.6 percent away, so we hope you will approve the  
13 project.

14 Thank you.

15 CHAIRWOMAN OLSON: Thank you.

16 Questions from Board members?

17 (No response.)

18 CHAIRWOMAN OLSON: Seeing none, I would  
19 ask for a roll call vote.

20 MR. ROATE: Thank you, Madam Chair.

21 Motion made by Senator Burzynski; seconded  
22 by Ms. Hemme.

23 Senator Burzynski.

24 MEMBER BURZYNSKI: I vote yes based on

1 lack of opposition.

2 MR. ROATE: Thank you.

3 Ms. Hemme.

4 MEMBER HEMME: Yes, based on staff  
5 reports.

6 MR. ROATE: Thank you.

7 Mr. McGlasson.

8 MEMBER MC GLASSON: Yes, based on staff  
9 reports.

10 MR. ROATE: Thank you.

11 Mr. McNeil.

12 MEMBER MC NEIL: Yes, based on the report  
13 and the testimony here.

14 MR. ROATE: Thank you.

15 Ms. Murphy.

16 MEMBER MURPHY: Yes, based on today's  
17 testimony.

18 MR. ROATE: Thank you.

19 Mr. Sewell.

20 VICE CHAIRMAN SEWELL: I vote yes.

21 Excellent explanation for \$5.13.

22 (Laughter.)

23 MR. ROATE: Thank you.

24 Madam Chair.

1           CHAIRWOMAN OLSON: I vote yes for reasons  
2       stated.

3           MR. ROATE: Thank you.

4           That's 7 votes in the affirmative.

5           CHAIRWOMAN OLSON: Motion passes.

6           Congratulations.

7           MS. WRIGHT: Thank you.

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1 CHAIRWOMAN OLSON: Next, I would call  
2 17-057, Valley Ambulatory Surgery Center.

3 May I have a motion to approve  
4 Project 17-057, Valley Ambulatory Surgery Center,  
5 to establish an ambulatory surgery treatment  
6 center.

7 VICE CHAIRMAN SEWELL: So moved.

8 CHAIRWOMAN OLSON: Second, please.

9 MEMBER MC NEIL: Second.

10 CHAIRWOMAN OLSON: If you have written  
11 testimony, the court reporter would appreciate  
12 your leaving it if you can.

13 THE COURT REPORTER: Would you raise your  
14 right hands, please.

15 (Five witnesses sworn.)

16 THE COURT REPORTER: Thank you.

17 CHAIRWOMAN OLSON: Mr. Constantino, your  
18 report.

19 MR. CONSTANTINO: Thank you, Madam Chair.

20 The Applicants are proposing to establish  
21 a multispecialty ASTC in approximately  
22 24,530 gross square feet of leased space at a  
23 cost of approximately \$16.6 million and an  
24 expected completion date of October 31st, 2019.

1           There was opposition to this project,  
2           there was a public hearing held, and we do have  
3           findings.

4           I do apologize to the Board. I did not  
5           attach their safety net impact statement, as  
6           Mr. Vinson pointed out to us this morning.  
7           Mr. Vinson was correct.

8           However, in the -- if you look at the  
9           exemption, which is C-01, there's a detail which  
10          the Applicants provided additional information  
11          regarding charity care that Jeannie had requested  
12          back in -- or was submitted to us back in  
13          January of '18.

14          CHAIRWOMAN OLSON: Thank you,  
15          Mr. Constantino.

16          Comments for the Board?

17          MR. TAPARO: Good afternoon.

18          CHAIRWOMAN OLSON: Good afternoon.

19          MR. TAPARO: Is that fine?

20          CHAIRWOMAN OLSON: Yes, you're good.

21          MR. TAPARO: Good afternoon. My name is  
22          Tony Taparo, T-a-p-a-r-o. I'm the president of  
23          operations for the Atlantic Group at Surgery  
24          Partners.

1           Seated with me today are Jennifer Baldock,  
2           our senior vice president and general counsel;  
3           Mr. Dan Hauer, our facility administrator;  
4           Dr. Giamberdino, our facility medical director;  
5           and Dan Lawler, our CON counsel.

6           I want to thank the Health Facilities and  
7           Services Review Board members and all the staff  
8           for your time today.

9           Valley Ambulatory Surgery Center is  
10          requesting approval to relocate its multispecialty  
11          ASC in a newly constructed, steel framed, all-  
12          brick-exterior building --

13          MS. AVERY: George -- sorry. Go ahead.

14          MR. TAPARO: Go ahead?

15          MS. AVERY: Yes.

16          MR. TAPARO: -- down the street from its  
17          current location.

18          By establishing a new, state-of-the-art  
19          facility, Valley will be able to provide patients  
20          and staff a better clinical environment in a more  
21          efficient space, avoid erroneous disruption in  
22          service to the patients and physicians, and avoid  
23          exorbitant cost repairs to the existing facility.

24          The proposed new facility will consist of

1 six operating rooms, two procedure rooms with  
2 three dedicated 23-hour private recovery suites.  
3 The project will not increase operating rooms or  
4 add new categories of service, and no area health  
5 care providers have opposed our application.

6 In 2017 Valley performed 7,312 surgical  
7 cases. As I previously mentioned, the current  
8 building is 30 years old and now outdated and  
9 simply no longer suitable as an ambulatory surgery  
10 center.

11 The extensive repairs and upgrades needed  
12 would cause lengthy facility closures and a major  
13 disruption of patient care, interfere with  
14 physicians' ability to schedule surgical  
15 procedures, harm employee morale, and would still  
16 not meet the current standards for today's ASCs.

17 I would like to acknowledge and thank the  
18 broad-based supporters of this project: The Mayor  
19 of St. Charles, the Kane County Board chairman,  
20 State Representatives from the 49th, 50th, and  
21 65th districts, the State Senators from the 25th  
22 and 33rd districts, the executive director from  
23 the Kane County Health Department, and the  
24 St. Charles Chamber of Commerce.



1           Again, I want to thank the CON Board and  
2           the staff for the time and the opportunity to  
3           present this project, as we will continue to be  
4           the low cost, high quality care provider to  
5           patients in St. Charles and the surrounding  
6           communities for the next 30 years.

7           Mr. Hauer and Dr. Giamberdino will address  
8           the specific reasons for this relocation project,  
9           and Mr. Lawler will then address the findings of  
10          the staff report.

11          Thank you.

12          MR. HAUER: Good afternoon. My name is  
13          Daniel Hauer, H-a-u-e-r.

14          Can you hear me?

15          CHAIRWOMAN OLSON: Closer.

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

17          MR. HAUER: Good afternoon. My name is  
18          Daniel Hauer, H-a-u-e-r. I'm the administrator  
19          for Valley Ambulatory Surgery Center.

20          I'd like to thank everyone here today for  
21          their ongoing commitment to ensure patients  
22          maintain access to health care services in our  
23          state.

24          Now a little history of Valley Ambulatory

1     Surgery Center: Valley was founded in 1987 by a  
2     group of physicians with a vision that outpatient  
3     surgery can be safely performed outside of the  
4     traditional hospital delivery model, where true  
5     one-on-one experiences can happen and physician-  
6     to-patient approaches would allow for  
7     individualized, patient-centered treatment plans.

8             30 years and more than 110,000 patients  
9     later, here we are. We have earned a strong  
10    reputation in the Fox Valley as the place for  
11    elective surgery with some of the best quality  
12    outcomes in the nation. Valley is requesting a  
13    CON permit to relocate to a new state-of-the-art  
14    facility down the street from our current  
15    location.

16            Since 1987 health care standards and  
17    patient expectations have evolved dramatically.  
18    For example, our current building construction and  
19    electrical infrastructure are based on codes that  
20    are from the 1980s. Another example is our  
21    plumbing infrastructure that is failing due to  
22    corrosion and age.

23            In addition, compliance with the American  
24    Disability Act is an ever-growing challenge and

1 concern. Many areas of the building are still  
2 behind the times, from accessible doors, toilets,  
3 sinks. Even the grade of our parking lot and  
4 walkways are not compliant.

5 As for the expectation and demand of  
6 today's surgical patient, there is a need for  
7 larger operating rooms to accommodate higher  
8 acuity cases. Moreover, patients expect health  
9 care facilities to offer a modern and  
10 accommodating atmosphere where amenities are  
11 plentiful and privacy is maintained.

12 In summary, this request for our  
13 relocation is a testament of our continued  
14 commitment to the community and should be  
15 perceived as nothing more than an opportunity to  
16 offer patients a state-of-the-art surgery center  
17 where safety and preparedness meet welcoming and  
18 convenient.

19 Please approve this project. Thank you  
20 for your time today.

21 CHAIRWOMAN OLSON: Thank you.

22 DR. GIAMBERDINO: Good afternoon. I'm  
23 Anthony Giamberdino, G-i-a-m-b-e-r-d-i-n-o. I'm a  
24 physician.

1           My perspective on this CON application is  
2   informed by long firsthand experience with this  
3   center. I've been a full-time staff  
4   anesthesiologist at Valley Ambulatory for  
5   27 years. For the past 10 years I've served as  
6   the center's medical director and chief of  
7   anesthesia services, so there's probably no one in  
8   a better position to assess the abilities and  
9   limitations of this building than I am.

10           I also have the unique perspective on this  
11   CON because, while serving as the VASC medical  
12   director, I'm also one of the co-owners of the  
13   building and, thus, part of the landlord group.  
14   In other words, I have a financial interest in  
15   seeing the center stay in its current building,  
16   but, you know, based on what I see with the  
17   building and my ability to take good care of my  
18   patients, I have to go with my patients' interest  
19   first, and I think this building has way outlived  
20   its usefulness. So I'm here today to express my  
21   strong support for this application.

22           As stated before, the building is 30 years  
23   old and is currently not suitable for use as an  
24   ASC. One of our chief problems is there's been

1 multiple evolutions in the life safety code and  
2 infection control guidelines over the last  
3 30 years, and this building is just not positioned  
4 to keep up with those changes and meet those  
5 standards. It's becoming progressively more  
6 difficult to get through an accreditation survey  
7 based on the physical plant.

8 As Daniel stated, the current building is  
9 not handicapped-accessible in accordance with the  
10 current ADA recommendations. Our sterile  
11 processing work space is not separated into clean  
12 and dirty instrument areas, and the loading dock  
13 is not designed to protect the integrity of  
14 medical products.

15 The infrastructure of the current building  
16 has numerous serious electrical and plumbing  
17 deficiencies and is not cabled for modern IT  
18 needs. More importantly, we've had leaking fire  
19 sprinkler lines and a malfunctioning fire alarm  
20 that has actually resulted in false alarms and  
21 closing the center for periods of time, meaning  
22 cancellations of people's surgeries and delaying  
23 of their care.

24 Staff lockers do not connect directly to

1 the sterile corridor, as is required to prevent  
2 one way -- to preserve one-way flow of traffic  
3 from nonsterile to sterile areas of the facility.

4 The building exterior requires extensive  
5 roofing and foundation repairs. The main entrance  
6 and the interior have significant layout problems  
7 that can only be addressed through teardown and  
8 reconstruction. I could go on.

9 To avoid the long-term interruption in  
10 patient care that would be required to gut the  
11 place and do a massive rebuilding, Valley plans to  
12 relocate to a new steel-frame building with less  
13 total square footage and a more efficient and  
14 modern design. The new facility would be just a  
15 quarter mile from our current facility.

16 The new facility would be convenient for  
17 patients and staff, compliant with current codes  
18 and best practices, and feature a cost-efficient  
19 layout with new mechanical and electrical systems.

20 Moreover -- and I think importantly going  
21 forward -- this new building would be much better  
22 suited to adapt to life safety and infection  
23 control guidelines as they evolve in the future.  
24 I think we've adapted our building as far as it

1 can be adapted.

2 Valley has an outstanding clinical staff.  
3 We urgently need a modern facility to meet the  
4 outpatient surgical needs of the greater  
5 St. Charles area for years to come. I respectfully  
6 urge your favorable consideration for this CON  
7 application.

8 Thank you for your time.

9 CHAIRWOMAN OLSON: Thank you.

10 MR. LAWLER: Thank you.

11 Good afternoon. My name is Dan Lawler.  
12 I'm a partner with the law firm of Barnes &  
13 Thornburg, and I'd like to respond to the  
14 negatives in the staff report on this project.

15 As your general counsel, Ms. Mitchell,  
16 knows, I've been thinking and writing a lot about  
17 the effect of negatives in the staff report. In  
18 fact, I've been thinking and writing a lot about  
19 that for a long time. I've been involved in over  
20 20 court cases relating to CON permits over  
21 the years. Present circumstances notwithstanding,  
22 I'm on the Board's side more often than not in  
23 those cases.

24 But whether I'm on the Board's side or on

1 the other side, I've always taken a consistent  
2 position as to the effect of negatives in a staff  
3 report. I've always taken the position that the  
4 Board has discretion to approve projects that have  
5 negative findings in the staff report. The Board  
6 rules allow that, and the Courts have long  
7 recognized that discretion.

8 People have different ways of thinking  
9 about this discretion. And the way I look at it  
10 is that Mr. Constantino and the staff strictly  
11 apply the law, while the Board can apply grace.  
12 It doesn't have to, but it has the discretion and  
13 the authority to.

14 Another way to look at it is that  
15 Mr. Constantino and the staff apply the letter of  
16 the law jot and tittle, and this Board can follow  
17 the spirit of the law. That is a principle the  
18 Courts recognize, as well.

19 The statutory language of the Planning Act  
20 is that a project must be in accord with the  
21 Board's criteria, and Courts have said that "in  
22 accord with" means the same thing as "substantial  
23 conformance." Courts have also interpreted the  
24 term "substantial compliance" to mean such



1 compliance as will assure that the beneficial  
2 effect of the rule will be achieved.

3 In other words, is the purpose behind the  
4 rule being achieved? Is the spirit of the law  
5 fulfilled? And if it is, this Board has the  
6 discretion and authority to approve a project.

7 The Valley Ambulatory project fulfills the  
8 letter of the law on the large majority of the  
9 criteria and the spirit of the law as to the  
10 others. The negatives relate to our utilization,  
11 the utilization of other facilities, and a few  
12 financial criteria.

13 I'll take the last first. The purpose of  
14 the financial criteria are to determine whether  
15 the project is financially viable. If a facility  
16 isn't going to be financially viable, it should  
17 not be built.

18 Valley Ambulatory Surgery Center has  
19 demonstrated its financial viability by virtue of  
20 the fact that it has been in operation for  
21 30 years. The center is financially viable, and  
22 its financial viability will be enhanced by this  
23 project in a number of significant ways.

24 First, a new, modern facility will be less

1     costly to operate. Second, our lease payments  
2     will be significantly less. And, third, when we  
3     relocate, we will be discontinuing the  
4     postsurgical recovery care demonstration program  
5     that we have been operating and has been a net  
6     loss on our financial operations.

7             Most operators that participated in this  
8     demonstration program have already discontinued  
9     their own recovery care centers for financial  
10    reasons. We will be discontinuing ours.

11            Valley Ambulatory has demonstrated its  
12    financial viability for three decades, and this  
13    project will improve its financial operations. It  
14    fulfills the purpose of the financial viability  
15    criteria.

16            Regarding the utilization criteria, there  
17    are at least two purposes behind this: First, the  
18    Board has a policy that health care facilities  
19    should ideally operate at a minimum target  
20    utilization rate. Every facility has fixed  
21    operating costs, and the higher the utilization,  
22    the lower operating costs per unit of service.  
23    Lowering health care costs is an important goal of  
24    the Planning Act.

1           A second purpose behind the utilization  
2     target is to avoid unnecessary duplication of  
3     services. That's another important goal in the  
4     Planning Act. When there are lots of area  
5     facilities with excess capacity and  
6     underutilization, the creation of more capacity  
7     and more underutilization could result in the  
8     unnecessary duplication of health care facilities,  
9     contrary to the purposes of the Act.

10          The Valley Ambulatory project will not  
11     reduce utilization at existing facilities, and it  
12     will not be an unnecessary duplication of  
13     services. Courts have recognized that one of the  
14     easiest ways to tell if a project will impact  
15     existing facilities by reducing their utilization  
16     is that those facilities will show up and object  
17     to the project and ask this Board to deny it.

18          Here, not one existing provider has  
19     objected to this application. We notified every  
20     provider within 45 minutes' travel time, told them  
21     exactly what we're doing. Not one of them opposes  
22     this project.

23          Another factor the Courts recognize that  
24     directly impacts the utilization criteria is

1     whether a project involves a new facility that  
2     expands services and adds to capacity or whether  
3     it is simply a relocation project without  
4     expansion. In a court case very much like our  
5     project, a surgery center in Hinsdale was  
6     relocating its existing facility without  
7     expansion.

8             Unlike ours, they had other providers show  
9     up and object and then challenge the Board's  
10    approval because there were negative findings in  
11    the staff report under the utilization and  
12    unnecessary duplication criteria.

13            The Court upheld the Board's decision to  
14    issue the permit and specifically noted that the  
15    Applicant was not seeking permission to increase  
16    capacity in its facility and noted that relocation  
17    without expansion is different from expansion of  
18    capacity. Under these circumstances, the Court  
19    held that approval of the permit was within the  
20    Board's discretion.

21            Like the Hinsdale project, we are  
22    relocating without expanding. In addition, we  
23    have no providers objecting, as they did.

24            Finally, regarding our own utilization,

1 the criteria require us to project that we will  
2 hit target utilization within the second year of  
3 operation. Our facility has tremendous growth in  
4 cases last year, and we documented that in the  
5 application.

6 We had 22 percent increase in just the  
7 last 12 months. In projecting our utilization, we  
8 did not use 22 percent or 20 or 10 or even 5.  
9 With just a 3.8 percent growth rate, we will be at  
10 target utilization, and that is what we used in  
11 our projections.

12 This morning you heard a persistent  
13 opponent, Mr. Sam Vinson. I know Sam Vinson. My  
14 old law firm and his old law firm were in the same  
15 brick building, and Sam would regularly hold court  
16 in the bar in our atrium after-hours. I would  
17 occasionally stop in, order an iced tea, and hear  
18 the most incredible stories from Sam Vinson, but  
19 I never heard such an incredible story as the  
20 landlord in St. Charles who suddenly developed a  
21 passion for safety net services in Kane County.

22 Maybe that landlord is really interested  
23 in the revenue stream from his 30-year-old  
24 wood-frame building that is not ADA compliant and

1 not safety code compliant, but if he is concerned  
2 about the safety net, let me put his mind at ease.  
3 This project will have no impact on the safety  
4 net. We know this because not one provider has  
5 claimed that the project will have an effect on  
6 their safety net services. They all received  
7 notice of this project; they identified no adverse  
8 impact. The safety net is safe.

9 We have a good project here; it meets the  
10 letter of the law on the large majority of  
11 criteria and the spirit of the law on the criteria  
12 for which negative findings were made. This  
13 project is well within your discretion to approve,  
14 and we respectfully request your approval today.

15 CHAIRWOMAN OLSON: Thank you.

16 Questions from Board members?

17 (No response.)

18 CHAIRWOMAN OLSON: So -- go ahead,  
19 Mr. Sewell.

20 VICE CHAIRMAN SEWELL: I have more of a  
21 comment since CON counsel moved over into teaching  
22 mode.

23 I've got --

24 CHAIRWOMAN OLSON: Can you use your mic?

1           VICE CHAIRMAN SEWELL: Yes.

2           I have some experience with the Courts,  
3 also, because years ago -- too many to count --  
4 I was a health system agency director for suburban  
5 Cook and DuPage County. And we said no to a  
6 project and this Board then said yes, and we  
7 prevailed in court because the Court ruled that a  
8 State agency must follow its own rules when the  
9 rule is a clear, unambiguous rule. So that's sort  
10 of a -- I don't know -- punctuation on some of  
11 your remarks.

12           Also, we've all recognized that there's a  
13 distinction between the needs of an institution  
14 versus the needs of a community. All the time  
15 what's good for an institution are not necessarily  
16 good for, you know, a community, and I think  
17 that's where our discretion comes in. We can't  
18 act as if we're Board members of an institution.  
19 We're Board members of a system, and we have to  
20 think about the system.

21           So I'm not disagreeing with anything  
22 you've said. I just think we need some periods  
23 and commas and exclamation points on some of the  
24 things you said.

1           Also, on this financial viability  
2           criterion that you mentioned, one of the problems  
3           there was, yeah, you didn't meet the cushion  
4           ratio, but the State agency report said that you  
5           didn't provide some of the financial ratio  
6           information for it to be evaluated one way or  
7           another. And that's difficult for us, too.

8           So -- any comments on that?

9           MR. LAWLER: Yes. I'll have Mr. Taparo  
10          address that.

11          We did provide the entire Form 10K for  
12          Surgery Partners, which has their-- everything  
13          that they can disclose about their financials.  
14          The ratios that were not provided -- or that were  
15          not satisfied -- relate to the surgery -- the  
16          surgery center's financials at their level.

17          But Surgery Partners is also supporting  
18          this project, and, as I indicated, the project has  
19          been financially viable for 30 years.

20          But, Tony, could you address the financial  
21          resources of Surgery Partners?

22          MR. TAPARO: Yes.

23          As Dan indicated, we did file the K-1.  
24          Our financials are strong as a company, and



1 we've -- financially, we've got bank support, and  
2 we have our company support.

3 So it's a very financially viable project,  
4 and we've got financial commitments both from the  
5 banks and from our corporate office.

6 VICE CHAIRMAN SEWELL: My concern is much  
7 more narrow than that. It's absent financial  
8 ratios, not so much whether you're financially  
9 viable overall.

10 Am I correct that one or two of the --

11 MR. CONSTANTINO: Yeah.

12 VICE CHAIRMAN SEWELL: -- ratios we asked  
13 for just weren't provided?

14 MR. CONSTANTINO: Yeah. The Applicants  
15 are required to provide the financial ratios. And  
16 they did in one case and they didn't in another.

17 And Surgery Partners could only disclose  
18 what Mr. Lawler said because they're traded on --  
19 I don't know what exchange.

20 What exchange are you traded on?

21 MR. TAPARO: NASDAQ.

22 MR. CONSTANTINO: Pardon?

23 MR. TAPARO: NASDAQ.

24 MR. CONSTANTINO: NASDAQ.

1           MR. TAPARO: So there was certain  
2 information that we were not at liberty to  
3 provide.

4           VICE CHAIRMAN SEWELL: And can you say  
5 that --

6           MR. TAPARO: But we did provide the  
7 complete K-1 and our completed financials as of  
8 12/31/2016.

9           VICE CHAIRMAN SEWELL: Can you say that  
10 the ones that you could not provide were the ones  
11 that were absent?

12           In other words, this NASDAQ limitation  
13 that was on you, that led you to not provide some  
14 of the ratios that were asked for?

15           That's what I'm trying to get at.

16           MR. LAWLER: Right. So based upon the  
17 information that could be disclosed, the ratios  
18 could not be calculated. So -- yeah.

19           VICE CHAIRMAN SEWELL: All right. Okay.

20           CHAIRWOMAN OLSON: Other questions or  
21 comments?

22           (No response.)

23           CHAIRWOMAN OLSON: So just to clarify --

24           VICE CHAIRMAN SEWELL: No.

1 CHAIRWOMAN OLSON: So I just wanted to  
2 clarify.

3 There's -- you're not changing the number  
4 of ORs? You're simply relocating your current  
5 number of ORs to a new site based on the building  
6 that's outdated?

7 MR. LAWLER: That's correct. It's not  
8 increasing. In fact, we're reducing one OR and  
9 increasing one procedure room.

10 CHAIRWOMAN OLSON: Okay.

11 MR. LAWLER: And so everybody's clear, we  
12 actually have two applications. One is to  
13 discontinue the existing and then to --

14 CHAIRWOMAN OLSON: Right.

15 MR. LAWLER: -- establish the other.

16 CHAIRWOMAN OLSON: All right.

17 Any other questions or comments?

18 (No response.)

19 CHAIRWOMAN OLSON: Seeing none, I would  
20 ask for a roll call vote.

21 MR. ROATE: Thank you, Madam Chair.

22 Motion made by Mr. Sewell; seconded by  
23 Mr. McNeil.

24 Senator Burzynski.

Transcript of Full Meeting  
Conducted on February 27, 2018

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1           MEMBER BURZYNSKI: Based on what I perceive  
2 as the trade-offs of being able to move to a  
3 new facility and the benefits to the patients,  
4 I vote yes.

5           MR. ROATE: Thank you.

6           Ms. Hemme.

7           MEMBER HEMME: I vote yes based on those  
8 stated reasons.

9           MR. ROATE: Thank you.

10          Mr. McGlasson.

11          MEMBER MC GLASSON: I vote yes.

12          It seems to me to be more of a  
13 modernization, even, than a relocation.

14          MR. ROATE: Thank you.

15          Mr. McNeil.

16          MEMBER MC NEIL: I vote yes because it's a  
17 30-year improvement. All of us maybe have been  
18 better 30 years ago but buildings aren't.

19          (Laughter.)

20          DR. GIAMBERDINO: Thank you.

21          MR. ROATE: Thank you.

22          Ms. Murphy.

23          MEMBER MURPHY: I vote yes based on all of  
24 the information contained in the report, the

1 information we heard at the hearing, and the  
2 explanations given today.

3 MR. ROATE: Thank you.

4 Mr. Sewell.

5 VICE CHAIRMAN SEWELL: I vote no, failure  
6 to meet projected utilization, service demand,  
7 treatment room need assessment, service  
8 accessibility, unnecessary duplication of  
9 services, and financial viability.

10 MR. ROATE: Thank you.

11 Madam Chair.

12 CHAIRWOMAN OLSON: I vote yes based on the  
13 fact that it's a relocation. If it was a new  
14 project, it would be more difficult for me to  
15 approve.

16 MR. ROATE: Thank you.

17 That's 6 votes in the affirmative, 1 vote  
18 in the negative.

19 CHAIRWOMAN OLSON: The motion passes.

20 MR. LAWLER: Thank you.

21 MR. TAPARO: Thank you.

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1 CHAIRWOMAN OLSON: And I think you're just  
2 going to stay there. Right?

3 MR. LAWLER: I'm sorry?

4 CHAIRWOMAN OLSON: We're going to do your  
5 exemption --

6 MR. LAWLER: Oh, that's right.

7 CHAIRWOMAN OLSON: -- so don't go  
8 anywhere. You're not done yet.

9 Valley Ambulatory Surgery. This is 048-17.

10 May I have a motion to approve  
11 Exemption 048-17, Valley Ambulatory Surgery  
12 Center, to discontinue an ASTC.

13 May I have a motion, please.

14 MEMBER BURZYNSKI: So moved.

15 CHAIRWOMAN OLSON: A second?

16 MS. MURPHY: Second.

17 CHAIRWOMAN OLSON: So am I correct that  
18 this discontinuation -- all that's required of the  
19 Applicant is to provide all the necessary  
20 information and the Board has to approve it?

21 MR. CONSTANTINO: That's right. That's  
22 correct.

23 CHAIRWOMAN OLSON: And your report would  
24 be that --

1 MR. CONSTANTINO: -- all the information  
2 was required.

3 CHAIRWOMAN OLSON: Okay.

4 Then I would ask for a roll call vote.

5 MR. ROATE: Thank you, Madam Chair.

6 Motion made by Senator Burzynski; seconded  
7 by Ms. Murphy.

8 Senator Burzynski.

9 MEMBER BURZYNSKI: I vote yes based on the  
10 fact that all the required information was  
11 presented.

12 MR. ROATE: Thank you.

13 Ms. Hemme.

14 MEMBER HEMME: Yes, based on the staff  
15 reports and previously stated reasons.

16 MR. ROATE: Thank you.

17 Mr. McGlasson.

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

20 MR. ROATE: Thank you.

21 Mr. McNeil.

22 MEMBER MC NEIL: Yes, based on the staff  
23 report.

24 MR. ROATE: Thank you.

1 Ms. Murphy.

2 MEMBER MURPHY: Yes, based on reasons  
3 previously stated.

4 MR. ROATE: Thank you.

5 Mr. Sewell.

6 VICE CHAIRMAN SEWELL: Yes, reasons  
7 already stated.

8 MR. ROATE: Thank you.

9 Madam Chair.

10 CHAIRWOMAN OLSON: Yes. The Applicant met  
11 the criteria.

12 MR. ROATE: Thank you.

13 That's 7 votes in the affirmative.

14 CHAIRWOMAN OLSON: The motion passes.

15 MR. LAWLER: Thank you.

16 DR. GIAMBERDINO: Thank you.

17 MR. TAPARO: Thank you.

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1 CHAIRWOMAN OLSON: Next, we have  
2 Project 17-058, Premier Cardiac Surgery Center.  
3 May I have a motion to approve  
4 Project 17-058, Premier Cardiac Surgery Center, to  
5 establish a limited specialty ambulatory surgery  
6 treatment center.  
7 A motion, please.  
8 MEMBER MURPHY: Motion.  
9 VICE CHAIRMAN SEWELL: Second.  
10 MEMBER MC NEIL: Second.  
11 THE COURT REPORTER: Would you raise your  
12 right hands, please.  
13 (Five witnesses sworn.)  
14 THE COURT REPORTER: Thank you.  
15 CHAIRWOMAN OLSON: Mr. Constantino, your  
16 report, please.  
17 MR. CONSTANTINO: Thank you, Madam Chair.  
18 The Applicants are proposing to establish  
19 a limited specialty ambulatory surgical treatment  
20 facility in Merrionette Park at a cost of  
21 \$1.2 million. The project completion date is  
22 December 31st, 2018.  
23 The Applicants have asked us to increase  
24 the project completion date to December 31st,

1 2018.

2 CHAIRWOMAN OLSON: You mean 2019?

3 MR. CONSTANTINO: There was no public  
4 hearing requested.

5 MR. HYLAK-REINHOLTZ: '18, two months.

6 MR. CONSTANTINO: There was no opposition  
7 and there were findings on this project.

8 CHAIRWOMAN OLSON: What are we increasing  
9 the date to?

10 MR. CONSTANTINO: The date of completion,  
11 from October 31st, 2018, to December 31st, 2018.

12 CHAIRWOMAN OLSON: Okay. Thank you.

13 Okay. Comments for the Board?

14 DR. KINDER: Good afternoon, Chairperson  
15 Olson and other distinguished members of the State  
16 Board.

17 My name is Dr. Charles Kinder, K-i-n-d-e-r.

18 I'm here on behalf of Premier Cardiac Surgery  
19 Center and Heart Care Centers of Illinois, the  
20 Coapplicants on this project. I'm a physician,  
21 board certified in cardiology and  
22 electrophysiology, which is heart rhythm.

23 I'm here today asking you to grant a CON  
24 permit for our proposed single-specialty

1 ambulatory surgical treatment center which will be  
2 located in Merrionette Park, Illinois,  
3 approximately 115th and Kedzie.

4 At the table I'm joined to my immediate  
5 left by our attorney and CON consultant, Joseph  
6 Hylak-Reinholtz; to his left, Mark Berlin, our  
7 chief operating officer of Heart Care Centers of  
8 Illinois. And two other physicians are seated  
9 with us today, Drs. Robert Iaffaldano and  
10 Ron Stella, both of whom can speak today if  
11 necessary.

12 If you'd permit me to do so, I'd like to  
13 provide a brief summary of the project before  
14 taking any questions.

15 CHAIRWOMAN OLSON: Please. Go ahead.

16 DR. KINDER: Thank you for allowing me to  
17 provide a brief summary of the project. As I  
18 already stated, we are proposing --

19 THE COURT REPORTER: Excuse me. Just --  
20 breathe just a little bit.

21 (Laughter.)

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

23 DR. KINDER: Thank you for allowing me to  
24 provide a brief summary of the project. As

1 I already stated, we are proposing the  
2 establishment of a single-specialty surgery  
3 center. We are seeking approval for the  
4 cardiovascular category of service.

5 The proposed surgery center will have one  
6 procedure room, which will be located within  
7 leased space totaling 4,172 gross department  
8 square feet. The total cost of this project is  
9 just slightly less than 1.2 million. The entire  
10 cost of the project will be funded by cash.

11 The proposed surgery center is needed for  
12 the following reasons: First of all, we want to  
13 ensure continued access to high quality cardiology  
14 care. For the last two years that this data has  
15 been kept, we've been in the top 0.8 percent -- so  
16 the 99th percentile in the country -- of both  
17 quality and efficiency as cardiology by Medicare.  
18 We want to continue to provide this access to  
19 quality cardiology care and heart rhythm  
20 procedures in our geographic service area.

21 We established Heart Care Centers of  
22 Illinois in the Blue Island area about 40 years  
23 ago. We'd like to continue to work in that area.  
24 As the Board knows, access to vital health care

1 services has been threatened as a result of  
2 significant budget cuts to Medicare reimbursement  
3 for physician office-based rates over the past  
4 couple of years. If our office-based practice is  
5 forced to close, the entire geographic service  
6 area would be without outpatient cardiac surgical  
7 care.

8 The plan to transition our office-based  
9 lab, or OBL, to a part-time/hybrid ASTC,  
10 ambulatory surgical treatment center, will provide  
11 our financial health and allow us to continue  
12 treating patients in our GSA, which includes a  
13 number of Federally designated medically  
14 underserved areas and a shortage of health care  
15 professionals.

16 Also, being able to keep our site in  
17 Merrionette Park operating successfully will  
18 ensure that our patients have a close and  
19 convenient location for outpatient cardiology  
20 care. Again, we are the only outpatient site in  
21 our GSA that provides our range of services in any  
22 type of setting outside of a hospital.

23 Second, we want to increase access to  
24 outpatient surgical care, moving more surgical

1 procedures away from hospitals and into our  
2 surgery center, which will result in significant  
3 cost savings, both to the payers and the patients.

4 As a very concrete example, the  
5 implantation of a defibrillator, which is what  
6 I do, would reimburse a hospital, by Medicare,  
7 \$32,000. At our ASTC it would be \$28,000. So in  
8 doing just 100 implantable defibrillators at our  
9 surgical site as opposed to the hospital would  
10 save Medicare, in that single year, \$4 million.

11 Likewise, the implantation of a pacemaker  
12 in a hospital pays the hospital, by Medicare,  
13 \$10,000. At our surgical site we pay \$8,000,  
14 saving \$2,000. And, again, a hundred cases in  
15 a year would be 2 million. So in just doing a  
16 hundred implantable defibrillators and a hundred  
17 pacemakers, Medicare saves \$6 million.

18 Now, on the payers' side, this is a  
19 geographically underserved area. The 20 percent  
20 copay, therefore, on \$4,000 is going to be \$800  
21 less for the patient at our surgical center for a  
22 defibrillator and \$400 less for a pacemaker.

23 For these reasons I believe there's a  
24 clear need for our proposed surgery center.

1 I urge each of you to vote yes and approve our  
2 CON permit request.

3 At this time we would be happy to answer  
4 questions. I thank you once again for your time  
5 and consideration.

6 CHAIRWOMAN OLSON: Thank you, Doctor.  
7 Questions from Board members?

8 (No response.)

9 CHAIRWOMAN OLSON: So I --

10 VICE CHAIRMAN SEWELL: I --

11 CHAIRWOMAN OLSON: Go ahead. You go  
12 first.

13 VICE CHAIRMAN SEWELL: You know, in the  
14 past we've had these ambulatory surgery treatment  
15 centers, and we don't have criteria to distinguish  
16 between sort of the specialty-type ambulatory  
17 surgery treatment centers and the others.

18 And it appears -- and either you or the  
19 staff correct me if I'm wrong -- that what we have  
20 here is a cardiovascular category of service. And  
21 I guess in a perfect world where we had criteria,  
22 we'd have them by category of service and we'd be  
23 able to look at the system that way.

24 Is that sort of framing this correctly?

1 MR. CONSTANTINO: Yes.

2 VICE CHAIRMAN SEWELL: Okay.

3 MR. CONSTANTINO: I want to make one  
4 thing -- I want to point out one thing.

5 They are not performing cardiac cath.  
6 They'd have to come back in to see you to get  
7 approval to do that.

8 VICE CHAIRMAN SEWELL: Yeah. That's  
9 another category of service.

10 MR. CONSTANTINO: Right.

11 VICE CHAIRMAN SEWELL: But it's a  
12 cardiovascular ambulatory surgery treatment  
13 center; right?

14 MR. HYLAK-REINHOLTZ: That's correct.

15 CHAIRWOMAN OLSON: And just to keep going  
16 along that same line, if I understood you  
17 correctly, Doctor, you're the only one in this  
18 area that's performing these procedures outside of  
19 a hospital setting?

20 DR. KINDER: Yes, ma'am.

21 MR. HYLAK-REINHOLTZ: I'll just expand a  
22 little bit.

23 Joseph Hylak-Reinholtz, legal counsel,  
24 H-y-l-a-k, hyphen, R-e-i-n-h-o-l-t-z.



1           My 4-year-old daughter will love to learn  
2   how to spell that when she's in kindergarten.

3           (Laughter.)

4           MR. HYLAK-REINHOLTZ: To answer your  
5   question about existing ambulatory surgery centers  
6   in our GSA, there are 37 ambulatory surgery  
7   centers. Of those 37, only 3 are approved for the  
8   cardiovascular category of service.

9           One of those was recently approved by this  
10   Board last year, Chicago Vascular. They are a  
11   single-specialty center and should meet their own  
12   capacity and wouldn't have access to take on  
13   additional cases, and they're a very narrow subset  
14   of the cardiovascular category of service.

15          There is Rush ambulatory surgery center,  
16   which is 31 minutes away from us. Although while  
17   they are approved to do cardio care, if you look  
18   at their website, they don't even a list it as an  
19   available option for their patients.

20          The same is true with Loyola ambulatory  
21   surgery center, which is 35 minutes away. Again,  
22   a very minimal amount of cardio care that they do  
23   there, maybe a couple hundred cases a year.  
24   Again, not something even advertised on their

1 website as a service for patients.

2 So we pretty much would be the only game  
3 in town in our 45-minute GSA.

4 CHAIRWOMAN OLSON: Thank you.

5 MR. CONSTANTINO: Mr. Sewell, I want to  
6 point out one other thing.

7 The Board is required to look at capacity  
8 within the 45-minute service area. Now, while  
9 there is no -- three ASTCs that provide that  
10 service, those hospitals do provide this service.

11 MR. HYLAK-REINHOLTZ: And thank you,  
12 Mr. Constantino.

13 And I think Dr. Kinder had a great point  
14 that when you compare hospital care versus  
15 outpatient surgery care -- on a broader sense, a  
16 Berkeley study that's included in our application  
17 quoted a report by the office -- Federal OIG,  
18 which said if only half of the hospital outpatient  
19 department cases were moved into an ASC setting,  
20 Medicare would save \$2.4 billion a year.

21 The same report said, if the number of  
22 ASTCs were doubled over 10 years, Medicare would  
23 save \$57.6 billion by getting the lower  
24 reimbursements. And that's just the

1 reimbursement; that doesn't cover the patient  
2 copay angle of this.

3 So -- and especially in an area where  
4 there's a number of medically underserved areas  
5 and populations and professional -- Health  
6 Professional Shortage Areas, I think this would be  
7 a fantastic service for this community.

8 CHAIRWOMAN OLSON: Thank you.

9 Other questions or comments?

10 Oh, Doctor.

11 MEMBER GOYAL: Thank you, Madam Chair.

12 My name is Arvind Goyal, and I'm  
13 ex officio on this Board from Medicaid.

14 I'd have three or four questions. So,  
15 one, what is your Medicaid mix? Can you project  
16 that?

17 MR. HYLAK-REINHOLTZ: I can pull it out.

18 DR. KINDER: It was part of our  
19 application, but I do believe we stuck to the  
20 classic definition of Medicaid only. We have a  
21 lot of managed Medicaid patients we take care of,  
22 as well.

23 MEMBER GOYAL: That's not --

24 DR. KINDER: Joe's looking it up right now.

1           MEMBER GOYAL: When you find it, please  
2 blurt it out.

3           MR. HYLAK-REINHOLTZ: I have it. And,  
4 actually, I used to have your -- your -- I played  
5 your role back in the mid-2000s when I used to  
6 work for the HFS so --

7           MEMBER GOYAL: You look very smart.  
8 (Laughter.)

9           MR. HYLAK-REINHOLTZ: -- it's nice to make  
10 your acquaintance. It's good to be on both sides  
11 of the table.

12           So our forecasted payer mix, we would do,  
13 in 2018, 62 1/2 percent Medicare, and that would  
14 stay standard over a three-year period.

15           Our Medicaid rate would also be around the  
16 5 percent average range at the end of three years.  
17 A number of things that we do is largely covered  
18 by Medicare. That's why there's a differential  
19 there.

20           MEMBER GOYAL: Thank you.

21           Another question: You talked a whole lot,  
22 Dr. Kinder -- I was very impressed -- about the  
23 cost difference to Medicare in an ASTC versus a  
24 hospital, so I'm interested in two questions on

1       that point.

2               One, would you differentiate and tell us  
3       what percentage of your population at the ASTC  
4       would end up in the hospital because of  
5       complications or some ancillary findings that you  
6       discover at the time you are working in an ASTC.

7               DR. KINDER: That's an excellent question.  
8       Thank you, Doctor.

9               The answer is that these patients who  
10       would come to the ASC would be well vetted in our  
11       outpatient office setting where we would  
12       understand whether they have any significant  
13       problems with their plumbing, their coronary  
14       arteries. We would know exactly the strength of  
15       their heart pump, and we would know about all  
16       their comorbidities.

17               When you look -- so very few of them who  
18       would be done in the ASC would end up at the  
19       hospital.

20               When you look at safety studies, it's been  
21       shown to be quite safe to perform the implantation  
22       of a defibrillator or pacemaker and allow the  
23       patient to go home the same day, so that's clearly  
24       fine from a safety and cost standpoint.

1           We have three heart rhythm doctors in our  
2 group, and our complication rate is  
3 extraordinarily low, which helped land us in the  
4 99 percentile of the Medicare Federal data for  
5 quality and cost.

6           With regard to complications, if you look  
7 at the registered databases, the chance of having  
8 a significant morbid event is in the ballpark of  
9 1 in 500 to 1 in a thousand. So if we project  
10 doing a thousand cases a year, one or two  
11 patients, at most, would end up needing hospital  
12 care following the ASC procedure.

13           MEMBER GOYAL: Okay. Are those the only  
14 two procedures you plan on doing at this ASTC?

15           You mentioned two.

16           DR. KINDER: Right. We -- the current  
17 plan is to do pacemakers and defibrillators.  
18 There are also implantable lubricors, which are  
19 given to people who pass out frequently and we  
20 don't know the cause.

21           So an implantable lubricor is inserted  
22 under the skin and records your rhythm at all  
23 times. That would be a procedure that we would  
24 consider doing there.

1           There's a number of other procedures that  
2   are possible, depending on how things change at  
3   the Federal level. And because we're trying to  
4   keep this to a narrow cardiovascular category,  
5   we'd like to stay open to be able to evolve to the  
6   needs of the community and the local population.

7           But at the present time, as I outlined,  
8   those would be the main procedures that we'd be  
9   looking to do.

10          MEMBER GOYAL: And no vascular procedures?

11          I mean -- carotids?

12          DR. KINDER: Not at this time.

13          MEMBER GOYAL: Nothing vascular?

14          DR. KINDER: No carotid procedures at this  
15   time would be envisioned.

16          MEMBER GOYAL: Okay.

17          Now, one final question, then: Physician  
18   reimbursement at the ASTC, is that projected to be  
19   any different than it would be in a hospital  
20   setting?

21          I know they've been talking global; it  
22   hasn't taken effect at the hospital yet. But  
23   could you comment on that?

24          DR. KINDER: Sure.

1           My understanding is that they're  
2   relatively similar. In other words, there's no  
3   dramatic difference in what the physician gets  
4   paid to do the actual procedure, whether it's done  
5   in the hospital or in the ASC.

6           MEMBER GOYAL: Thank you very kindly.  
7   I appreciate it.

8           CHAIRWOMAN OLSON: Other questions?

9           MEMBER BURZYNSKI: My ears are getting  
10   tired. But I think -- did I hear you mention  
11   earlier that, if they did do the vascular-type  
12   surgeries, they would have to come back in front  
13   of this Board?

14          MR. CONSTANTINO: If they do cardiac cath,  
15   they would have to come back and get approval from  
16   this Board to do that.

17          MEMBER BURZYNSKI: Thank you.

18          CHAIRWOMAN OLSON: Other questions or  
19   comments?

20          (No response.)

21          CHAIRWOMAN OLSON: Seeing none, I would  
22   ask for a roll call vote.

23          MR. ROATE: Thank you, Madam Chair.

24          Motion made by Ms. Murphy; seconded by



1 Mr. Sewell.

2 Senator Burzynski.

3 MEMBER BURZYNSKI: I'll vote aye, based on  
4 the testimony we've heard today.

5 MR. ROATE: Thank you.

6 Ms. Hemme.

7 MEMBER HEMME: Yes, based on the testimony  
8 we've heard today.

9 MR. ROATE: Thank you.

10 Mr. McNeil -- or Mr. McGlasson.

11 MEMBER MC GLASSON: Yes. Based on the  
12 positive impact on Medicare, yes.

13 MR. ROATE: Thank you.

14 Mr. McNeil.

15 MEMBER MC NEIL: Yes, based on the report  
16 and the testimony.

17 MR. ROATE: Thank you.

18 Ms. Murphy.

19 MS. MURPHY: Yes, in light of the  
20 explanations given today to the staff report's  
21 negative findings.

22 MR. ROATE: Thank you.

23 Mr. Sewell.

24 VICE CHAIRMAN SEWELL: I vote yes and

1 then urge us, as a Board, to move it along in  
2 terms of developing different categories of  
3 service for ambulatory surgery treatment centers.

4 MR. ROATE: Thank you.

5 Madam Chair.

6 CHAIRWOMAN OLSON: I vote yes for reasons  
7 stated.

8 MR. ROATE: Thank you.

9 That's 7 votes in the affirmative.

10 CHAIRWOMAN OLSON: The motion passes.

11 Congratulations.

12 The court reporter has requested a break,  
13 three or four minutes.

14 (A recess was taken from 3:03 p.m. to  
15 3:10 p.m.)

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1 CHAIRWOMAN OLSON: Okay. We're ready to  
2 get started again.

3 Next, we have Project 17-069, Memorial  
4 Hospital-East Medical Clinics Building.

5 May I have a motion to approve  
6 Project 17-069, Memorial Hospital-East Medical  
7 Building.

8 A motion, please.

9 MEMBER MURPHY: Motion.

10 CHAIRWOMAN OLSON: May I have a second.

11 VICE CHAIRMAN SEWELL: Second.

12 CHAIRWOMAN OLSON: The Applicant will be  
13 sworn in.

14 THE COURT REPORTER: Would you raise your  
15 right hands, please.

16 (Three witnesses sworn.)

17 THE COURT REPORTER: Thank you.

18 CHAIRWOMAN OLSON: Mr. Constantino.

19 MR. CONSTANTINO: Madam Chairman, on the  
20 first page of your report, under "Project Cost,"  
21 that should read "38,290,267" instead of "32."

22 CHAIRWOMAN OLSON: Thank you.

23 MR. CONSTANTINO: I apologize for the  
24 mistake I made.

1           The Applicants propose to construct an  
2   addition, second phase, to a medical clinics  
3   building currently under construction in Shiloh,  
4   Illinois. The project cost is \$38.3 million, and  
5   the completion date is December 15th, 2019.

6           There was no public hearing and no  
7   opposition to this project. We did have one  
8   finding related to the reasonableness of the  
9   project cost.

10          Thank you, Madam Chair.

11          CHAIRWOMAN OLSON: Thank you,  
12   Mr. Constantino.

13          Comments?

14          MR. TURNER: Thank you.

15          My name is Mark Turner. I'm the president  
16   of Memorial Regional Health Services, which is  
17   also Memorial Hospital in Belleville and Memorial  
18   Hospital-East in Shiloh.

19          Thank you to the staff. We appreciate  
20   your work. It's important.

21          Thank you to the Board. We appreciate  
22   your time this afternoon. We will try and keep  
23   our comments to the point and on task.

24          We're excited about this project, which

1 represents a major addition to a medical clinics  
2 building already on campus at Memorial Hospital-  
3 East, approved by this Board and completed at the  
4 end of last year.

5 This project -- the original portion of  
6 the building was approximately 70,500 square feet.  
7 This second phase will be very much the same size,  
8 very close to that size. We realized during  
9 construction of the initial project that the  
10 demand for medical office space was continuing to  
11 increase and rise and we needed additional space.

12 The addition you're reviewing, as I said,  
13 is about the same size with approximately  
14 one-third of the building occupied by the  
15 Alvin J. Siteman Cancer Center, a collaboration  
16 of BJC and Washington University.

17 The Siteman Cancer Center is really what  
18 makes this project very special. We're excited  
19 about what it brings to our community. It's an  
20 asset to our community, as many Southern Illinois  
21 patients travel to St. Louis to the Siteman Cancer  
22 Center there for their care. It performs over  
23 3200 -- Siteman performs over 3200 radiation  
24 oncology treatments on Illinois residents --

1       excuse me, residents from our primary service  
2       area -- on an annual basis.

3               We're excited about this project. We'll  
4       keep matters moving, and I'll let Greg Bratcher  
5       introduce you to Siteman Cancer Center.

6               MR. BRATCHER: Hi. Again, My name is Greg  
7       Bratcher, B-r-a-t-c-h-e-r.

8               And the Siteman Cancer Center is one of  
9       49 comprehensive cancer centers as designated by  
10      the National Institutes of Health. To put that in  
11      perspective, there are about 5,000 hospitals in  
12      the US, and there are about 1500 cancer centers  
13      designated by the American College of Surgeons.  
14      This is one of 49.

15              In metro Chicago you have two, at the  
16      University of Chicago and Northwestern, but  
17      they're not in every major city -- they aren't in  
18      Indianapolis; they aren't in Kansas City -- and  
19      the reason is their rigorous criteria.

20              And I'll do them really quickly. I had  
21      some other examples, but in the interest of time,  
22      I'll just tell you what makes them go.

23              You have to be world-class excellent at  
24      both -- delivering cutting-edge care today. You

1 have to have a commitment to multidisciplinary  
2 research for finding the cures for tomorrow. And  
3 then you have to -- and that's the driving force  
4 behind this project -- push all of that out into  
5 the community. You can't sit on the ivory campus  
6 and just do your thing. You have to get this out  
7 into the community. That is the driving force  
8 behind this project.

9 I could tell you about some of the great,  
10 cool things we're doing, but in the interest of  
11 time, I'll tell you about one because you get a  
12 lot of dialysis projects.

13 We have perfected and one of our doctors  
14 has perfected the partial removal of a kidney,  
15 leaving behind a kidney that can function while  
16 removing the tumor using robotic surgery. And  
17 many of those patients end up not needing  
18 dialysis. That's the kind of thing that we will  
19 bring to the Southern Illinois market.

20 We'd appreciate your positive vote.  
21 Thank you.

22 CHAIRWOMAN OLSON: Thank you.

23 MR. AXEL: Thank you, Greg.

24 My name is Jack Axel with Axel &

1 Associates. I am going to address the single  
2 negative finding, that being the construction and  
3 construction contingency costs per square foot.

4 As noted in the staff report, the norm for  
5 clinical areas within a medical clinics building  
6 is approximately \$267 per square foot. We are  
7 anticipating \$329 a square foot.

8 Attachment C to the application identifies  
9 the anticipated construction costs for each of the  
10 clinical areas included within the project, and  
11 the areas with the exception of radiation oncology  
12 are slightly below the norm. The radiation  
13 oncology area is estimated to cost approximately  
14 \$390 a square foot, causing the negative finding.

15 I don't believe that there has been a  
16 medical clinics building brought before this Board  
17 in recent memory that has included medical  
18 oncology; however, our construction cost estimate  
19 is based on similar projects recently completed by  
20 Siteman in Missouri, and we are confident that our  
21 cost estimate is reasonable.

22 I would like to simply remind the Board,  
23 before we entertain questions, that this project  
24 has received no opposition of any kind.



1 Thank you.

2 CHAIRWOMAN OLSON: Thank you.

3 MR. TURNER: Questions?

4 CHAIRWOMAN OLSON: Yes.

5 Questions from Board members?

6 (No response.)

7 CHAIRWOMAN OLSON: I just had one. I just  
8 wanted to -- I think I'm -- part of the cost is  
9 this linear accelerator; right? We've had this  
10 before where that's -- requires a whole lot of  
11 extra hoo-ha to get that --

12 MR. TURNER: It's the concrete -- well,  
13 the protection of the radiation. So it's anywhere  
14 from 3 to 6 feet of concrete, depending on how you  
15 design the structure. Solid walls and ceilings,  
16 so it's very expensive.

17 CHAIRWOMAN OLSON: Okay. Thank you.

18 Other questions or comments?

19 (No response.)

20 CHAIRWOMAN OLSON: Seeing none, I'd ask  
21 for a roll call vote.

22 MR. ROATE: Thank you, Madam Chair.

23 Motion made by Ms. Murphy; seconded by  
24 Mr. Sewell.

1 Senator Burzynski.

2 MEMBER BURZYNSKI: I believe the Applicant  
3 has successfully explained the reason for  
4 noncompliance and I vote yes.

5 CHAIRWOMAN OLSON: Thank you.

6 Ms. Hemme.

7 MEMBER HEMME: I vote yes for the reason  
8 previously stated.

9 MR. ROATE: Thank you.

10 Mr. McGlasson.

11 MEMBER MC GLASSON: I vote yes for that  
12 same reason.

13 MR. ROATE: Thank you.

14 Mr. McNeil.

15 MEMBER MC NEIL: Yes, for the reason so  
16 stated.

17 MR. ROATE: Thank you.

18 Ms. Murphy.

19 MEMBER MURPHY: Yes, based on today's  
20 testimony.

21 MR. ROATE: Thank you.

22 Mr. Sewell.

23 VICE CHAIRMAN SEWELL: I vote yes. This  
24 is a good explanation for the reasonableness of

1 the project cost.

2 MR. ROATE: Thank you.

3 Madam Chair.

4 CHAIRWOMAN OLSON: I vote yes, as well.

5 I wish you really good luck with this  
6 project. It's needed.

7 MR. AXEL: Thank you very much.

8 MR. TURNER: Thank you.

9 MR. ROATE: 7 votes in the affirmative.

10 MR. BRATCHER: Thank you.

11 CHAIRWOMAN OLSON: Congratulations.

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Transcript of Full Meeting  
Conducted on February 27, 2018

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1 CHAIRWOMAN OLSON: Finally, we have  
2 applications subsequent to intent to deny.

3 I would call to the table Project 17-019,  
4 SwedishAmerican Hospital.

5 May I have a motion to approve  
6 Project 17-019, SwedishAmerican Hospital, for a  
7 major modernization.

8 Motion, please.

9 VICE CHAIRMAN SEWELL: So moved.

10 CHAIRWOMAN OLSON: And a second.

11 MEMBER MC NEIL: Second.

12 THE COURT REPORTER: Would you raise your  
13 right hands, please.

14 (Four witnesses sworn.)

15 THE COURT REPORTER: Thank you. Please  
16 print your names.

17 CHAIRWOMAN OLSON: Mr. Constantino, your  
18 report.

19 MR. CONSTANTINO: Thank you, Madam Chair.

20 The Applicants propose a major  
21 modernization on the campus of SwedishAmerican  
22 Hospital in Rockford, Illinois, which includes the  
23 construction of a five-story patient tower.

24 The proposed cost of the project is

1 approximately \$126,000 -- or -- million dollars --  
2 and the expected completion date is November 30th,  
3 2022.

4 There was a public hearing on this  
5 project, there was opposition, and the Applicants  
6 received an intent to deny previously at --  
7 I believe it was the September 26th meeting.

8 Subsequent, the Applicants modified the  
9 project. It was a Type A modification. They  
10 reduced the cost by \$2.2 million, reduced the  
11 gross square footage, and reduced the number of  
12 pediatric beds from 28 to 10. We did have  
13 findings related to this project.

14 One last thing: On the summary of  
15 findings, that should be positive for the  
16 Part 1120. That's on page 5 of your report.

17 Thank you.

18 CHAIRWOMAN OLSON: Thank you, Mike.

19 Comments for the Board?

20 DR. BORN: Good afternoon.

21 CHAIRWOMAN OLSON: Good afternoon.

22 DR. BORN: Thank you, Chairwoman Olson and  
23 members of the Illinois Health Facilities and  
24 Services Review Board, for your service to our

1 state.

2 I'm Dr. Michael Born, the president and  
3 CEO of SwedishAmerican, a division of UW Health.  
4 I'm honored to be here today to ask your approval  
5 for our hospital's revised modernization CON  
6 application, Project 17-019.

7 Seated with me today to my left is Dr. Ann  
8 Gantzer, vice president, patient services, and  
9 chief nurse officer; Jedediah Cantrell to my far  
10 left, vice president of operations for  
11 SwedishAmerican; and our CON attorney, Dan Lawler.

12 This has been a long journey for us. We  
13 filed this application in April of last year and  
14 were first heard at the September meeting. We  
15 received a supermajority of the votes at that  
16 meeting, 4 to 2, but needed 5 and received an  
17 intent to deny.

18 While we were disappointed by that setback  
19 for this \$126 million modernization project,  
20 I will be among the first to recognize and say  
21 that the concerns raised at the September meeting  
22 were legitimate. We've taken them to heart and,  
23 after technical assistance with Board staff, we  
24 have modified the project to address your

1 questions. You were right. This modified project  
2 comes back before this Board as a better project.

3 In addition to substantially reducing our  
4 existing pediatric bed capacity, which was the  
5 focus of the concerns in September, we also  
6 reduced the overall project cost by millions of  
7 dollars, and we successfully addressed the one  
8 negative finding under the financial criteria so  
9 that the staff report is now fully positive on all  
10 financial criteria.

11 This project represents the modernization  
12 of our over-50-year-old flagship hospital tower  
13 and includes the construction of a women's and  
14 children's tower. As represented by the support  
15 letters listed in Appendix A of the staff report,  
16 the public comments presented to you today by  
17 community leaders and many elected officials, as  
18 well as the other letters of support and petitions  
19 in this project file, this investment to improve  
20 our health care in Rockford, in the Rockford  
21 region, is vitally important.

22 We have overwhelming local and statewide  
23 support for this project. At the public hearing  
24 in May of last year, there was one opposing

1 organization, but they were opposing a different  
2 project and a different application. At the time  
3 we also had pending an exemption application for a  
4 10-bed neonatal intensive care unit, and the  
5 public hearing on that project was held  
6 back-to-back on the same day at the same location  
7 as the public hearing on this project.

8 The opponent was there to oppose the NICU  
9 application and spoke at both hearings, but they  
10 made clear that it was only the NICU and not the  
11 modernization that they were opposing, and that is  
12 noted in the staff report today.

13 Interestingly, that organization has  
14 remained silent until today, when they once again  
15 are attempting to link these projects with flawed  
16 logic. Our separate NICU application was approved  
17 by this Board last June, and since that approval  
18 until today no one has made any objection to this  
19 project.

20 When we modified the project in November  
21 in response to the intent to deny, your staff  
22 published an opportunity for a second public  
23 hearing on the modified project, and no requests  
24 for hearing were submitted.



1           No letters of opposition have been  
2       submitted, as indicated in the staff report, and  
3       the agenda today shows that this is an unopposed  
4       project. The fact that today's opposition was  
5       apparently organized at the 11th hour and again  
6       attempts to link the modernization project to the  
7       NICU exemption suggests an attempt to confuse,  
8       create distraction, and stifle competition rather  
9       than to provide a thoughtful, organized opposition  
10      based on arguments and merit.

11           You have a project before you now that is  
12      better than when you saw it last September.

13           I wanted to thank you again for your time  
14      and attention to our project. I respectfully ask  
15      for your support of this revised and worthy  
16      hospital modernization project to better serve the  
17      people of Northern Illinois.

18           I now want to ask our CON counsel,  
19      Dan Lawler, to address the negative findings in  
20      the staff report.

21           MR. LAWLER: Thank you, Dr. Born. My name  
22      is Dan Lawler, L-a-w-l-e-r.

23           Sorry for not doing that before. I should  
24      know better -- and no tutorials now.

1 (Laughter.)

2 MR. LAWLER: You're a wise man.

3 VICE CHAIRMAN SEWELL: Old.

4 MR. LAWLER: This is a nonsubstantive  
5 project. We are not adding any new categories of  
6 service; we are not increasing the total number of  
7 beds; we are reducing beds.

8 We substantially reduced pediatric beds to  
9 respond to concerns raised by the Board last  
10 September. We currently have 28 pediatric beds;  
11 we are reducing that to 10. 10 beds will allow us  
12 to just barely cover our historical peak census of  
13 pediatric patients, so the reduction leaves us  
14 with the minimum number of beds to continue  
15 serving our historical caseload.

16 As the staff report indicates on page 16,  
17 we are projecting to be at target utilization by  
18 the second year of operation, as the criteria  
19 requires.

20 The negatives in the staff report relate  
21 mainly to department sizes and utilization. We  
22 have 14 different clinical departments involved.  
23 The total square footage in those 14 departments  
24 is just 0.2 percent above what the State standards

1 would allow in total for all those departments.  
2 That is less than 300 square feet in a project  
3 that is well over 200,000 square feet.

4 We were way under the State standard for  
5 many departments. We were over in some. But when  
6 you add them up, we are very, very close to the  
7 total that would be allowable. Please note that  
8 most of the areas in -- clinical areas -- in which  
9 we were over the standard are in the existing  
10 building.

11 Almost 90,000 square feet of this project  
12 is remodeling a 50-year-old building. Now that  
13 I'm in my 60s, a 50-year-old building doesn't seem  
14 as ancient to me as it used to be, but we're still  
15 talking about 1960s hospital design, and that was  
16 before this Board was created and before the State  
17 standards came into existence. We can only work  
18 within the constraints they made for us 50 years  
19 ago.

20 In the new construction, in the women's  
21 and children's tower, we meet most of the  
22 department sizes. Where we weren't constrained by  
23 the existing structure, we did everything we could  
24 to meet your standards.

1           One area where we were over -- and it was  
2           the largest overage -- was the special-care  
3           nursery. There's a good reason for that.

4           My firstborn twins were in a special care  
5           nursery for five weeks, not at Swedish but in a  
6           Chicago-area hospital. I'm sure that unit met the  
7           State standard because it was so packed with  
8           incubators and monitors and pumps and panels and  
9           cabinets that there was hardly anyplace to walk.

10          The State standard essentially requires  
11          all incubators to be in a single room. There has  
12          been much literature -- and it's referenced in our  
13          application -- promoting single rooms for mother  
14          and baby, and this has been clinically proven to  
15          produce better outcomes. The neonatologists and  
16          clinicians are advocating for this now.

17          SwedishAmerican serves a population with a  
18          high percentage of at-risk mothers who tend to  
19          deliver premature and underweight babies, and that  
20          is why we designed this special-care nursery as  
21          we did.

22          Regarding the utilization negatives, the  
23          concerns and questions raised at the last meeting  
24          focused on pediatrics, and we have addressed these

1 with the modification to the project. The other  
2 areas we've previously explained, and they are  
3 noted in the staff report.

4 With all the talk we heard about NICU this  
5 morning, one might think that we were asking the  
6 Board to approve a new 10-bed NICU today. We are  
7 not. We already have a 10-bed NICU. It's not  
8 operational but it was approved by this Board last  
9 June. We have been working with the Department of  
10 Public Health since last June to -- in connection  
11 with the licensing of the NICU.

12 The only reason that the NICU was even  
13 mentioned in this project is that, when the new  
14 women's and children's tower is finished, we are  
15 going to move the existing NICU -- that's already  
16 been approved by this Board -- into the new tower.  
17 And whether there was a new tower or not, we are  
18 still going to have the NICU.

19 The vote today has nothing to do with  
20 whether or not SwedishAmerican has a NICU. The  
21 vote today is only going to determine whether that  
22 NICU will be in a new, modern, state-of-the-art  
23 building or whether it will be in a 50-year-old  
24 structure.

1           We believe the project substantially  
2 complies with the criteria, and we respectfully  
3 request your approval.

4           Thank you.

5           CHAIRWOMAN OLSON: Thank you.

6           Questions from Board members?

7           Mr. Burzynski.

8           MEMBER BURZYNSKI: Thank you.

9           Mr. Lawler, pretty well, I think, summed  
10 up the difference -- or the concerns relative to  
11 the NICU.

12           But just from a staff standpoint, does  
13 that pretty well summarize what we're doing here  
14 this afternoon?

15           MR. CONSTANTINO: Yes.

16           MEMBER BURZYNSKI: Okay. Thank you.

17           I think it's interesting, you know.

18 I used to serve the Rockford area and served  
19 SwedishAmerican Hospital, Rockford Memorial  
20 Hospital, Saint Anthony's Hospital.

21           And, you know, for many, many years I've  
22 seen a lot of this going on. (Indicating.)

23           And it's frustrating to me because I would  
24 hope that all of us have a tremendous amount of

1 concern for the community and for the patients  
2 that you represent. And, certainly, you know,  
3 when we have these squabbles -- and this is more  
4 than a squabble. It's a brawl. It is not very --  
5 it doesn't speak highly of the area, let's put it  
6 that way. So I hope that we can cease and desist  
7 from that and some of the attacks and -- personal  
8 attacks, et cetera -- that we've seen in the past.

9           You know, having said that, I'm sure that  
10 you-all have looked at the NICU very closely. You  
11 are -- from the comments I heard today, you will  
12 proceed with that regardless. It's just a  
13 question of whether it's going to be in an old  
14 building or whether it's going to be in a modern  
15 facility.

16           Having said that, I do know that you-all  
17 have expressed and have certainly been a leader in  
18 the community relative to development of the  
19 community and support for the community.  
20 I commend you for that. Mr. Lawler basically  
21 answered my question relative to the NICU.

22           So thank you.

23           CHAIRWOMAN OLSON: Mr. Sewell.

24           VICE CHAIRMAN SEWELL: One of the things

1 I'm not real clear on is -- what's the  
2 relationship between this proposal and the  
3 Level III perinatal system that we have? And  
4 maybe Mr. Dart might have something on that.

5 Doesn't IDPH sort of manage that, the  
6 Level III system?

7 MEMBER DART: Well, the department  
8 certainly approves those.

9 VICE CHAIRMAN SEWELL: But there's no  
10 concerns about this project?

11 MEMBER DART: It's been proceeding as  
12 indicated since July so -- not that I'm aware of.

13 VICE CHAIRMAN SEWELL: Okay.

14 Any comments on that?

15 MR. LAWLER: No. We'll just add that the  
16 day after we were approved last June, we were in  
17 meeting with Director Shah and Shannon Lightner at  
18 IDPH, and we've been working with them since as we  
19 progressed with the NICU project.

20 VICE CHAIRMAN SEWELL: Okay.

21 DR. GANTZER: And at this -- sorry.

22 And at this point we have our designation  
23 survey scheduled for October 24th, 2018.

24 CHAIRWOMAN OLSON: Yes.



1           MEMBER MC NEIL: So in terms of services,  
2     room, all of that, the only new thing proposed are  
3     new bricks, mortar, electrical, optical --  
4     physical things that are 50 years old or that have  
5     been repaired for 50 years; is that true?

6           MR. LAWLER: That's correct, yeah.

7           CHAIRWOMAN OLSON: Other questions or  
8     comments?

9           (No response.)

10          CHAIRWOMAN OLSON: Seeing none, I would  
11     ask for a roll call vote.

12          MR. ROATE: Thank you, Madam Chair.

13          Motion made by Mr. Sewell; seconded by  
14     Ms. Hemme.

15          Senator Burzynski.

16          MEMBER BURZYNSKI: As I stated before, I'm  
17     very familiar with Swedes, and I know that they  
18     are very civic-minded, pro patient, and I'm sure  
19     that they're going to do what's in the best  
20     interest of their patients and of their base of  
21     patients right there in the Rockford area.

22          So I vote yes.

23          MR. ROATE: Thank you.

24          Ms. Hemme.

1           MEMBER HEMME: I also deal a lot with the  
2 Rockford area hospitals as an employer in the  
3 area, and I will say that I'm always impressed  
4 with Swedes.

5           And so I vote yes so that you can  
6 modernize your building.

7           MR. ROATE: Thank you.

8           Mr. McGlasson.

9           MEMBER MC GLASSON: I vote yes. I can see  
10 no reason not to.

11          MR. ROATE: Thank you.

12          Mr. McNeil.

13          MEMBER MC NEIL: I vote yes. I know  
14 nothing about you.

15          (Laughter.)

16          MEMBER MC NEIL: I go through Rockford.  
17 However, from the report and your responses,  
18 I voted yes.

19          MR. ROATE: Thank you.

20          Ms. Murphy.

21          MEMBER MURPHY: I vote yes based on the  
22 testimony and the explanations for the negative  
23 findings.

24          Good luck.

1 MR. ROATE: Thank you.

2 Mr. Sewell.

3 VICE CHAIRMAN SEWELL: I vote yes for the  
4 reasons stated by Ms. Murphy.

5 MR. ROATE: Thank you.

6 Madam Chair.

7 CHAIRWOMAN OLSON: The Chair finds it  
8 necessary to abstain from this vote.

9 MR. ROATE: Thank you.

10 That's 6 votes in the affirmative;  
11 1 abstaining.

12 CHAIRWOMAN OLSON: The motion passes.  
13 Congratulations.

14 DR. GANTZER: Thank you.

15 DR. BORN: Thank you.

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1 CHAIRWOMAN OLSON: Okay. Under new  
2 business, I would like a motion to keep the  
3 executive meeting transcripts closed.

4 May I have a motion.

5 MEMBER BURZYNSKI: So moved.

6 CHAIRWOMAN OLSON: And a second?

7 MEMBER MURPHY: Second.

8 CHAIRWOMAN OLSON: All those in favor  
9 say aye.

10 (Ayes heard.)

11 CHAIRWOMAN OLSON: Ann, a legislative  
12 update?

13 MS. GUILD: Hi. I'm going to be very  
14 brief here.

15 This doesn't -- I did a handout for the  
16 Board members, so you-all have it. And if anyone  
17 has any questions, please feel free to give me a  
18 call.

19 For those in the audience, the bills on  
20 the list are House Bill 4645, 4891, 4892, 4949,  
21 and 5069.

22 4892 is an HFSRB initiative. All of these  
23 bills are still in rules. There's a few bills  
24 where I might want some feedback.

1           Senate Bill 33, Senate Amendment 1, is a  
2 bill that prohibits Planning Board staff or Review  
3 Board staff from providing advisory opinions on  
4 potential changes of ownership, stating that  
5 they're not reviewable. There's some additional  
6 process things in the bill that we would have to  
7 go through.

8           There was a hearing on February 20th, in  
9 subcommittee on business entities, and Jeannie and  
10 I both testified. It's now postponed in  
11 judiciary.

12           But from the conversation that came out of  
13 that meeting, the -- we were -- with  
14 legislators -- we were thinking that it might be  
15 appropriate -- there was a lot of discussion about  
16 transparency -- to post advisory opinions on our  
17 website.

18           And I guess if -- we would do that unless  
19 any Board member has any objection to that.

20           CHAIRWOMAN OLSON: I think it just goes  
21 along with transparency, and I would agree with  
22 that.

23           So does anybody have any objections to  
24 posting?

1 MEMBER GOYAL: Madam Chair -- Madam Chair.

2 CHAIRWOMAN OLSON: Yes.

3 MEMBER GOYAL: No objections. My  
4 objection wouldn't count anyway.

5 But my suggestion is that you update the  
6 website maybe once a year, once every six months,  
7 because my fear is that at some point in time what  
8 information is there would become obsolete.

9 MS. MITCHELL: Well, we update our website  
10 realtime. Maybe not exactly realtime but very  
11 frequently, almost on a daily basis.

12 MEMBER GOYAL: Oh, okay.

13 CHAIRWOMAN OLSON: Thank you, though.

14 MS. GUILD: The next bill I'm going to  
15 talk a little bit more about is Senate Bill 1773,  
16 House Amendment 4 -- well, today, House  
17 Amendment 8.

18 It is a bill to extend and change the  
19 hospital assessment program, which brings about  
20 \$3 1/2 billion in to the State of Illinois through  
21 a Federal match.

22 There was a provision in there that  
23 created a hospital transformation review committee  
24 within HFS and would exclude projects that are

1 approved by that Board from the purview of our  
2 Board.

3 I don't anticipate that there would be  
4 that many of those projects, but the goal is to --  
5 for struggling hospitals -- to create a  
6 mechanism -- and there's also a pool of money  
7 attached -- for them to transform into something  
8 other than a hospital that will still continue to  
9 help meet community needs.

10 Anyway, there were some issues with the  
11 bill from our perspective because they -- some  
12 terminology. They didn't understand that our --  
13 what we call an exemption is different than  
14 "exempt" in Webster's dictionary.

15 There was no clarity in it that, once a  
16 project is done with its transformation -- once  
17 there's a transformation project that's  
18 complete -- it still has to -- anything else it  
19 does in the future will still be subject to Board  
20 jurisdiction and that they had to report to us if  
21 they made any changes in beds and services.

22 Everyone was quite willing to make those  
23 changes, and today that bill came out of committee  
24 unanimously, and it includes the changes that we

1 wanted to see.

2 CHAIRWOMAN OLSON: Good.

3 MS. GUILD: So -- and then the last bill  
4 on the list is Senate Bill 3230, which is the same  
5 as House Bill 4891, and it's in Senate assignments  
6 so nothing's happened yet.

7 CHAIRWOMAN OLSON: I have a question on  
8 that.

9 So change the requirement for a quorum to  
10 four members. How do you get 5 votes if there's  
11 four people?

12 MS. MITCHELL: It would change from 5 to 4.

13 MS. GUILD: You won't need 5 votes.

14 CHAIRWOMAN OLSON: So any project would  
15 only need 4 votes to pass?

16 MS. GUILD: It's a bill to address  
17 concerns about if we have vacancies or members who  
18 have conflicts and we don't have a quorum.

19 CHAIRWOMAN OLSON: Yeah, I understand  
20 that. I don't have any problem with that. But  
21 I just was worried about the 5 -- about the  
22 5 positive votes if you only have four people.

23 MS. GUILD: The proponents characterized  
24 it as a placeholder on the last call that we had,



1 and I don't know whether they're going to go  
2 forward with it or try to change it.

3 MS. AVERY: They're going to -- they're  
4 possibly going to hold it --

5 MS. GUILD: Right.

6 MS. AVERY: -- but haven't really  
7 determined. Because of the appointment with our  
8 new members and being at full capacity, it may not  
9 even go forward.

10 MS. GUILD: Right.

11 CHAIRWOMAN OLSON: Okay.

12 Corrections to profiles?

13 Do you have one?

14 MEMBER GOYAL: Madam Chair, could you have  
15 this HB5069 explained a little bit?

16 MS. GUILD: Sure.

17 This is an Illinois Department of Public  
18 Health initiative, and they want to repeal the  
19 Illinois End Stage Renal Disease Facility Act and  
20 rely upon certification, Medicare and Medicaid  
21 certification.

22 They -- there was a drafting error that,  
23 basically, could give us a gap. If this were to  
24 pass before June 1st, 2018 -- and, as you know,

1 that's fairly unlikely -- there could be a gap in  
2 our coverage of ESRD facilities; not likely but  
3 possible.

4 I have talked to the department's  
5 legislative liaison to see if we could get an  
6 amendment done quickly to fix that problem and  
7 seemed amenable but had to run it up the flagpole  
8 so we'll see.

9 But that's what that bill is about.

10 MEMBER GOYAL: Thank you.

11 CHAIRWOMAN OLSON: Other questions?

12 (No response.)

13 CHAIRWOMAN OLSON: So there's one profile  
14 change.

15 May I have a motion to change the HSHS  
16 St. Joseph's Hospital, Breese, to correct their  
17 2015/2016 profile.

18 To accept that correction, a motion?

19 MEMBER BURZYNSKI: So moved.

20 VICE CHAIRMAN SEWELL: Second.

21 CHAIRWOMAN OLSON: All those in favor  
22 say aye.

23 (Ayes heard.)

24 CHAIRWOMAN OLSON: Motion passes.

1           Do you want to tell us what's up with the  
2     financial report?

3           MS. AVERY: Yes.

4           So we were receiving the financial reports  
5     from IDPH for each meeting. In the discussion  
6     with Kim Palmer, who handles those, she asked if  
7     we could do them on a quarterly stance.

8           So we will receive those reports for  
9     March at the April meeting, for June at the  
10    July meeting, and the closing report in September.  
11    And in October -- in September we'll receive the  
12    first quarter report for FY19.

13          So she'll have them on a quarterly  
14    schedule in accordance with our meeting dates, but  
15    if we need any information prior to that or if  
16    anyone wants them in a different form, she will be  
17    willing to do that for us.

18          But it was just easier for her to do it on  
19    a quarterly time period in accordance with some of  
20    the reportings from the comptroller's office.

21          CHAIRWOMAN OLSON: Questions?

22          (No response.)

23          CHAIRWOMAN OLSON: Okay. And our next  
24    meeting is April 17th, 2018, again back here,

1       which is a change from initially. It was going to  
2       be in Springfield. It is now here.

3               May I have a motion to adjourn.

4               VICE CHAIRMAN SEWELL: So moved.

5               MEMBER MC NEIL: Second.

6               CHAIRWOMAN OLSON: All those in favor?

7               (Ayes heard.)

8               (Off the record at 3:44 p.m.)

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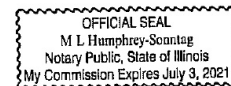
24

CERTIFICATE OF SHORTHAND REPORTER

I, Melanie L. Humphrey-Sonntag, Certified  
Shorthand Reporter No. 084-004299, CSR, RDR, CRR,  
CRC, FAPR, 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 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  
March, 2018.

My commission expires July 3, 2021.



MELANIE L. HUMPHREY-SONNTAG

NOTARY PUBLIC IN AND FOR ILLINOIS

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