Transcript of Full Meeting

Date: February 27, 2018
Case: State of Illinois Health Facilities and Services Review Board

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HEALTH FACILITIES AND SERVICES REVIEW BOARD

FULL MEETING

Bolingbrook, Illinois 60490

Tuesday, February 27, 2018

9:02 a.m.

BOARD MEMBERS PRESENT:

KATHY OLSON, Chairwoman

RICHARD SEWELL, Vice Chairman

BRAD BURZYNSKI

BARBARA HEMME

JOHN MC GLASSON, SR.

RON MC NEIL

MARIANNE ETERNO MURPHY

Job No. 167322

Pages: 1 - 316

Reported by: Melanie L. Humphrey-Sonntag,

CSR, RDR, CRR, FAPR

EX OFFICIO MEMBERS PRESENT:

BILL DART, IDPH

ARVIND K. GOYAL, IHFS

ALSO PRESENT:

JEANNIE MITCHELL, General Counsel

COURTNEY AVERY, Administrator

MICHAEL CONSTANTINO, IDPH Staff

ANN GUILD, Compliance Manager

GEORGE ROATE, IDPH Staff

C O N T E N T S

C O N T E N T S C O N T I N U E D

C O N T E N T S C O N T I N U E D

P R O C E E D I N G S

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

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

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

May I have a roll call, please.

MR. ROATE: Yes, Madam Chair.

Brad -- Senator Burzynski.

MEMBER BURZYNSKI: Here.

MR. ROATE: Deanna Demuzio is absent.

Ms. Hemme.

MEMBER HEMME: Here.

MR. ROATE: Mr. Johnson is absent.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, sir.

MR. ROATE: Mr. McNeil.

MEMBER MC NEIL: Present.

MR. ROATE: Ms. Murphy.

MEMBER MURPHY: Here.

MR. ROATE: Mr. Sewell.

VICE CHAIRMAN SEWELL: Here.

MR. ROATE: Madam Chair.

CHAIRWOMAN OLSON: Here.

MR. ROATE: Seven in attendance.

CHAIRWOMAN OLSON: Thank you.

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

VICE CHAIRMAN SEWELL: So moved.

MEMBER BURZYNSKI: Second.

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

Now, Mr. Sewell.

VICE CHAIRMAN SEWELL: I still move.

CHAIRWOMAN OLSON: All right.

MEMBER BURZYNSKI: I still second.

CHAIRWOMAN OLSON: All in favor say aye.

(Ayes heard.)

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

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

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

Is there activity to come out of executive session?

(No response.)

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

MS. MITCHELL: Yes.

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

CHAIRWOMAN OLSON: May I have a motion, please.

MEMBER BURZYNSKI: So moved.

CHAIRWOMAN OLSON: And a second.

MEMBER MURPHY: Second.

CHAIRWOMAN OLSON: All those in favor say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: The motion passes.

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

MEMBER MURPHY: Motion.

VICE CHAIRMAN SEWELL: Second.

CHAIRWOMAN OLSON: All those in favor say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: Opposed, like sign.

(No response.)

CHAIRWOMAN OLSON: The motion passes.

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

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

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

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

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

MS. MITCHELL: Please come up.

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

CHAIRWOMAN OLSON: Go ahead, Steve.

Go ahead, Steve. You can start, please.

SENATOR STADELMAN: Good morning.

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

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

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

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you, Representative Stadelman.

Thank you.

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

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

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

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

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

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

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

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

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

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

Thank you very much.

CHAIRWOMAN OLSON: Thank you.

Next, please.

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

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

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

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

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

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

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

CHAIRWOMAN OLSON: Thank you.

Next, please.

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

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

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

would increase costs.

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

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

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

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

MR. ROATE: Two minutes.

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

CHAIRWOMAN OLSON: Please conclude.

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

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

MR. BEA: Good morning.

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

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

In addition, they're trying to get this

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

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

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

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

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

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

MR. ROATE: Two minutes.

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you, all.

MR. CREQUE: Where would you like these?

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

Jeannie, the next five.

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

your name for the court reporter.

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

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

CHAIRWOMAN OLSON: Somebody please go ahead.

MR. VAN DEN HEUVEL: Good morning.

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

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

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

MR. VAN DEN HEUVEL: Sure.

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

In June 2017 UW/Swedes received

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

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

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

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

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

MR. ROATE: Two minutes.

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next, please.

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

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

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

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

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

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

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

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

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

For this reason, please deny this project.

CHAIRWOMAN OLSON: Thank you.

Next.

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

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

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

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

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

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

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

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

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

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

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

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

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

In a broader sense, the city of

Rockford --

MR. ROATE: Two minutes.

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

Thank you for your time and your attention.

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

Next five.

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

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

CHAIRWOMAN OLSON: You can go ahead and start.

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

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

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

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

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

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

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

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

MR. ROATE: Two minutes.

PASTOR DIXON: We ask --

CHAIRWOMAN OLSON: Please conclude.

PASTOR DIXON: We are in support of this project.

CHAIRWOMAN OLSON: Thank you.

Next.

MR. HANEY: Good morning.

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

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

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

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

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

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

Thank you very much.

CHAIRWOMAN OLSON: Thank you.

Next.

Can you please just pass the mic.

DR. DORSEY: Good morning.

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

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

allow that unit to accept more transfers from Northern Illinois.

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

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

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

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

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

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

And I urge you to deny this CON application.

CHAIRWOMAN OLSON: Thank you, Doctor.

Next.

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

Avenue.

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

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

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

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

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

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

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

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

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

CHAIRWOMAN OLSON: Thank you, Doctor.

Next.

DR. HERNANDEZ: Good morning.

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

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

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

(Laughter.)

DR. HERNANDEZ: I'm sorry.

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

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

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

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

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

For these reasons I would urge you to deny

the UW/Swedes CON application.

Thank you.

CHAIRWOMAN OLSON: Thank you, Doctor.

Next, Jeannie.

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

THE COURT REPORTER: Please leave your remarks.

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

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

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

MAYOR MC NAMARA: Good morning.

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

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

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

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

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

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

behavioral health needs.

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

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

CHAIRWOMAN OLSON: Thank you, Mr. Mayor.

Next.

MR. HOULIHAN: William P. Houlihan. William, W-i-l-l-i-a-m; P.; Houlihan, H-o-u-l-i-h-a-n.

Good morning. My name is Bill Houlihan. I serve as the state director for United States Senator Dick Durbin. Senator Durbin joins his Senate colleague from Illinois, Tammy Duckworth, in supporting the SwedishAmerican Hospital modernization project.

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

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

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

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

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

The major modernizations and new

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

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

Thank you so much.

CHAIRWOMAN OLSON: Thank you.

Next.

MS. RIPSCH: Good morning.

CHAIRWOMAN OLSON: Good morning.

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

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

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

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

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

Crusader's decision to move care from

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

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

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

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

Thank you.

CHAIRWOMAN OLSON: Are there five?

MS. MITCHELL: I called five names.

CHAIRWOMAN OLSON: Who are we missing?

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

I might be pronouncing that incorrectly.

CHAIRWOMAN OLSON: Going once, going twice.

Okay. Go ahead. Please, anybody can start.

MS. BEBINGER: Good morning. My name is

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

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

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

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

Meadowbrook Geneva is the future of health

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

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

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

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

nursing care admissions.

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

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

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

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

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

MR. ROATE: Two minutes.

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

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

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

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

20 criteria to justify the proposed CON project.

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

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

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

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

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

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next, please.

MR. WEISS: My name is Daniel Weiss,

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

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

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

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

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

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

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

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

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

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

MR. ROATE: Two minutes.

MR. WEISS: We strongly oppose this project.

CHAIRWOMAN OLSON: Thank you.

Next, Jeannie.

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

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

comments, please leave them at the table.

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

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

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

Any questions from the operation or

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

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

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

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

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

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

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

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

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

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

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

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

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

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

I truly believe that another facility --

MR. ROATE: Two minutes.

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

CHAIRWOMAN OLSON: Please conclude.

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

CHAIRWOMAN OLSON: Please conclude.

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

CHAIRWOMAN OLSON: I need you to conclude.

MS. LONG: -- by building another facility.

Thank you.

MS. MORAN: Hello. My name is Jenny Moran, J-e-n-n-y M-o-r-a-n. I'm the human resources director at BRIA of Geneva.

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

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

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

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

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

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

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

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

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

Thank you very much.

CHAIRWOMAN OLSON: Thank you, all.

Next five, please.

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

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

Anybody.

Thank you.

MR. VAVRINCHIK: Hi. Good morning. My

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

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

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

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

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

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

CHAIRWOMAN OLSON: Right into the mic,

please.

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next, please.

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

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

CHAIRWOMAN OLSON: Please speak into the microphone.

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

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

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

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

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

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

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

CHAIRWOMAN OLSON: Thank you.

Next, please.

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

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

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

the project.

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next, please.

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

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

The staff demand -- excuse me.

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you, sir.

Five more.

There's three more for Meadowbrook, and

then we'll take a short break.

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

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

CHAIRWOMAN OLSON: Somebody can go ahead.

Please.

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

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

CHAIRWOMAN OLSON: Pull that close.

MR. FRANK: Sorry.

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next, please.

MS. CHESLEY: Good morning.

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

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

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

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next, please.

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

I am a board-certified geriatrician, and

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

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

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next, please.

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

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

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

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

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

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

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

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

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

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

basis.

MR. ROATE: Two minutes.

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

CHAIRWOMAN OLSON: Thank you.

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

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

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

Jeannie, could you call the next five.

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

(No response.)

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

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

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

I'm the CEO for Extended Care Consulting,

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

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

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

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

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

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

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

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

MR. ROATE: Two minutes.

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next, please.

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

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

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

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

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

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

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

The Smith Crossing project is not needed

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

CHAIRWOMAN OLSON: Thank you.

Next, please.

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

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

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

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

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

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

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

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

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

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

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

MR. ROATE: Two minutes.

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

CHAIRWOMAN OLSON: Please conclude.

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

CHAIRWOMAN OLSON: Please conclude.

MR. ELLENS: -- can stay there.

CHAIRWOMAN OLSON: Thank you.

Next, please.

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

CHAIRWOMAN OLSON: Pull it closer.

MR. TAYLOR: Can you hear me? Sorry.

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

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

living project on their existing campus.

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

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

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

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

CHAIRWOMAN OLSON: Thank you.

Next.

MS. MITCHELL: Niki Mehta --

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

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

CHAIRWOMAN OLSON: Somebody please start.

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next, please.

MS. MAUCERI: Good morning. My name is

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

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

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

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

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

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next, please.

MR. BERKOVITS: Good morning. My name is

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

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

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

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

Failure to meet these four criteria speaks

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

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

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

Thank you.

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

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

addition is a 100 percent increase from their current licensure.

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

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

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

2016.

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

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

I would ask the Board to recognize Smith

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

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

CHAIRWOMAN OLSON: Thank you.

Next.

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

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

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

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

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

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

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

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

MR. ROATE: Two minutes.

MR. WEINTRAUB: Thank you.

We oppose this request and ask that it be denied.

CHAIRWOMAN OLSON: Thank you.

Next five, please.

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

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

(No response.)

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

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

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

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

speak against the Smith Crossing project.

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

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

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

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

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

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

CHAIRWOMAN OLSON: Thank you.

Next, please.

MR. MIELNICKI: Good morning, Board.

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

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

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next, please.

Either direction.

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

CHAIRWOMAN OLSON: Yeah. Just make sure

you clarify.

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

CHAIRWOMAN OLSON: That's fine.

MR. VINSON: Am I appropriate?

CHAIRWOMAN OLSON: Yes, you're appropriate.

MR. VINSON: Thank you.

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

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

CHAIRWOMAN OLSON: We appreciate that.

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

CHAIRWOMAN OLSON: Thank you.

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

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

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

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

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

either.

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

MR. ROATE: Two minutes.

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

CHAIRWOMAN OLSON: I need you to conclude.

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

Now --

CHAIRWOMAN OLSON: Thank you.

MR. VINSON: -- the point of --

CHAIRWOMAN OLSON: Sir, your two minutes are up.

MR. VINSON: Excuse me?

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

Thank you.

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

CHAIRWOMAN OLSON: Thank you.

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Finally, please.

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

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

CHAIRWOMAN OLSON: Can you move your mic a

little closer?

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

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

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

new building.

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

CHAIRWOMAN OLSON: Thank you.

That concludes the public participation hearing of the agenda.

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

And Courtney will tell you what they are.

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

VICE CHAIRMAN SEWELL: So moved.

CHAIRWOMAN OLSON: Second.

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

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

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

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

(Ayes heard.)

CHAIRWOMAN OLSON: Opposed?

(No response.)

CHAIRWOMAN OLSON: Motion passes.

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

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

MEMBER MURPHY: Motion.

VICE CHAIRMAN SEWELL: Second.

CHAIRWOMAN OLSON: All those in favor?

(Ayes heard.)

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

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

Mr. Constantino.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

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

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

Thank you, Madam Chair.

CHAIRWOMAN OLSON: Thank you, Mike.

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

Extension requests, there are none.

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

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

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

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

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

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

A motion, please.

VICE CHAIRMAN SEWELL: So moved.

CHAIRWOMAN OLSON: And a second.

MEMBER MURPHY: Second.

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

Do you want to swear them in?

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

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

(Seven witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chair.

The Applicants are proposing to establish

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

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

Thank you, Madam Chair.

CHAIRWOMAN OLSON: Thank you, Mr. Constantino.

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

MR. FOLEY: Yes, ma'am.

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

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

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

CHAIRWOMAN OLSON: You'll be fine.

MR. FOLEY: But this project, obviously,

is very important to me.

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

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

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

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

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

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

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

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

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

I might correct Charles. I am not Chris

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

MR. FOLEY: I did that on purpose.

MR. NICK VANGEL: I know you did.

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

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

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

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

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

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

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

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

Planning area need. The Board's

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

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

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

We did, in fact, submit pictures to the

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

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

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

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

nowhere near the state as a whole.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

page 105 of the application.

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

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

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

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

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

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

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

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

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

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

Some of those are, as I had said

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

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

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

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

Chris, if you would continue.

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

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

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

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

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

MR. NICK VANGEL: Thank you, Chris.

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

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

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

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

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

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

We again urge you to approve our project

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

Thank you so much.

CHAIRWOMAN OLSON: Thank you.

Questions from Board members?

Mr. Sewell.

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

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

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

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

Robert.

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

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

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

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

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

recent Greystone letter.

MR. CONSTANTINO: No.

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

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

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

We have to refer to Mr. Kniery.

MR. KNIERY: Sorry.

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

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

VICE CHAIRMAN SEWELL: 60.88 percent.

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

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

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

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

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

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

VICE CHAIRMAN SEWELL: It relates to for-profit.

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

VICE CHAIRMAN SEWELL: Okay.

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

CHAIRWOMAN OLSON: Other questions?

MEMBER MC GLASSON: Yes.

CHAIRWOMAN OLSON: Marianne and then Mr. McGlasson.

MEMBER MURPHY: Thank you.

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

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

MR. CONSTANTINO: That's correct.

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

MR. KNIERY: Yes.

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

So they were able to qualify the number of

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

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

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

MR. KNIERY: Correct.

MEMBER MURPHY: Okay. Thank you.

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

MEMBER MURPHY: Thank you.

MR. KNIERY: Yes.

CHAIRWOMAN OLSON: Mr. McGlasson.

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

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

Isn't the ratio of semiprivate rooms to

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

MR. KNIERY: I'll keep going.

MR. FOLEY: He's doing good.

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

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

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

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

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

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

abeyance.

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

MS. MITCHELL: A timetable for project completion?

MEMBER MC GLASSON: Uh-huh.

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

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

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

THE COURT REPORTER: I'm sorry.

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

THE COURT REPORTER: Thank you.

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

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

MR. NICK VANGEL: Absolutely.

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

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

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

But we need the mix because the success of

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

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

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

CHAIRWOMAN OLSON: Mr. Burzynski and

then --

MEMBER BURZYNSKI: Thank you.

These are just questions for points of clarification.

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

MR. NICK VANGEL: We have. We have.

MEMBER BURZYNSKI: Okay.

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

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

MEMBER BURZYNSKI: Okay. Thank you.

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

MR. CONSTANTINO: No, not yet.

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

MR. KNIERY: Yes.

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

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

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

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

CHAIRWOMAN OLSON: Other questions?

VICE CHAIRMAN SEWELL: This is for Mike,

also.

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

MR. CONSTANTINO: We use --

VICE CHAIRMAN SEWELL: We do it for right now?

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

VICE CHAIRMAN SEWELL: And --

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

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

MR. CONSTANTINO: Yeah. What --

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

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

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

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

MR. CONSTANTINO: That's correct.

VICE CHAIRMAN SEWELL: Okay. Not 150?

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

VICE CHAIRMAN SEWELL: All right.

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

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

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

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

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

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

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

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

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

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

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

MR. NICK VANGEL: Yes, that is correct.

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

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

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

CHAIRWOMAN OLSON: Okay.

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

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

MR. NICK VANGEL: Pardon me?

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

MR. CHRIS VANGEL: Yes.

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

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

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

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

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

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

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

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

Dr. Goyal, please go ahead.

MEMBER GOYAL: Thank you, Madam Chair.

MR. FOLEY: Technical difficulties.

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

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

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

The question has to do with everybody

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

Did I hear you correctly?

MR. NICK VANGEL: That's correct.

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

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

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

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

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

CHAIRWOMAN OLSON: Barbara.

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

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

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

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

I'll defer to Robert.

MR. JAFARI: I can address that.

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

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

MR. JAFARI: For every facility it's

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

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

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

MEMBER HEMME: Well, both Medicare and Medicaid.

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

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

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

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

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

CHAIRWOMAN OLSON: Yes.

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

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

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

MR. JAFARI: Yes.

CHAIRWOMAN OLSON: Other questions from the Board?

MEMBER MC GLASSON: It's not a question.

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

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

MEMBER HEMME: I'll second.

CHAIRWOMAN OLSON: All those in favor say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: Opposed, like sign.

(No response.)

CHAIRWOMAN OLSON: Okay. The motion is amended.

Is that -- are you guys okay with that?

MR. JAFARI: Yeah, that's acceptable.

MR. NICK VANGEL: That is acceptable.

CHAIRWOMAN OLSON: All right. Thank you.

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

MR. ROATE: Thank you, Madam Chair.

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

Senator Burzynski.

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

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

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

MR. ROATE: Thank you.

Ms. Hemme.

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

MR. ROATE: Thank you.

Mr. McGlasson.

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

MR. ROATE: Thank you.

Mr. McNeil.

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

address the issues and that's extremely important.

MR. ROATE: Thank you.

Ms. Murphy.

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

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: I vote no.

The project still fails to meet pretty critical criteria.

MR. ROATE: Thank you.

Madam Chair.

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

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

MR. ROATE: Thank you, Madam Chair.

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

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

CHAIRWOMAN OLSON: That's correct -- no, no --
MS. AVERY: March 31st.
CHAIRWOMAN OLSON: -- '18.
MS. MITCHELL: '19.
MEMBER MC GLASSON: '19.
CHAIRWOMAN OLSON: Oh, '19? Okay.
MR. ROATE: March 31st, 2019?
MEMBER MC NEIL: Yes.
MR. ROATE: Very good.
Thank you.
CHAIRWOMAN OLSON: Okay. The motion passes.
Congratulations.
MR. KNIERY: Thank you.
MR. FOLEY: Thank you very much.
MR. NICK VANGEL: Thank you very much.
CHAIRWOMAN OLSON: It is almost 12:15. We'll break for lunch for one hour -- oh, until one o'clock. I'm sorry.
We'll break for lunch until one o'clock.
(A recess was taken from 12:13 p.m. to 1:02 p.m.)
- - -

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

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

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

A motion, please.

MEMBER MURPHY: Motion.

CHAIRWOMAN OLSON: May I have a second.

VICE CHAIRMAN SEWELL: Second.

MEMBER BURZYNSKI: Second.

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

CHAIRWOMAN OLSON: Okay.

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

CHAIRWOMAN OLSON: Okay.

MR. CONSTANTINO: I apologize.

MS. AVERY: Thank you.

CHAIRWOMAN OLSON: Thank you.

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

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

The Applicant will be sworn in.

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

(Five witnesses sworn.)

THE COURT REPORTER: Thank you.

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

MR. CONSTANTINO: Thank you, Madam Chair.

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

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

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

CHAIRWOMAN OLSON: Thank you, Mike.

MR. CONSTANTINO: Thank you, Madam Chair.

CHAIRWOMAN OLSON: Comments for the Board?

MR. KNIERY: Thank you, Chair.

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

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

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

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

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

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

support for this project.

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

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

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

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

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

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

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

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

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

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

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

CHAIRWOMAN OLSON: That's fine.

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

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

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

CHAIRWOMAN OLSON: Yeah. I think you need

to address those, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

nine months of days' cash on hand.

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

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

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

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

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

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

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

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

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

Many times after our admissions director

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

should they outlive their means.

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

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

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

Thank you.

CHAIRWOMAN OLSON: Thank you.

Questions or comments from Board members?

Mr. Sewell.

VICE CHAIRMAN SEWELL: Yeah.

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

in their application.

MR. CONSTANTINO: Yes, from hospitals.

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

MR. CONSTANTINO: Yeah.

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

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

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

Frank, would you add to that --

VICE CHAIRMAN SEWELL: Respectfully,

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

MR. KNIERY: Yeah.

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

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

Am I describing that correctly?

MR. MARNERIS: Yes, you are.

Mr. Constantino and his staff did describe that and the reasons why the State has that when we met with them last month.

We felt that, instead of trying to do an RFP with the banks before we had a project and then paying a $20,000 fee if the project didn't go through, we'd be better served -- let's get the project approved and then let's go out and get the financing.

We have worked with three banks

continually throughout this process. Besides First Midwest Bank, which spoke this morning in support of the project, we've also worked with Huntington Bank and Byline Bank, and they all want to be part of this project.

VICE CHAIRMAN SEWELL: Okay.

CHAIRWOMAN OLSON: Other questions?

(No response.)

CHAIRWOMAN OLSON: So I just want to make sure I have these numbers right.

Was it last year that you had 2,494 referrals, of which you were only able to accommodate about 14 percent?

MR. GUAJARDO: So we started taking in our information on January 1st of 2016, and it ended on June 30th, 2017, so it's a span of 18 months.

CHAIRWOMAN OLSON: Okay. But that is the correct number? 2,494 referrals, of which you were only able to accommodate about 13 percent of them?

MR. GUAJARDO: That's correct.

MR. MORADO: Yes.

CHAIRWOMAN OLSON: Other questions?

(No response.)

CHAIRWOMAN OLSON: Seeing none, I would ask for a roll call vote.

MR. ROATE: Thank you, Madam Chair.

Motion made by Ms. Murphy; seconded by Senator Burzynski.

Senator Burzynski.

MEMBER BURZYNSKI: Again, this is one I struggle a little bit with.

I understand, in particular, the financing aspect of this and your concern of spending $20,000 and whatever, but I would suggest -- or I would guess that you've already spent a tremendous amount of money on architectural and those kinds of things. I don't know that. Or even purchase of the property or looking at your property.

But, anyway, having said that, I think you've addressed a lot of the issues that are here today, and I will support the project.

I vote yes.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: I vote yes for the same reason.

I think you've addressed all of the financial concerns that I had with this.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: I vote yes for reasons stated.

MR. ROATE: Thank you.

Mr. McNeil.

MEMBER MC NEIL: Yes. You've met the criteria and by updating with the messages here.

MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: I'm going to vote yes based on the testimony here today.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: I'm going to vote no.

There are too many of the financial ratios that are not met. I didn't think the explanation was satisfactory.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: I'm going to vote yes,

based on the fact that there's a 274-bed need in this HSA, and I believe that, if they meet all the CARF ratios --

THE COURT REPORTER: I'm sorry.

CHAIRWOMAN OLSON: I believe, if CARF feels they meet all the appropriate ratios, that we're probably pretty secure in the financial information we received.

THE COURT REPORTER: Thank you.

MR. ROATE: That's 6 votes in the affirmative, 1 in the negative.

CHAIRWOMAN OLSON: The motion passes.

MR. KNIERY: Thank you.

CHAIRWOMAN OLSON: Congratulations.

MR. MARNERIS: Thank you.

MR. MC GEE: Thank you.

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CHAIRWOMAN OLSON: Next, I would call to the table Project 17-052, Dialysis Center Beverly.

May I have a motion to approve Project 17-052, Dialysis Center Beverly, to establish a 14-station ESRD facility.

I'm sorry -- Dialysis Care Center Beverly.

May I have a motion.

MEMBER MURPHY: Motion.

CHAIRWOMAN OLSON: May I have a second, please.

MEMBER BURZYNSKI: Second.

CHAIRWOMAN OLSON: The Applicant will be sworn in, please.

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

(Five witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chair.

The Applicants propose to establish a 14-station ESRD facility in 6,313 gross square feet of leased space at a cost of approximately $1.6 million. The expected completion date is

October 31st, 2019.

We did receive a comment on the State Board staff report. I placed it in -- the hard copy in front of you this morning. It was sent by email last week.

CHAIRWOMAN OLSON: Thank you, Mr. Constantino.

Am I okay now?

MR. ROATE: Is it better?

CHAIRWOMAN OLSON: I can hear myself. I'm not worried about me hearing myself. I'm worried about everybody else.

No?

UNIDENTIFIED MALE: No, we can't hear you.

CHAIRWOMAN OLSON: Comments for the Board?

DR. SALAKO: Good afternoon, Board. Thank you for allowing us to speak.

I am Babajide Salako, Dr. Salako, B-a-b-a-j-i-d-e; Salako, S-a-l-a-k-o. I am the CEO of the Dialysis Care Center. I am represented here today with my team.

To my extreme left is Ms. Kristin Paoletti, who is my senior director of clinical services. Next to her is Ms. Melissa Smith, who

is my area administrator and head of my home program, my home dialysis program.

Next to her is Mr. Asim Shazzad, who is my chief operating officer, and right next to me here is Dr. Sarika Chopra, who is an associate nephrologist that works in the dialysis care center.

I have a few comments, and then we will be available for questions.

CHAIRWOMAN OLSON: Please.

DR. SALAKO: On October 25th, 2016, I had the benefit of appearing here before the Board. And if you'll recall -- I'm sure you see many providers -- we asked for CONs for our two clinics, DCC Oak Lawn and DCC Olympia Fields.

And at that time we requested for the CON, we were -- these were four sort of in-centers in the state of Illinois, and we requested those CONs because we felt -- this was a physician-owned dialysis provider, physician-managed dialysis provider.

We were very heavy in the home dialysis sphere, and we were looking for a way to have a continuum of care for our dialysis patients as

they transitioned out of home therapies into in-center therapies. And we felt that, by staying within our network of providers, we could continue to, A, manage those patients, give them the quality of care that we needed, and, B, continue to encourage those patients to get back into the home program.

Well, I'm very happy to report that, since those two clinics are open, they are -- they were certified without any deficiencies by CMS. As of today, February 27th, they are 50 percent occupancy.

What we saw during the trend of walls construction and openness of those two clinics were, for the first time in the areas where we were serving, we were now providing patients with options. Several patients were driving up, knocking on the doors of the clinics, telling our contractors that -- "When are these clinics going to open? We want to switch from DaVita or Fresenius to the clinics."

And in the weeks since our clinics have opened, just the rapid admissions we've been able to get into our clinics shows that there's a need

out there for other providers to come into the dialysis sphere to provide good dialysis care for patients. So that's the first thing I want to clearly state to the Board.

Other things we've been able to fully ascertain is -- as we have an open-door policy, we've been able to admit several patients, indigent patients, patients without insurances, patients waiting to get their Medicaid. You know, so we have an open-door policy. And several patients have come to us saying, you know, "I was rejected by, you know, the program at Christ Hospital. We can't place this patient in a Fresenius or DaVita. Will you take this patient?"

And we've said yes because we feel that we're providing a service to the community, and we believe that, with the expert care of my physicians and my nursing staff, we would rather admit the patient than deprive the patient of dialysis care based on their lack of or undesirable insurance.

Those are the two main things I want to get across.

Now, fast-forward to this project. Once

again, our nephrology practice continues to grow. We have more physicians working with us, and our physicians, once again, are saying, "We have all these patients on dialysis, on home therapies, in this particular part of town. We want to be able to have our own dialysis clinic that will ensure that, without losing those patients -- they go to Fresenius or DaVita -- and all of a sudden, hey, they place them on a home hemodialysis, they don't come back to PED."

That is something that we would like to really avoid and one of the reasons why we believe that we should go ahead and cater to those patients.

I'll let my medical director, Dr. Chopra, say a few words and the rest of my team.

DR. CHOPRA: Good afternoon. Can you hear me?

So I'm a nephrologist in the area where this dialysis unit would potentially open. In this area is where I take care of a large number of local patients with chronic kidney disease. And as the State Board survey tells us, there is a need for 75 dialysis chairs in this area alone.

Based on the number of CKD patients that I see in clinic and that my partners see in clinic, we certainly see a need for these chairs on the horizon. Given the expected care need, I believe this unit would provide a huge local service, one that also allows for flexibility and options for our patients.

The proposed center is close to acute care hospitals where our patients get quick access to inpatient care. They also wouldn't have to choose between keeping their nephrologist or traveling 30, 40 minutes before and after each dialysis session three times a week. Being able to retain one's physician is a huge part of patient comfort and continuity of care, which we know is very beneficial for our patients.

Also, I'd be able to provide more oversight and have more control over my patient care, and, as Dr. Salako discussed, this would help me continue my patient care plans to transition them back to home dialysis and even to transplant.

So based on the State Board's survey recommendations and what I see in my own CKD

clinic in this area, I think that this unit would serve my patients very well.

MS. SMITH: My name is Melissa Smith. I am an area manager for --

CHAIRWOMAN OLSON: Closer.

MS. SMITH: My name is Melissa Smith. I am an area manager for the company and also a hope therapies nurse. I come as an advocate for the patients, both current and future, that would be in use of this facility.

I can speak from personal experience with the patients out in the area where the approved McHenry DCC is going to be opening for the patients that are currently on home therapies in that program.

They're excited to see that, in the event that their dialysis catheter fails, that they have an option to remain within our program in a facility that is going to have the same quality of care and values that we carry currently with our patients and we're not going to have to transfer them out to different companies where they're going to lose their care team, potentially have to switch nephrologists, and items like that that

would have them have to restart their whole process with forming the relationships with their care team.

So the appropriate facility within this area would -- at the Beverly DCC -- would provide the current and future patients with that same opportunity. It is very important to have that continuity of care because it increases patient likelihood to come and be compliant.

Noncompliance is a huge issue in the dialysis world. But when you have that strong relationship with your care team, patients are more likely to come when they're supposed to come, receive their medications, really want to be involved in their care. So this facility would give them the opportunity to continue that care with their nephrologist and their care team.

MS. PAOLETTI: Hello. Sorry. Can you hear me?

My name is Kristin Paoletti. I'm the senior director --

CHAIRWOMAN OLSON: Pull it closer.

MS. PAOLETTI: My name is Kristin Paoletti. I'm the senior director of clinical

operations with Dialysis Care Centers.

I just want to wrap up by saying that continuing care is very important for quality. In order to continue to keep our patients on track for a transplant, just to continue better care, the continuity of care coming from our home programs to our in-centers is pretty vital, to make sure that these patients transition well.

Thank you.

CHAIRWOMAN OLSON: Thank you.

Questions from Board members?

Mr. Sewell.

VICE CHAIRMAN SEWELL: Yes.

I want to talk about a couple of the items in the State agency report that I don't think your letter of February 15 addresses.

Start with the financial viability. Why didn't you submit the financial ratios?

DR. SALAKO: Well, regarding financial viability, we are a company where we -- we have a trust. As you can see, we have a letter from a bank saying we have over $10 million in capital development money. That was shown as evidence. The letter was submitted to the State Board.

The way we -- we don't keep our funding -- we don't keep our funding cash in our ongoing capital -- in our ongoing current account, so what we do is we have a capital investment fund. And at the time when needed, we supply the letter to the State agency saying, "Hey, we have $10.1 million readily available for this project." This project is going to cost us $1.6 million. We are well funded for this project and for any other expansion of our business.

VICE CHAIRMAN SEWELL: Why didn't you submit the financial ratios?

That's an interesting statement but it's not the answer to my question.

MR. SHAZZAD: I think it was -- the financial ratios were included.

VICE CHAIRMAN SEWELL: I'm sorry?

MR. SHAZZAD: I believe they were included in that --

DR. SALAKO: In the initial application.

VICE CHAIRMAN SEWELL: Well, according to the State agency report, you know, you didn't qualify for the waiver, which means you wouldn't have to submit them --

MR. SHAZZAD: Correct.

VICE CHAIRMAN SEWELL: -- but you didn't provide the ratios and supporting information for those ratios as a comparison between the State standard and an analysis of your financial statements --

MR. SHAZZAD: We did.

VICE CHAIRMAN SEWELL: -- to show where you fit.

Mr. Constantino, are there financial ratios?

MR. SHAZZAD: We provided a pro forma.

MR. CONSTANTINO: They provided a pro forma income statement.

VICE CHAIRMAN SEWELL: But no ratios?

MR. CONSTANTINO: No ratios.

VICE CHAIRMAN SEWELL: I just want to know why you didn't do it. I have my students do that just as an exercise. It's not a big deal.

MR. SHAZZAD: I'm sorry. We'll do it next time.

VICE CHAIRMAN SEWELL: The other thing is on the planning area need. Again, I'm trying to see if your letter of February 15 really addresses

this issue, and I guess I don't understand. It doesn't appear that you have been specific with respect to the referrals that you would receive.

And I'm trying to understand -- it doesn't look like this letter really addresses the concern in the State agency report.

MR. CONSTANTINO: Yes. What we require -- what they provided was their population identified by CKD 3, 4, and 5.

VICE CHAIRMAN SEWELL: Okay.

MR. CONSTANTINO: And it appeared to me, when I reviewed it, that this was similar to the letter they provided for the applications that were approved for the facility 20 minutes from this one. Okay?

And it appears there -- it means -- there's duplicates of what they provided. I wanted them to identify each individual that would be utilizing the proposed new facility, this facility. And that wasn't provided, no.

VICE CHAIRMAN SEWELL: Okay.

MR. SHAZZAD: And -- I'm sorry. Can I answer that?

We reviewed the data that was provided.

There were some duplications; however, I would like to point out there were an additional 219 patients on the newer updated data that was provided with the application.

So there was additional data.

VICE CHAIRMAN SEWELL: But not referral letters?

MR. SHAZZAD: No, with referral letters.

VICE CHAIRMAN SEWELL: Were there referral letters?

MR. CONSTANTINO: The nephrologist provided a referral letter, but the information they provided us was their total population for CKD 3, 4, and 5 and not individual patients that would be utilizing the proposed facility --

VICE CHAIRMAN SEWELL: Yeah.

MR. CONSTANTINO: -- and that's what we needed or that's what we wanted here.

And they had one other -- I want to back up a minute.

They were approved -- the Board approved them for two facilities, one in Oak Lawn and one in Olympia Fields. Both have been certified for Medicare. We got that information last week.

So they have been certified, and they're up and running.

VICE CHAIRMAN SEWELL: Uh-huh.

MR. CONSTANTINO: My concern -- and I expressed this on the other applications they submitted -- is the cost of these facilities. I can't understand why they can do it so much cheaper than DaVita and Fresenius, the two largest opera- -- dialysis operators in the world.

That's my biggest concern. I don't believe we're getting all of the capital costs that are required by the Board.

VICE CHAIRMAN SEWELL: Okay.

DR. SALAKO: Can I answer that? I'll answer the cost question.

First of all, lucky for us, we have -- we're a small company. Our overhead is very minimal -- our overhead is very minimal. Unlike the CEO of DaVita, I don't have a Gulfstream IV jet that I have to put in the cost of the project, so our projects are coming -- I wish I did. But our projects are coming in honestly at the square footage.

Going back, the rate for the square

footage, we did 110 to $150 per square feet. Our overhead cost as a business, as a company, is so much smaller than a company with 50,000 employees with a huge corporate headquarters.

So these are the relative -- we have direct construction costs. And one of the things we did today was have the builder, landlord, talk in the public comment this morning. He came in and said he's going to do a turnkey project for us. These are ways in which we're very, very nimble and very, very creative in how to get our costs much lower.

By getting our costs much lower, our overhead is much smaller. That's why we're able to -- we're very flexible, and, unlike the big providers, we can now accept patients that, you know, pay little or sometimes nothing because we really try to -- we really try to offer a service here and try to offer an alternative to the LDLs. If we're going to build a clinic for 3- or $4 million, I think it becomes extremely -- extremely difficult for anybody to run a profitable business that way.

So we start by cost-cutting, we start by

being reasonable, and we always continue with that kind of mind-set in our organization.

CHAIRWOMAN OLSON: Other questions or comments?

Dr. Goyal.

MEMBER GOYAL: Thank you, Madam Chair.

I can -- George, did you fix it?

MR. ROATE: It should be on.

CHAIRWOMAN OLSON: Put your mouth closer to it. It's on.

MS. AVERY: It's on.

MEMBER GOYAL: If you say so.

Can you hear me?

MR. SHAZZAD: Yes.

MEMBER GOYAL: My name is Arvind Goyal, and I represent Medicaid.

Would you explain to me one item on page 6 of your application that says your Medicaid percentage is 2 percent. That's surprising. Could you talk about that a little bit?

DR. SALAKO: You know, just straightforward Medicaid. But, remember, in Illinois now almost everybody has some kind of Medicaid provider plan, so you're going to have

another type of Medicaid plan but -- not exactly for Medicaid but you're looking at, as of today, you know, Medicare managed plans, Medicare/Medicaid plans so --

MEMBER GOYAL: So that's not Medicaid?

MR. SHAZZAD: No, that's not.

DR. SALAKO: No, no, no.

MEMBER GOYAL: Should you or could you? Because that is Medicaid.

DR. SALAKO: If you put the whole group together, then we're looking at almost 30, 40 percent of our patients will be Medicaid as of today.

MEMBER GOYAL: Okay.

So I will ask Mr. Constantino, do you remember getting that impression, what percentage is Medicaid --

MR. CONSTANTINO: I --

MEMBER GOYAL: -- total?

Or is it -- is this the number?

MR. CONSTANTINO: That's the information that was provided to us by the Applicants, yes, Doctor.

MEMBER GOYAL: All right.

MR. CONSTANTINO: I don't -- that's the only number we have, is what is in that report, yes.

MEMBER GOYAL: So "Medicaid managed care" is Medicaid?

DR. SALAKO: Yes. So for all intents --

THE COURT REPORTER: Wait. You need your microphone, please.

DR. SALAKO: For all intents and purposes, we segregate that out. But if we include the Medicaid managed plans into it, then our numbers probably could be as high as 30 or 40 percent.

MEMBER GOYAL: Okay.

I have one other question, Madam Chair, if I may.

CHAIRWOMAN OLSON: Yes.

MEMBER GOYAL: And that is, could you tell the Board what your procedures might be when you get a new dialysis patient.

How do you sort out what kind of documentation you perform to determine if this patient is suitable for home dialysis? Plus, what procedures do you use to make sure the patient is appropriate or not appropriate for

transplantation?

DR. SALAKO: First of all, it's about patient choice, and it starts with patient education. An educated patient makes an educated choice.

So depending on where the patient is seen. As I say, is the patient seen by the physician in the clinic? Or is the patient seen by the physician in the hospital?

At whatever point, if the patient is seen pre-ESRD, we have a very robust patient education plan where we provide treatment options for the patient and we tell the patient, "These are the modalities that are available to you, these are the kinds of support you will get," and those alternatives in terms of treatment options would include transplant, obviously.

So we painstakingly educate the patients along what is available to them. You'll be very surprised the number of patients on dialysis who have transferred to us from other providers who will tell you things like "I never knew there was something called peritoneal dialysis" and they've been on dialysis for two or three years. Okay?

So we painstakingly educate our patients to make an informed choice. Once we work with the patients, family members, their support team, we really say, "Listen. If -- based on where we -- what you would like to do, we will give you all the care and support that you need."

And invariably, when the patients are educated, the percentage of patients that will take a home therapy increases tremendously, you know, as compared to the uneducated patient. You know, patients tell you things like, "Oh, I can't do home dialysis -- home therapy because" -- for instance -- "I don't have a caregiver." Well -- you know, or "My house is too small," all sorts of different reasons.

And you work with the patients. You work with them to educate them. You look at their operational or situational contingencies, and you really try to provide for them what both you and -- both the physicians and the nursing team and the care team and the patients feel is the best therapy for them.

And once you do that, a happy patient -- your patient's first -- is a successful patient.

Their outcomes are better. It's bad enough being on dialysis. But if you have a care team that really works with the patient, you'd be amazed about how well you can get a patient to do.

One other thing: In terms of transplants, every patient gets educated on transplant. And, you know, every patient gets -- we sign the patients up with transplant centers at Loyola, Christ Hospital, all across the state, and the patients get the required education. They get on the transplant list. They get transplant triaged. And once they get transplant triaged as needed, a healthy percentage of our patients do get transplanted, and we're really happy for them when they do get transplanted.

MEMBER GOYAL: Could you -- that's a great answer, and I appreciate the education.

Could you estimate what percentage of your new chronic kidney disease patients end up getting a transplant versus dialysis?

DR. SALAKO: I don't have the data for 2017, but I believe our data for 2016 is about 6.5 to 7 percent. But, you know, I'll have to get back with you with the exact numbers.

MEMBER GOYAL: Thank you.

CHAIRWOMAN OLSON: Other questions? Comments?

(No response.)

CHAIRWOMAN OLSON: Seeing none, I would ask for a roll call vote.

MR. ROATE: Thank you, Madam Chair.

Pardon my question. Can you remind me who made the motion and who seconded?

CHAIRWOMAN OLSON: Didn't you make the motion, Marianne?

MEMBER MURPHY: I did.

CHAIRWOMAN OLSON: And who down here seconded?

MEMBER BURZYNSKI: (Indicating.)

MR. ROATE: Thank you.

Motion made by Ms. Murphy; seconded by Senator Burzynski.

Senator Burzynski.

MEMBER BURZYNSKI: Based on the information we've received this afternoon, I will support the proposal. Aye.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: I don't feel that the financial information was sufficient enough, and so I vote no.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: I agree that -- with some hesitancy on the financial information, but I don't know what the downside is of -- they're not serving patients right now in a facility if we deny it. If they ultimately have financial problems, then they don't serve patients then, either.

So I think I like the idea that they are trying to break new ground and I'll support that.

MR. ROATE: Thank you.

Mr. McNeil.

MEMBER MC NEIL: I will vote yes because you did explain your financials. You have, what, $10.1 million in the bank? This is a $1.3-million project. Therefore, you have cash on hand.

MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: I'm going to vote yes for the reasons just stated.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: I vote no.

This is an application that could receive my support if they had answered the questions asked by the State agency.

If you -- if we request referral letters, give us referral letters. If we ask for financial ratios, give us financial ratios. They didn't do that.

So I vote no.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: With a little bit of trepidation, I'm going to vote yes here because I do believe that this is a model that offers an alternative patient choice, increased access. There is a 75-station need, and there was no opposition to the project.

So I vote yes.

MR. ROATE: Thank you, Madam Chair.

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

CHAIRWOMAN OLSON: The motion passes.

Congratulations.

MR. SHAZZAD: Thank you.

DR. CHOPRA: Thank you.

DR. SALAKO: Thank you.

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CHAIRWOMAN OLSON: Next, we have Project 17-053, DaVita Ford City Dialysis.

May I have a motion to approve Project 17-053, DaVita Ford City Dialysis, to establish a 12-station ESRD facility.

MEMBER BURZYNSKI: So moved.

CHAIRWOMAN OLSON: Second, please.

MEMBER MURPHY: Second.

CHAIRWOMAN OLSON: The Applicant will be sworn in, please.

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

(Three witnesses sworn.)

THE COURT REPORTER: Thank you. And please print your names on the sheet.

CHAIRWOMAN OLSON: Mr. Constantino.

MR. CONSTANTINO: Thank you, Madam Chair.

The Applicants propose to establish a 12-station ESRD facility in 7,000 gross square feet of leased space at a cost of $3 1/2 million.

The expected completion date is August 31st, 2019. There was no opposition, no public hearing, and no findings.

CHAIRWOMAN OLSON: Thank you,

Mr. Constantino.

In light of that report, would you like to -- do you have some comments? Please.

MR. BHATTACHARYYA: Yes. I just wanted to introduce myself. I'm the new division vice president at DaVita, so I wanted to introduce myself to the Board.

CHAIRWOMAN OLSON: A new table -- a new face at the table.

MR. BHATTACHARYYA: That's right.

And given the fully positive State agency report, I'll keep my comments brief.

But I just want to give just a brief overview of the dialysis market here in Chicago, especially for the new members here.

As you-all know, kidney disease is a major health burden in the United States. About 30 percent are -- excuse me -- 30 million, about 15 percent of US adults, are afflicted with that disease, and this often progresses to end stage renal disease where these patients need treatment three times a week, 52 weeks a year to stay alive. And the name of my company, DaVita, actually means "to give life," which is what our men and women in

our clinics do every single day.

And so because of the frequency of that treatment, the way we approach the market is to try and ask for a small number of stations across a wide geography in the city so that it's easily accessible for patients in those local markets.

And from a clinical perspective, DaVita is -- both nationally and in Chicago -- the clinical leader in terms of clinical outcomes, as verified by CMS through the five-star program and other programs.

So, again, I just wanted to introduce myself, and we'll be happy to take any questions.

CHAIRWOMAN OLSON: Thank you.

Questions from Board members?

(No response.)

CHAIRWOMAN OLSON: Seeing none, I'd ask for a roll call vote.

MR. ROATE: Thank you, Madam Chair.

Motion made by Senator Burzynski; seconded by Ms. Murphy.

Senator Burzynski.

MEMBER BURZYNSKI: Based on the staff reports, I vote yes.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Based on the staff reports, I vote yes.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Based on staff reports, I vote yes.

MR. ROATE: Thank you.

Mr. McNeil.

MEMBER MC NEIL: Based on staff reports and meeting criteria, I vote yes.

MR. ROATE: Thank you.

Ms. Murphy.

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

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: I vote yes; no findings.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: Yes, for reasons stated.

MR. ROATE: Thank you.

7 votes in the affirmative.

CHAIRWOMAN OLSON: The motion passes.

Congratulations.

And thanks for introducing yourself.

MS. FRIEDMAN: I'd like to think we could get a vote even if we had negative findings, so we're going to work on that.

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CHAIRWOMAN OLSON: Project 17-054, Lurie Children's Hospital.

May I have a motion to approve Project 17-054, Lurie Children's Hospital, for an expansion project in its oncology ICU department.

A motion, please.

MEMBER MURPHY: Moved.

CHAIRWOMAN OLSON: May I have a second.

VICE CHAIRMAN SEWELL: Second.

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

(Five witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chair.

The Applicants are proposing to expand inpatient hematology and oncology service with the addition of a 24-bed ICU unit adjacent to the existing 24-bed pediatric medical/surgical unit.

The anticipated completion date for the project is September 30th, 2020. The project cost is approximately $27.2 million. There was no opposition to this project, no public hearing, and

we did have one finding related to the cost of the project.

Thank you, Madam Chair.

CHAIRWOMAN OLSON: Comments for the Board?

MR. MAGOON: Good morning. My name is Patrick Magoon. I have the privilege of serving as the president and chief executive officer of Ann and Robert H. Lurie Children's Hospital in Chicago.

With me here this afternoon is Dr. Stewart Goldman to my immediate left. Dr. Goldman is the division chief of hematology, oncology, neuro-oncology, and stem cell transplant. To his left is Mr. Eric Hoffman, senior director of facility services.

To my immediate right is Mr. Ralph Weber, our CON consultant, and to his right is Dr. Michelle Stephenson, our executive vice president and chief operating officer.

The project before you today proposes to add 24 intensive care beds dedicated to cancer care on the 17th floor of Lurie Children's Hospital. If approved, this unit will be adjacent to the existing 24-bed hematology/oncology

medical/surgical unit. Colocating the ICU with the existing medical/surgical units on the same floor enhances the coordination of care for cancer patients on both units, and it greatly facilitates the work of our teams, of our hematology and oncology specialists.

This bed expansion project addresses the need for additional ICU beds. Lurie Children's ICU patient volumes have increased by an average of 14.2 percent per year over the last seven years. Last year in May you approved our project to add 44 ICU beds on the 22nd floor to address a portion of this need.

In the "Alternative" section of the permit application, we referenced this 24-bed hem/onc ICU project on the 17th floor as an expanded project with the 44 ICU beds on the 22nd floor; however, we had not advanced our planning of the 17th-floor project sufficiently to have included it at that time and went forward with the 22nd-floor project, so here we are today requesting your approval for the beds to support the specific hematology/ oncology needs.

Similar to the ICU total growth, the

growth in our hematology/oncology medical/surgical service has increased significantly, and it has implications for the proposed ICU project.

Let me highlight just a few of the numbers from the application that we've submitted.

First, our medical/surgical hem/onc volumes have increased on average of 10.5 percent per year for the past four years. Last year we had approximately 9,500 med/surg hem/onc patient days. Over 7500 patient days were served in the 24-bed unit for an occupancy level of 86 percent. As a result of the high occupancy level, over 8900 -- or pardon me -- 1,900 days spilled over to other med/surg units.

About 30 percent or over 2800 of these individual med/surgical patient days were ICU eligible. At this rate of growth, over 6500 ICU-eligible medical/surgical patient days are forecast for the year 2022, the second year after the project is to be completed.

This is an average daily census of 18 ICU patients or 75 percent occupancy over the 24 ICU beds, which exceeds the State standard of 60 percent.

The ICU project is continued evidence of the growth that we've seen since we've moved from our Lincoln Park campus to that of our academic partner, the Feinberg School of Medicine.

For the past 20 years, Lurie Children's has established partner relationships with 16 hospitals across northeastern Illinois. Over half or nine of these partner hospital relationships have been sustained since the Review Board approved our new hospital in February of 2008.

These collaborative relationships have both enhanced patient care locally -- we're able to keep children in their local community, where it's more convenient and it's more accessible, and it also provides us the opportunity to provide complex care to those children who need the tertiary referral center that we have downtown.

Furthermore and most importantly, the ongoing recruitment of pediatric subspecialists at Lurie Children's has provided an important referral source for physicians throughout the region.

Dr. Goldman will now discuss developments

in hematology/oncology and the need clinically for the ICU unit.

Dr. Goldman.

DR. GOLDMAN: Thank you.

I am really pleased and honored to be here with you today to represent our hematology/oncology staff, our patients, and families. These children, adolescents, and young adults and their families fight courageous battles.

The good news is that, through research and our clinical trials, that we're now having increasing chances for these children and young adults to survive. I want to talk to you just about a few of the accomplishments and exciting things that we're doing at this time.

I start with our trial of using the human IL 12 gene that's put in through an adenovirus, the common cold virus, done surgically for patients with high-risk brain tumors that have no operative or other curative intent.

As I can explain to you, the IL 12 has been like the gas pedal on our immune system, and we've tried to harness this for many years. Unfortunately, when you turn the immune system on

without a way to control it, the side effects of turning the immune system on outweigh the benefit of cancer-fighting therapies.

We now are able to regulate IL 12 by taking a pill called veledimex, which is a ligand. Without this ligand the gene will not be turned on. Lurie Children's is the first institution in the country of the planned three institutions -- the other two being Dana-Farber Cancer Institute at Harvard and UC-San Francisco Children's Hospital -- to provide this therapy.

And when we speak about brain tumors, we think about the 8 million people in the Chicagoland area. If 18 percent of those are children, looking at our incidence of CNS tumors, we would expect about 80 patients in the Chicagoland area diagnosed a year.

New patients to our institution, those that are newly diagnosed or come to us after a diagnosis of brain tumor, either recurrence or for treatment, last year was between 160 to 170 new patients, so the need continues to grow for the therapies we provide.

Stem cell transplantation and cellular

therapy are areas that we have tremendous growth. We are now embarking on the world of chimeric antigen receptor T cells where we can, again, harness the body's cells to fight cancer.

I'm very proud to tell you that a New England Journal article will be coming out in the next few weeks led by one of our physicians, Dr. Thompson, who -- we've been able to take patients with thalassemia and, through manipulating a gene, have now made them transfusion independent and, basically, taken away from the need of constantly being near their hospitals.

This Bluebird trial we're now extending to young adults and soon to children with sickle cell anemia to keep them away from being transfusion dependent. We also perform bone marrow transplantation for patients who have matched donors with sickle cell anemia and transplantation.

Our bone marrow transplantation program has grown at a tremendous rate. This year, in this first financial quarter of 2018, we're doing approximately 25 of these procedures.

Last but not least -- again, our growth is important, but our ability to make sure we care for each individual child and their family with the best possible care requires a team approach. Having our unit with our specialized physicians, nurses, child life specialists, and staff is essential to delivering the very finest possible quality we can for the children we serve.

Thank you.

MR. MAGOON: So our specialty programs, such as hematology and oncology and stem cell transplant, have resulted in Lurie Children's ranking as a top children's hospital in Illinois and ranking number seventh in the country by US News and World Report. Lurie Children's is the only children's hospital in Illinois to be on the Best Children's Hospital Honor Roll for six consecutive years.

And as you know, we're the primary teaching site for Northwestern University's Feinberg School of Medicine, training over a hundred fellows and a hundred pediatric residents each year.

As you know from previous applications,

Lurie Children's has a special commitment to serving all of Illinois' children, including those insured by the Medicaid program. In fiscal year 2017, 56 percent of our inpatient days and 46 percent of our outpatient services were provided to patients covered by Medicaid or a Medicaid managed care plan.

This is -- as you may know, there was only one negative finding in the State report. Our $620 cost per square foot is about $139 above the State standard of $481 for this project. We appreciate that the State staff report on our project includes the documentation we provided for the several reasons explaining the higher capital costs that are not found in a typical project.

These include construction in a high-rise building requiring dedicated elevators and maintaining positive airflow pressure to prevent pathogens from the work area from entering the adjacent medical/surgical unit serving immunocompromised hematology and oncology patients on that unit.

Plumbing installation needed to support the 17th floor causes description to the ceilings

and the finishes on the 16th floor below. Extended phasing of the project is needed to minimize disruption on the 16th floor below, our pediatric intensive care unit, and to the specialized care on the 18th floor above, which is our infusion therapy unit.

Eric Hoffman is here, who can offer further information regarding the details if you'd like. But, collectively, our justification explains more than the $139 per square foot in spending above the State standard.

In closing, I want to thank the Illinois Health Facilities staff and Board for their excellent partnership in reviewing this project and their technical assistance, and we thank you on behalf of those that we serve for your consideration of this project.

CHAIRWOMAN OLSON: Thank you.

Are there questions from Board members?

(No response.)

CHAIRWOMAN OLSON: Seeing none, I would ask for a roll call vote.

MR. ROATE: Thank you, Madam Chair.

Motion made by Ms. Murphy; seconded by

Mr. Sewell.

Senator Burzynski.

MEMBER BURZYNSKI: I vote yes based on the testimony we've heard today.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on the testimony we've heard today.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the testimony we've heard today.

MR. ROATE: Thank you.

Mr. McNeil.

MEMBER MC NEIL: Yes, based on the report and the testimony.

MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: Yes, based on the explanations given today for the one staff finding.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: Yes, for reasons

stated by Ms. Murphy.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: Yes, as well, for reasons stated by Ms. Murphy.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRWOMAN OLSON: The motion passes.

Congratulations. Thank you for your presentation.

MR. MAGOON: Thank you.

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CHAIRWOMAN OLSON: Next, we have 17-056, Fresenius Kidney Care Galesburg.

May I have a motion to approve Project 17-056, Fresenius Kidney Care Galesburg, to relocate an existing 14-station ESRD facility.

A motion?

MEMBER BURZYNSKI: So moved.

CHAIRWOMAN OLSON: Thank you.

A second?

MEMBER HEMME: Second.

CHAIRWOMAN OLSON: Thank you.

VICE CHAIRMAN SEWELL: Did you get a second?

CHAIRWOMAN OLSON: Yes.

Please be sworn in.

THE COURT REPORTER: If you could ask them to leave their documents, even the later ones.

Would you raise your right hands, please.

(Two witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: Mr. Constantino.

MR. CONSTANTINO: Thank you, Madam Chair.

The Applicants are proposing to discontinue an existing 14-station ESRD facility

in Galesburg, Illinois, and establish a 14-station replacement facility in Galesburg.

The cost of the project is approximately $6.9 million, and the expected completion date is December 31st, 2019. We had one finding related to this project. There was no opposition and no public hearing.

Thank you, Madam Chair.

CHAIRWOMAN OLSON: Thank you, Mr. Constantino.

Comments?

MS. CONNOR: Yes. Thank you.

My name is Clare Connor, C-o-n-n-o-r, and with me is Lori Wright, W-r-i-g-h-t. I'm CON counsel to Fresenius, and Lori is the CON specialist.

As always, thank you to Mr. Constantino and Mr. Roate for their assistance and thank you to the Board for your time and to the new Board members for agreeing to serve on the Board.

As Mike said, there is no opposition. This application is simply to relocate an existing 14-station facility in Galesburg, Illinois, to another location which will provide more space.

That is important for patient care and quality as well as staff satisfaction because our current space is quite cramped.

Also, we have a 24-patient home program at this location. As you've heard from a prior presentation, home therapy is a very good form of therapy for patients. It typically is associated with better outcomes and lower cost.

Although it's not necessarily appropriate for all patients, we do have a very busy home program, and we would like to expand it. There are patients who want to get into it, but we cannot due to the limited space for our current location.

The one finding that we had was on cost of the project. And Mike can correct me if I'm wrong, but that cost relates to the modernization cost. This is a new construction building that we will be leasing space in if you approve our project and we are able to relocate to it, and our modernization costs, which are the build-out costs for the space, exceeded your standard by 2.6 percent.

Typically Fresenius projects always come

under what we estimate, but, nonetheless, we were over based upon the standard that is calculated to a midpoint of construction, and the standard that was used for -- or the time frame was 2018.

If you use 2019, we would meet your standard. And because this is new construction space, we probably will not get that space turned over to us for modernization until latter 2018, which means the midpoint of construction would be in 2019, and then we would have met your standard, although, even not meeting it, we're only 2.6 percent away, so we hope you will approve the project.

Thank you.

CHAIRWOMAN OLSON: Thank you.

Questions from Board members?

(No response.)

CHAIRWOMAN OLSON: Seeing none, I would ask for a roll call vote.

MR. ROATE: Thank you, Madam Chair.

Motion made by Senator Burzynski; seconded by Ms. Hemme.

Senator Burzynski.

MEMBER BURZYNSKI: I vote yes based on

lack of opposition.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on staff reports.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on staff reports.

MR. ROATE: Thank you.

Mr. McNeil.

MEMBER MC NEIL: Yes, based on the report and the testimony here.

MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: Yes, based on today's testimony.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: I vote yes.

Excellent explanation for $5.13.

(Laughter.)

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: I vote yes for reasons stated.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRWOMAN OLSON: Motion passes.

Congratulations.

MS. WRIGHT: Thank you.

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CHAIRWOMAN OLSON: Next, I would call 17-057, Valley Ambulatory Surgery Center.

May I have a motion to approve Project 17-057, Valley Ambulatory Surgery Center, to establish an ambulatory surgery treatment center.

VICE CHAIRMAN SEWELL: So moved.

CHAIRWOMAN OLSON: Second, please.

MEMBER MC NEIL: Second.

CHAIRWOMAN OLSON: If you have written testimony, the court reporter would appreciate your leaving it if you can.

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

(Five witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chair.

The Applicants are proposing to establish a multispecialty ASTC in approximately 24,530 gross square feet of leased space at a cost of approximately $16.6 million and an expected completion date of October 31st, 2019.

There was opposition to this project, there was a public hearing held, and we do have findings.

I do apologize to the Board. I did not attach their safety net impact statement, as Mr. Vinson pointed out to us this morning. Mr. Vinson was correct.

However, in the -- if you look at the exemption, which is C-01, there's a detail which the Applicants provided additional information regarding charity care that Jeannie had requested back in -- or was submitted to us back in January of '18.

CHAIRWOMAN OLSON: Thank you, Mr. Constantino.

Comments for the Board?

MR. TAPARO: Good afternoon.

CHAIRWOMAN OLSON: Good afternoon.

MR. TAPARO: Is that fine?

CHAIRWOMAN OLSON: Yes, you're good.

MR. TAPARO: Good afternoon. My name is Tony Taparo, T-a-p-a-r-o. I'm the president of operations for the Atlantic Group at Surgery Partners.

Seated with me today are Jennifer Baldock, our senior vice president and general counsel; Mr. Dan Hauer, our facility administrator; Dr. Giamberdino, our facility medical director; and Dan Lawler, our CON counsel.

I want to thank the Health Facilities and Services Review Board members and all the staff for your time today.

Valley Ambulatory Surgery Center is requesting approval to relocate its multispecialty ASC in a newly constructed, steel framed, all-brick-exterior building --

MS. AVERY: George -- sorry. Go ahead.

MR. TAPARO: Go ahead?

MS. AVERY: Yes.

MR. TAPARO: -- down the street from its current location.

By establishing a new, state-of-the-art facility, Valley will be able to provide patients and staff a better clinical environment in a more efficient space, avoid erroneous disruption in service to the patients and physicians, and avoid exorbitant cost repairs to the existing facility.

The proposed new facility will consist of

six operating rooms, two procedure rooms with three dedicated 23-hour private recovery suites. The project will not increase operating rooms or add new categories of service, and no area health care providers have opposed our application.

In 2017 Valley performed 7,312 surgical cases. As I previously mentioned, the current building is 30 years old and now outdated and simply no longer suitable as an ambulatory surgery center.

The extensive repairs and upgrades needed would cause lengthy facility closures and a major disruption of patient care, interfere with physicians' ability to schedule surgical procedures, harm employee morale, and would still not meet the current standards for today's ASCs.

I would like to acknowledge and thank the broad-based supporters of this project: The Mayor of St. Charles, the Kane County Board chairman, State Representatives from the 49th, 50th, and 65th districts, the State Senators from the 25th and 33rd districts, the executive director from the Kane County Health Department, and the St. Charles Chamber of Commerce.

Again, I want to thank the CON Board and the staff for the time and the opportunity to present this project, as we will continue to be the low cost, high quality care provider to patients in St. Charles and the surrounding communities for the next 30 years.

Mr. Hauer and Dr. Giamberdino will address the specific reasons for this relocation project, and Mr. Lawler will then address the findings of the staff report.

Thank you.

MR. HAUER: Good afternoon. My name is Daniel Hauer, H-a-u-e-r.

Can you hear me?

CHAIRWOMAN OLSON: Closer.

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

MR. HAUER: Good afternoon. My name is Daniel Hauer, H-a-u-e-r. I'm the administrator for Valley Ambulatory Surgery Center.

I'd like to thank everyone here today for their ongoing commitment to ensure patients maintain access to health care services in our state.

Now a little history of Valley Ambulatory

Surgery Center: Valley was founded in 1987 by a group of physicians with a vision that outpatient surgery can be safely performed outside of the traditional hospital delivery model, where true one-on-one experiences can happen and physician-to-patient approaches would allow for individualized, patient-centered treatment plans.

30 years and more than 110,000 patients later, here we are. We have earned a strong reputation in the Fox Valley as the place for elective surgery with some of the best quality outcomes in the nation. Valley is requesting a CON permit to relocate to a new state-of-the-art facility down the street from our current location.

Since 1987 health care standards and patient expectations have evolved dramatically. For example, our current building construction and electrical infrastructure are based on codes that are from the 1980s. Another example is our plumbing infrastructure that is failing due to corrosion and age.

In addition, compliance with the American Disability Act is an ever-growing challenge and

concern. Many areas of the building are still behind the times, from accessible doors, toilets, sinks. Even the grade of our parking lot and walkways are not compliant.

As for the expectation and demand of today's surgical patient, there is a need for larger operating rooms to accommodate higher acuity cases. Moreover, patients expect health care facilities to offer a modern and accommodating atmosphere where amenities are plentiful and privacy is maintained.

In summary, this request for our relocation is a testament of our continued commitment to the community and should be perceived as nothing more than an opportunity to offer patients a state-of-the-art surgery center where safety and preparedness meet welcoming and convenient.

Please approve this project. Thank you for your time today.

CHAIRWOMAN OLSON: Thank you.

DR. GIAMBERDINO: Good afternoon. I'm Anthony Giamberdino, G-i-a-m-b-e-r-d-i-n-o. I'm a physician.

My perspective on this CON application is informed by long firsthand experience with this center. I've been a full-time staff anesthesiologist at Valley Ambulatory for 27 years. For the past 10 years I've served as the center's medical director and chief of anesthesia services, so there's probably no one in a better position to assess the abilities and limitations of this building than I am.

I also have the unique perspective on this CON because, while serving as the VASC medical director, I'm also one of the co-owners of the building and, thus, part of the landlord group. In other words, I have a financial interest in seeing the center stay in its current building, but, you know, based on what I see with the building and my ability to take good care of my patients, I have to go with my patients' interest first, and I think this building has way outlived its usefulness. So I'm here today to express my strong support for this application.

As stated before, the building is 30 years old and is currently not suitable for use as an ASC. One of our chief problems is there's been

multiple evolutions in the life safety code and infection control guidelines over the last 30 years, and this building is just not positioned to keep up with those changes and meet those standards. It's becoming progressively more difficult to get through an accreditation survey based on the physical plant.

As Daniel stated, the current building is not handicapped-accessible in accordance with the current ADA recommendations. Our sterile processing work space is not separated into clean and dirty instrument areas, and the loading dock is not designed to protect the integrity of medical products.

The infrastructure of the current building has numerous serious electrical and plumbing deficiencies and is not cabled for modern IT needs. More importantly, we've had leaking fire sprinkler lines and a malfunctioning fire alarm that has actually resulted in false alarms and closing the center for periods of time, meaning cancellations of people's surgeries and delaying of their care.

Staff lockers do not connect directly to

the sterile corridor, as is required to prevent one way -- to preserve one-way flow of traffic from nonsterile to sterile areas of the facility.

The building exterior requires extensive roofing and foundation repairs. The main entrance and the interior have significant layout problems that can only be addressed through teardown and reconstruction. I could go on.

To avoid the long-term interruption in patient care that would be required to gut the place and do a massive rebuilding, Valley plans to relocate to a new steel-frame building with less total square footage and a more efficient and modern design. The new facility would be just a quarter mile from our current facility.

The new facility would be convenient for patients and staff, compliant with current codes and best practices, and feature a cost-efficient layout with new mechanical and electrical systems.

Moreover -- and I think importantly going forward -- this new building would be much better suited to adapt to life safety and infection control guidelines as they evolve in the future. I think we've adapted our building as far as it

can be adapted.

Valley has an outstanding clinical staff. We urgently need a modern facility to meet the outpatient surgical needs of the greater St. Charles area for years to come. I respectfully urge your favorable consideration for this CON application.

Thank you for your time.

CHAIRWOMAN OLSON: Thank you.

MR. LAWLER: Thank you.

Good afternoon. My name is Dan Lawler. I'm a partner with the law firm of Barnes & Thornburg, and I'd like to respond to the negatives in the staff report on this project.

As your general counsel, Ms. Mitchell, knows, I've been thinking and writing a lot about the effect of negatives in the staff report. In fact, I've been thinking and writing a lot about that for a long time. I've been involved in over 20 court cases relating to CON permits over the years. Present circumstances notwithstanding, I'm on the Board's side more often than not in those cases.

But whether I'm on the Board's side or on

the other side, I've always taken a consistent position as to the effect of negatives in a staff report. I've always taken the position that the Board has discretion to approve projects that have negative findings in the staff report. The Board rules allow that, and the Courts have long recognized that discretion.

People have different ways of thinking about this discretion. And the way I look at it is that Mr. Constantino and the staff strictly apply the law, while the Board can apply grace. It doesn't have to, but it has the discretion and the authority to.

Another way to look at it is that Mr. Constantino and the staff apply the letter of the law jot and tittle, and this Board can follow the spirit of the law. That is a principle the Courts recognize, as well.

The statutory language of the Planning Act is that a project must be in accord with the Board's criteria, and Courts have said that "in accord with" means the same thing as "substantial conformance." Courts have also interpreted the term "substantial compliance" to mean such

compliance as will assure that the beneficial effect of the rule will be achieved.

In other words, is the purpose behind the rule being achieved? Is the spirit of the law fulfilled? And if it is, this Board has the discretion and authority to approve a project.

The Valley Ambulatory project fulfills the letter of the law on the large majority of the criteria and the spirit of the law as to the others. The negatives relate to our utilization, the utilization of other facilities, and a few financial criteria.

I'll take the last first. The purpose of the financial criteria are to determine whether the project is financially viable. If a facility isn't going to be financially viable, it should not be built.

Valley Ambulatory Surgery Center has demonstrated its financial viability by virtue of the fact that it has been in operation for 30 years. The center is financially viable, and its financial viability will be enhanced by this project in a number of significant ways.

First, a new, modern facility will be less

costly to operate. Second, our lease payments will be significantly less. And, third, when we relocate, we will be discontinuing the postsurgical recovery care demonstration program that we have been operating and has been a net loss on our financial operations.

Most operators that participated in this demonstration program have already discontinued their own recovery care centers for financial reasons. We will be discontinuing ours.

Valley Ambulatory has demonstrated its financial viability for three decades, and this project will improve its financial operations. It fulfills the purpose of the financial viability criteria.

Regarding the utilization criteria, there are at least two purposes behind this: First, the Board has a policy that health care facilities should ideally operate at a minimum target utilization rate. Every facility has fixed operating costs, and the higher the utilization, the lower operating costs per unit of service. Lowering health care costs is an important goal of the Planning Act.

A second purpose behind the utilization target is to avoid unnecessary duplication of services. That's another important goal in the Planning Act. When there are lots of area facilities with excess capacity and underutilization, the creation of more capacity and more underutilization could result in the unnecessary duplication of health care facilities, contrary to the purposes of the Act.

The Valley Ambulatory project will not reduce utilization at existing facilities, and it will not be an unnecessary duplication of services. Courts have recognized that one of the easiest ways to tell if a project will impact existing facilities by reducing their utilization is that those facilities will show up and object to the project and ask this Board to deny it.

Here, not one existing provider has objected to this application. We notified every provider within 45 minutes' travel time, told them exactly what we're doing. Not one of them opposes this project.

Another factor the Courts recognize that directly impacts the utilization criteria is

whether a project involves a new facility that expands services and adds to capacity or whether it is simply a relocation project without expansion. In a court case very much like our project, a surgery center in Hinsdale was relocating its existing facility without expansion.

Unlike ours, they had other providers show up and object and then challenge the Board's approval because there were negative findings in the staff report under the utilization and unnecessary duplication criteria.

The Court upheld the Board's decision to issue the permit and specifically noted that the Applicant was not seeking permission to increase capacity in its facility and noted that relocation without expansion is different from expansion of capacity. Under these circumstances, the Court held that approval of the permit was within the Board's discretion.

Like the Hinsdale project, we are relocating without expanding. In addition, we have no providers objecting, as they did.

Finally, regarding our own utilization,

the criteria require us to project that we will hit target utilization within the second year of operation. Our facility has tremendous growth in cases last year, and we documented that in the application.

We had 22 percent increase in just the last 12 months. In projecting our utilization, we did not use 22 percent or 20 or 10 or even 5. With just a 3.8 percent growth rate, we will be at target utilization, and that is what we used in our projections.

This morning you heard a persistent opponent, Mr. Sam Vinson. I know Sam Vinson. My old law firm and his old law firm were in the same brick building, and Sam would regularly hold court in the bar in our atrium after-hours. I would occasionally stop in, order an iced tea, and hear the most incredible stories from Sam Vinson, but I never heard such an incredible story as the landlord in St. Charles who suddenly developed a passion for safety net services in Kane County.

Maybe that landlord is really interested in the revenue stream from his 30-year-old wood-frame building that is not ADA compliant and

not safety code compliant, but if he is concerned about the safety net, let me put his mind at ease. This project will have no impact on the safety net. We know this because not one provider has claimed that the project will have an effect on their safety net services. They all received notice of this project; they identified no adverse impact. The safety net is safe.

We have a good project here; it meets the letter of the law on the large majority of criteria and the spirit of the law on the criteria for which negative findings were made. This project is well within your discretion to approve, and we respectfully request your approval today.

CHAIRWOMAN OLSON: Thank you.

Questions from Board members?

(No response.)

CHAIRWOMAN OLSON: So -- go ahead, Mr. Sewell.

VICE CHAIRMAN SEWELL: I have more of a comment since CON counsel moved over into teaching mode.

I've got --

CHAIRWOMAN OLSON: Can you use your mic?

VICE CHAIRMAN SEWELL: Yes.

I have some experience with the Courts, also, because years ago -- too many to count -- I was a health system agency director for suburban Cook and DuPage County. And we said no to a project and this Board then said yes, and we prevailed in court because the Court ruled that a State agency must follow its own rules when the rule is a clear, unambiguous rule. So that's sort of a -- I don't know -- punctuation on some of your remarks.

Also, we've all recognized that there's a distinction between the needs of an institution versus the needs of a community. All the time what's good for an institution are not necessarily good for, you know, a community, and I think that's where our discretion comes in. We can't act as if we're Board members of an institution. We're Board members of a system, and we have to think about the system.

So I'm not disagreeing with anything you've said. I just think we need some periods and commas and exclamation points on some of the things you said.

Also, on this financial viability criterion that you mentioned, one of the problems there was, yeah, you didn't meet the cushion ratio, but the State agency report said that you didn't provide some of the financial ratio information for it to be evaluated one way or another. And that's difficult for us, too.

So -- any comments on that?

MR. LAWLER: Yes. I'll have Mr. Taparo address that.

We did provide the entire Form 10K for Surgery Partners, which has their-- everything that they can disclose about their financials. The ratios that were not provided -- or that were not satisfied -- relate to the surgery -- the surgery center's financials at their level.

But Surgery Partners is also supporting this project, and, as I indicated, the project has been financially viable for 30 years.

But, Tony, could you address the financial resources of Surgery Partners?

MR. TAPARO: Yes.

As Dan indicated, we did file the K-1. Our financials are strong as a company, and

we've -- financially, we've got bank support, and we have our company support.

So it's a very financially viable project, and we've got financial commitments both from the banks and from our corporate office.

VICE CHAIRMAN SEWELL: My concern is much more narrow than that. It's absent financial ratios, not so much whether you're financially viable overall.

Am I correct that one or two of the --

MR. CONSTANTINO: Yeah.

VICE CHAIRMAN SEWELL: -- ratios we asked for just weren't provided?

MR. CONSTANTINO: Yeah. The Applicants are required to provide the financial ratios. And they did in one case and they didn't in another.

And Surgery Partners could only disclose what Mr. Lawler said because they're traded on -- I don't know what exchange.

What exchange are you traded on?

MR. TAPARO: NASDAQ.

MR. CONSTANTINO: Pardon?

MR. TAPARO: NASDAQ.

MR. CONSTANTINO: NASDAQ.

MR. TAPARO: So there was certain information that we were not at liberty to provide.

VICE CHAIRMAN SEWELL: And can you say that --

MR. TAPARO: But we did provide the complete K-1 and our completed financials as of 12/31/2016.

VICE CHAIRMAN SEWELL: Can you say that the ones that you could not provide were the ones that were absent?

In other words, this NASDAQ limitation that was on you, that led you to not provide some of the ratios that were asked for?

That's what I'm trying to get at.

MR. LAWLER: Right. So based upon the information that could be disclosed, the ratios could not be calculated. So -- yeah.

VICE CHAIRMAN SEWELL: All right. Okay.

CHAIRWOMAN OLSON: Other questions or comments?

(No response.)

CHAIRWOMAN OLSON: So just to clarify --

VICE CHAIRMAN SEWELL: No.

CHAIRWOMAN OLSON: So I just wanted to clarify.

There's -- you're not changing the number of ORs? You're simply relocating your current number of ORs to a new site based on the building that's outdated?

MR. LAWLER: That's correct. It's not increasing. In fact, we're reducing one OR and increasing one procedure room.

CHAIRWOMAN OLSON: Okay.

MR. LAWLER: And so everybody's clear, we actually have two applications. One is to discontinue the existing and then to --

CHAIRWOMAN OLSON: Right.

MR. LAWLER: -- establish the other.

CHAIRWOMAN OLSON: All right.

Any other questions or comments?

(No response.)

CHAIRWOMAN OLSON: Seeing none, I would ask for a roll call vote.

MR. ROATE: Thank you, Madam Chair.

Motion made by Mr. Sewell; seconded by Mr. McNeil.

Senator Burzynski.

MEMBER BURZYNSKI: Based on what I perceive as the trade-offs of being able to move to a new facility and the benefits to the patients, I vote yes.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: I vote yes based on those stated reasons.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: I vote yes.

It seems to me to be more of a modernization, even, than a relocation.

MR. ROATE: Thank you.

Mr. McNeil.

MEMBER MC NEIL: I vote yes because it's a 30-year improvement. All of us maybe have been better 30 years ago but buildings aren't.

(Laughter.)

DR. GIAMBERDINO: Thank you.

MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: I vote yes based on all of the information contained in the report, the

information we heard at the hearing, and the explanations given today.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: I vote no, failure to meet projected utilization, service demand, treatment room need assessment, service accessibility, unnecessary duplication of services, and financial viability.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: I vote yes based on the fact that it's a relocation. If it was a new project, it would be more difficult for me to approve.

MR. ROATE: Thank you.

That's 6 votes in the affirmative, 1 vote in the negative.

CHAIRWOMAN OLSON: The motion passes.

MR. LAWLER: Thank you.

MR. TAPARO: Thank you.

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CHAIRWOMAN OLSON: And I think you're just going to stay there. Right?

MR. LAWLER: I'm sorry?

CHAIRWOMAN OLSON: We're going to do your exemption --

MR. LAWLER: Oh, that's right.

CHAIRWOMAN OLSON: -- so don't go anywhere. You're not done yet.

Valley Ambulatory Surgery. This is 048-17.

May I have a motion to approve Exemption 048-17, Valley Ambulatory Surgery Center, to discontinue an ASTC.

May I have a motion, please.

MEMBER BURZYNSKI: So moved.

CHAIRWOMAN OLSON: A second?

MS. MURPHY: Second.

CHAIRWOMAN OLSON: So am I correct that this discontinuation -- all that's required of the Applicant is to provide all the necessary information and the Board has to approve it?

MR. CONSTANTINO: That's right. That's correct.

CHAIRWOMAN OLSON: And your report would be that --

MR. CONSTANTINO: -- all the information was required.

CHAIRWOMAN OLSON: Okay.

Then I would ask for a roll call vote.

MR. ROATE: Thank you, Madam Chair.

Motion made by Senator Burzynski; seconded by Ms. Murphy.

Senator Burzynski.

MEMBER BURZYNSKI: I vote yes based on the fact that all the required information was presented.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on the staff reports and previously stated reasons.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: Yes, based on reasons previously stated.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: Yes, reasons already stated.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: Yes. The Applicant met the criteria.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRWOMAN OLSON: The motion passes.

MR. LAWLER: Thank you.

DR. GIAMBERDINO: Thank you.

MR. TAPARO: Thank you.

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CHAIRWOMAN OLSON: Next, we have Project 17-058, Premier Cardiac Surgery Center.

May I have a motion to approve Project 17-058, Premier Cardiac Surgery Center, to establish a limited specialty ambulatory surgery treatment center.

A motion, please.

MEMBER MURPHY: Motion.

VICE CHAIRMAN SEWELL: Second.

MEMBER MC NEIL: Second.

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

(Five witnesses sworn.)

THE COURT REPORTER: Thank you.

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

MR. CONSTANTINO: Thank you, Madam Chair.

The Applicants are proposing to establish a limited specialty ambulatory surgical treatment facility in Merrionette Park at a cost of $1.2 million. The project completion date is December 31st, 2018.

The Applicants have asked us to increase the project completion date to December 31st,

2018.

CHAIRWOMAN OLSON: You mean 2019?

MR. CONSTANTINO: There was no public hearing requested.

MR. HYLAK-REINHOLTZ: '18, two months.

MR. CONSTANTINO: There was no opposition and there were findings on this project.

CHAIRWOMAN OLSON: What are we increasing the date to?

MR. CONSTANTINO: The date of completion, from October 31st, 2018, to December 31st, 2018.

CHAIRWOMAN OLSON: Okay. Thank you.

Okay. Comments for the Board?

DR. KINDER: Good afternoon, Chairperson Olson and other distinguished members of the State Board.

My name is Dr. Charles Kinder, K-i-n-d-e-r. I'm here on behalf of Premier Cardiac Surgery Center and Heart Care Centers of Illinois, the Coapplicants on this project. I'm a physician, board certified in cardiology and electrophysiology, which is heart rhythm.

I'm here today asking you to grant a CON permit for our proposed single-specialty

ambulatory surgical treatment center which will be located in Merrionette Park, Illinois, approximately 115th and Kedzie.

At the table I'm joined to my immediate left by our attorney and CON consultant, Joseph Hylak-Reinholtz; to his left, Mark Berlin, our chief operating officer of Heart Care Centers of Illinois. And two other physicians are seated with us today, Drs. Robert Iaffaldano and Ron Stella, both of whom can speak today if necessary.

If you'd permit me to do so, I'd like to provide a brief summary of the project before taking any questions.

CHAIRWOMAN OLSON: Please. Go ahead.

DR. KINDER: Thank you for allowing me to provide a brief summary of the project. As I already stated, we are proposing --

THE COURT REPORTER: Excuse me. Just -- breathe just a little bit.

(Laughter.)

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

DR. KINDER: Thank you for allowing me to provide a brief summary of the project. As

I already stated, we are proposing the establishment of a single-specialty surgery center. We are seeking approval for the cardiovascular category of service.

The proposed surgery center will have one procedure room, which will be located within leased space totaling 4,172 gross department square feet. The total cost of this project is just slightly less than 1.2 million. The entire cost of the project will be funded by cash.

The proposed surgery center is needed for the following reasons: First of all, we want to ensure continued access to high quality cardiology care. For the last two years that this data has been kept, we've been in the top 0.8 percent -- so the 99th percentile in the country -- of both quality and efficiency as cardiology by Medicare. We want to continue to provide this access to quality cardiology care and heart rhythm procedures in our geographic service area.

We established Heart Care Centers of Illinois in the Blue Island area about 40 years ago. We'd like to continue to work in that area. As the Board knows, access to vital health care

services has been threatened as a result of significant budget cuts to Medicare reimbursement for physician office-based rates over the past couple of years. If our office-based practice is forced to close, the entire geographic service area would be without outpatient cardiac surgical care.

The plan to transition our office-based lab, or OBL, to a part-time/hybrid ASTC, ambulatory surgical treatment center, will provide our financial health and allow us to continue treating patients in our GSA, which includes a number of Federally designated medically underserved areas and a shortage of health care professionals.

Also, being able to keep our site in Merrionette Park operating successfully will ensure that our patients have a close and convenient location for outpatient cardiology care. Again, we are the only outpatient site in our GSA that provides our range of services in any type of setting outside of a hospital.

Second, we want to increase access to outpatient surgical care, moving more surgical

procedures away from hospitals and into our surgery center, which will result in significant cost savings, both to the payers and the patients.

As a very concrete example, the implantation of a defibrillator, which is what I do, would reimburse a hospital, by Medicare, $32,000. At our ASTC it would be $28,000. So in doing just 100 implantable defibrillators at our surgical site as opposed to the hospital would save Medicare, in that single year, $4 million.

Likewise, the implantation of a pacemaker in a hospital pays the hospital, by Medicare, $10,000. At our surgical site we pay $8,000, saving $2,000. And, again, a hundred cases in a year would be 2 million. So in just doing a hundred implantable defibrillators and a hundred pacemakers, Medicare saves $6 million.

Now, on the payers' side, this is a geographically underserved area. The 20 percent copay, therefore, on $4,000 is going to be $800 less for the patient at our surgical center for a defibrillator and $400 less for a pacemaker.

For these reasons I believe there's a clear need for our proposed surgery center.

I urge each of you to vote yes and approve our CON permit request.

At this time we would be happy to answer questions. I thank you once again for your time and consideration.

CHAIRWOMAN OLSON: Thank you, Doctor.

Questions from Board members?

(No response.)

CHAIRWOMAN OLSON: So I --

VICE CHAIRMAN SEWELL: I --

CHAIRWOMAN OLSON: Go ahead. You go first.

VICE CHAIRMAN SEWELL: You know, in the past we've had these ambulatory surgery treatment centers, and we don't have criteria to distinguish between sort of the specialty-type ambulatory surgery treatment centers and the others.

And it appears -- and either you or the staff correct me if I'm wrong -- that what we have here is a cardiovascular category of service. And I guess in a perfect world where we had criteria, we'd have them by category of service and we'd be able to look at the system that way.

Is that sort of framing this correctly?

MR. CONSTANTINO: Yes.
VICE CHAIRMAN SEWELL: Okay.
MR. CONSTANTINO: I want to make one thing -- I want to point out one thing.
They are not performing cardiac cath. They'd have to come back in to see you to get approval to do that.
VICE CHAIRMAN SEWELL: Yeah. That's another category of service.
MR. CONSTANTINO: Right.
VICE CHAIRMAN SEWELL: But it's a cardiovascular ambulatory surgery treatment center; right?
MR. HYLAK-REINHOLTZ: That's correct.
CHAIRWOMAN OLSON: And just to keep going along that same line, if I understood you correctly, Doctor, you're the only one in this area that's performing these procedures outside of a hospital setting?
DR. KINDER: Yes, ma'am.
MR. HYLAK-REINHOLTZ: I'll just expand a little bit.
Joseph Hylak-Reinholtz, legal counsel, H-y-l-a-k, hyphen, R-e-i-n-h-o-l-t-z.

My 4-year-old daughter will love to learn how to spell that when she's in kindergarten.

(Laughter.)

MR. HYLAK-REINHOLTZ: To answer your question about existing ambulatory surgery centers in our GSA, there are 37 ambulatory surgery centers. Of those 37, only 3 are approved for the cardiovascular category of service.

One of those was recently approved by this Board last year, Chicago Vascular. They are a single-specialty center and should meet their own capacity and wouldn't have access to take on additional cases, and they're a very narrow subset of the cardiovascular category of service.

There is Rush ambulatory surgery center, which is 31 minutes away from us. Although while they are approved to do cardio care, if you look at their website, they don't even a list it as an available option for their patients.

The same is true with Loyola ambulatory surgery center, which is 35 minutes away. Again, a very minimal amount of cardio care that they do there, maybe a couple hundred cases a year. Again, not something even advertised on their

website as a service for patients.

So we pretty much would be the only game in town in our 45-minute GSA.

CHAIRWOMAN OLSON: Thank you.

MR. CONSTANTINO: Mr. Sewell, I want to point out one other thing.

The Board is required to look at capacity within the 45-minute service area. Now, while there is no -- three ASTCs that provide that service, those hospitals do provide this service.

MR. HYLAK-REINHOLTZ: And thank you, Mr. Constantino.

And I think Dr. Kinder had a great point that when you compare hospital care versus outpatient surgery care -- on a broader sense, a Berkeley study that's included in our application quoted a report by the office -- Federal OIG, which said if only half of the hospital outpatient department cases were moved into an ASC setting, Medicare would save $2.4 billion a year.

The same report said, if the number of ASTCs were doubled over 10 years, Medicare would save $57.6 billion by getting the lower reimbursements. And that's just the

reimbursement; that doesn't cover the patient copay angle of this.

So -- and especially in an area where there's a number of medically underserved areas and populations and professional -- Health Professional Shortage Areas, I think this would be a fantastic service for this community.

CHAIRWOMAN OLSON: Thank you.

Other questions or comments?

Oh, Doctor.

MEMBER GOYAL: Thank you, Madam Chair.

My name is Arvind Goyal, and I'm ex officio on this Board from Medicaid.

I'd have three or four questions. So, one, what is your Medicaid mix? Can you project that?

MR. HYLAK-REINHOLTZ: I can pull it out.

DR. KINDER: It was part of our application, but I do believe we stuck to the classic definition of Medicaid only. We have a lot of managed Medicaid patients we take care of, as well.

MEMBER GOYAL: That's not --

DR. KINDER: Joe's looking it up right now.

MEMBER GOYAL: When you find it, please blurt it out.

MR. HYLAK-REINHOLTZ: I have it. And, actually, I used to have your -- your -- I played your role back in the mid-2000s when I used to work for the HFS so --

MEMBER GOYAL: You look very smart.

(Laughter.)

MR. HYLAK-REINHOLTZ: -- it's nice to make your acquaintance. It's good to be on both sides of the table.

So our forecasted payer mix, we would do, in 2018, 62 1/2 percent Medicare, and that would stay standard over a three-year period.

Our Medicaid rate would also be around the 5 percent average range at the end of three years. A number of things that we do is largely covered by Medicare. That's why there's a differential there.

MEMBER GOYAL: Thank you.

Another question: You talked a whole lot, Dr. Kinder -- I was very impressed -- about the cost difference to Medicare in an ASTC versus a hospital, so I'm interested in two questions on

that point.

One, would you differentiate and tell us what percentage of your population at the ASTC would end up in the hospital because of complications or some ancillary findings that you discover at the time you are working in an ASTC.

DR. KINDER: That's an excellent question. Thank you, Doctor.

The answer is that these patients who would come to the ASC would be well vetted in our outpatient office setting where we would understand whether they have any significant problems with their plumbing, their coronary arteries. We would know exactly the strength of their heart pump, and we would know about all their comorbidities.

When you look -- so very few of them who would be done in the ASC would end up at the hospital.

When you look at safety studies, it's been shown to be quite safe to perform the implantation of a defibrillator or pacemaker and allow the patient to go home the same day, so that's clearly fine from a safety and cost standpoint.

We have three heart rhythm doctors in our group, and our complication rate is extraordinarily low, which helped land us in the 99 percentile of the Medicare Federal data for quality and cost.

With regard to complications, if you look at the registered databases, the chance of having a significant morbid event is in the ballpark of 1 in 500 to 1 in a thousand. So if we project doing a thousand cases a year, one or two patients, at most, would end up needing hospital care following the ASC procedure.

MEMBER GOYAL: Okay. Are those the only two procedures you plan on doing at this ASTC?

You mentioned two.

DR. KINDER: Right. We -- the current plan is to do pacemakers and defibrillators. There are also implantable lubricors, which are given to people who pass out frequently and we don't know the cause.

So an implantable lubricor is inserted under the skin and records your rhythm at all times. That would be a procedure that we would consider doing there.

There's a number of other procedures that are possible, depending on how things change at the Federal level. And because we're trying to keep this to a narrow cardiovascular category, we'd like to stay open to be able to evolve to the needs of the community and the local population.

But at the present time, as I outlined, those would be the main procedures that we'd be looking to do.

MEMBER GOYAL: And no vascular procedures? I mean -- carotids?

DR. KINDER: Not at this time.

MEMBER GOYAL: Nothing vascular?

DR. KINDER: No carotid procedures at this time would be envisioned.

MEMBER GOYAL: Okay.

Now, one final question, then: Physician reimbursement at the ASTC, is that projected to be any different than it would be in a hospital setting?

I know they've been talking global; it hasn't taken effect at the hospital yet. But could you comment on that?

DR. KINDER: Sure.

My understanding is that they're relatively similar. In other words, there's no dramatic difference in what the physician gets paid to do the actual procedure, whether it's done in the hospital or in the ASC.

MEMBER GOYAL: Thank you very kindly. I appreciate it.

CHAIRWOMAN OLSON: Other questions?

MEMBER BURZYNSKI: My ears are getting tired. But I think -- did I hear you mention earlier that, if they did do the vascular-type surgeries, they would have to come back in front of this Board?

MR. CONSTANTINO: If they do cardiac cath, they would have to come back and get approval from this Board to do that.

MEMBER BURZYNSKI: Thank you.

CHAIRWOMAN OLSON: Other questions or comments?

(No response.)

CHAIRWOMAN OLSON: Seeing none, I would ask for a roll call vote.

MR. ROATE: Thank you, Madam Chair.

Motion made by Ms. Murphy; seconded by

Mr. Sewell.

Senator Burzynski.

MEMBER BURZYNSKI: I'll vote aye, based on the testimony we've heard today.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on the testimony we've heard today.

MR. ROATE: Thank you.

Mr. McNeil -- or Mr. McGlasson.

MEMBER MC GLASSON: Yes. Based on the positive impact on Medicare, yes.

MR. ROATE: Thank you.

Mr. McNeil.

MEMBER MC NEIL: Yes, based on the report and the testimony.

MR. ROATE: Thank you.

Ms. Murphy.

MS. MURPHY: Yes, in light of the explanations given today to the staff report's negative findings.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: I vote yes and

then urge us, as a Board, to move it along in terms of developing different categories of service for ambulatory surgery treatment centers.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: I vote yes for reasons stated.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRWOMAN OLSON: The motion passes.

Congratulations.

The court reporter has requested a break, three or four minutes.

(A recess was taken from 3:03 p.m. to 3:10 p.m.)

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CHAIRWOMAN OLSON: Okay. We're ready to get started again.

Next, we have Project 17-069, Memorial Hospital-East Medical Clinics Building.

May I have a motion to approve Project 17-069, Memorial Hospital-East Medical Building.

A motion, please.

MEMBER MURPHY: Motion.

CHAIRWOMAN OLSON: May I have a second.

VICE CHAIRMAN SEWELL: Second.

CHAIRWOMAN OLSON: The Applicant will be sworn in.

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

(Three witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: Mr. Constantino.

MR. CONSTANTINO: Madam Chairman, on the first page of your report, under "Project Cost," that should read "38,290,267" instead of "32."

CHAIRWOMAN OLSON: Thank you.

MR. CONSTANTINO: I apologize for the mistake I made.

The Applicants propose to construct an addition, second phase, to a medical clinics building currently under construction in Shiloh, Illinois. The project cost is $38.3 million, and the completion date is December 15th, 2019.

There was no public hearing and no opposition to this project. We did have one finding related to the reasonableness of the project cost.

Thank you, Madam Chair.

CHAIRWOMAN OLSON: Thank you, Mr. Constantino.

Comments?

MR. TURNER: Thank you.

My name is Mark Turner. I'm the president of Memorial Regional Health Services, which is also Memorial Hospital in Belleville and Memorial Hospital-East in Shiloh.

Thank you to the staff. We appreciate your work. It's important.

Thank you to the Board. We appreciate your time this afternoon. We will try and keep our comments to the point and on task.

We're excited about this project, which

represents a major addition to a medical clinics building already on campus at Memorial Hospital-East, approved by this Board and completed at the end of last year.

This project -- the original portion of the building was approximately 70,500 square feet. This second phase will be very much the same size, very close to that size. We realized during construction of the initial project that the demand for medical office space was continuing to increase and rise and we needed additional space.

The addition you're reviewing, as I said, is about the same size with approximately one-third of the building occupied by the Alvin J. Siteman Cancer Center, a collaboration of BJC and Washington University.

The Siteman Cancer Center is really what makes this project very special. We're excited about what it brings to our community. It's an asset to our community, as many Southern Illinois patients travel to St. Louis to the Siteman Cancer Center there for their care. It performs over 3200 -- Siteman performs over 3200 radiation oncology treatments on Illinois residents --

excuse me, residents from our primary service area -- on an annual basis.

We're excited about this project. We'll keep matters moving, and I'll let Greg Bratcher introduce you to Siteman Cancer Center.

MR. BRATCHER: Hi. Again, My name is Greg Bratcher, B-r-a-t-c-h-e-r.

And the Siteman Cancer Center is one of 49 comprehensive cancer centers as designated by the National Institutes of Health. To put that in perspective, there are about 5,000 hospitals in the US, and there are about 1500 cancer centers designated by the American College of Surgeons. This is one of 49.

In metro Chicago you have two, at the University of Chicago and Northwestern, but they're not in every major city -- they aren't in Indianapolis; they aren't in Kansas City -- and the reason is their rigorous criteria.

And I'll do them really quickly. I had some other examples, but in the interest of time, I'll just tell you what makes them go.

You have to be world-class excellent at both -- delivering cutting-edge care today. You

have to have a commitment to multidisciplinary research for finding the cures for tomorrow. And then you have to -- and that's the driving force behind this project -- push all of that out into the community. You can't sit on the ivory campus and just do your thing. You have to get this out into the community. That is the driving force behind this project.

I could tell you about some of the great, cool things we're doing, but in the interest of time, I'll tell you about one because you get a lot of dialysis projects.

We have perfected and one of our doctors has perfected the partial removal of a kidney, leaving behind a kidney that can function while removing the tumor using robotic surgery. And many of those patients end up not needing dialysis. That's the kind of thing that we will bring to the Southern Illinois market.

We'd appreciate your positive vote. Thank you.

CHAIRWOMAN OLSON: Thank you.

MR. AXEL: Thank you, Greg.

My name is Jack Axel with Axel &

Associates. I am going to address the single negative finding, that being the construction and construction contingency costs per square foot.

As noted in the staff report, the norm for clinical areas within a medical clinics building is approximately $267 per square foot. We are anticipating $329 a square foot.

Attachment C to the application identifies the anticipated construction costs for each of the clinical areas included within the project, and the areas with the exception of radiation oncology are slightly below the norm. The radiation oncology area is estimated to cost approximately $390 a square foot, causing the negative finding.

I don't believe that there has been a medical clinics building brought before this Board in recent memory that has included medical oncology; however, our construction cost estimate is based on similar projects recently completed by Siteman in Missouri, and we are confident that our cost estimate is reasonable.

I would like to simply remind the Board, before we entertain questions, that this project has received no opposition of any kind.

Thank you.

CHAIRWOMAN OLSON: Thank you.

MR. TURNER: Questions?

CHAIRWOMAN OLSON: Yes.

Questions from Board members?

(No response.)

CHAIRWOMAN OLSON: I just had one. I just wanted to -- I think I'm -- part of the cost is this linear accelerator; right? We've had this before where that's -- requires a whole lot of extra hoo-ha to get that --

MR. TURNER: It's the concrete -- well, the protection of the radiation. So it's anywhere from 3 to 6 feet of concrete, depending on how you design the structure. Solid walls and ceilings, so it's very expensive.

CHAIRWOMAN OLSON: Okay. Thank you.

Other questions or comments?

(No response.)

CHAIRWOMAN OLSON: Seeing none, I'd ask for a roll call vote.

MR. ROATE: Thank you, Madam Chair.

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

Senator Burzynski.

MEMBER BURZYNSKI: I believe the Applicant has successfully explained the reason for noncompliance and I vote yes.

CHAIRWOMAN OLSON: Thank you.

Ms. Hemme.

MEMBER HEMME: I vote yes for the reason previously stated.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: I vote yes for that same reason.

MR. ROATE: Thank you.

Mr. McNeil.

MEMBER MC NEIL: Yes, for the reason so stated.

MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: Yes, based on today's testimony.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: I vote yes. This is a good explanation for the reasonableness of

the project cost.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: I vote yes, as well.

I wish you really good luck with this project. It's needed.

MR. AXEL: Thank you very much.

MR. TURNER: Thank you.

MR. ROATE: 7 votes in the affirmative.

MR. BRATCHER: Thank you.

CHAIRWOMAN OLSON: Congratulations.

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CHAIRWOMAN OLSON: Finally, we have applications subsequent to intent to deny.

I would call to the table Project 17-019, SwedishAmerican Hospital.

May I have a motion to approve Project 17-019, SwedishAmerican Hospital, for a major modernization.

Motion, please.

VICE CHAIRMAN SEWELL: So moved.

CHAIRWOMAN OLSON: And a second.

MEMBER MC NEIL: Second.

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

(Four witnesses sworn.)

THE COURT REPORTER: Thank you. Please print your names.

CHAIRWOMAN OLSON: Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chair.

The Applicants propose a major modernization on the campus of SwedishAmerican Hospital in Rockford, Illinois, which includes the construction of a five-story patient tower.

The proposed cost of the project is

approximately $126,000 -- or -- million dollars -- and the expected completion date is November 30th, 2022.

There was a public hearing on this project, there was opposition, and the Applicants received an intent to deny previously at -- I believe it was the September 26th meeting.

Subsequent, the Applicants modified the project. It was a Type A modification. They reduced the cost by $2.2 million, reduced the gross square footage, and reduced the number of pediatric beds from 28 to 10. We did have findings related to this project.

One last thing: On the summary of findings, that should be positive for the Part 1120. That's on page 5 of your report.

Thank you.

CHAIRWOMAN OLSON: Thank you, Mike.

Comments for the Board?

DR. BORN: Good afternoon.

CHAIRWOMAN OLSON: Good afternoon.

DR. BORN: Thank you, Chairwoman Olson and members of the Illinois Health Facilities and Services Review Board, for your service to our

state.

I'm Dr. Michael Born, the president and CEO of SwedishAmerican, a division of UW Health. I'm honored to be here today to ask your approval for our hospital's revised modernization CON application, Project 17-019.

Seated with me today to my left is Dr. Ann Gantzer, vice president, patient services, and chief nurse officer; Jedediah Cantrell to my far left, vice president of operations for SwedishAmerican; and our CON attorney, Dan Lawler.

This has been a long journey for us. We filed this application in April of last year and were first heard at the September meeting. We received a supermajority of the votes at that meeting, 4 to 2, but needed 5 and received an intent to deny.

While we were disappointed by that setback for this $126 million modernization project, I will be among the first to recognize and say that the concerns raised at the September meeting were legitimate. We've taken them to heart and, after technical assistance with Board staff, we have modified the project to address your

questions. You were right. This modified project comes back before this Board as a better project.

In addition to substantially reducing our existing pediatric bed capacity, which was the focus of the concerns in September, we also reduced the overall project cost by millions of dollars, and we successfully addressed the one negative finding under the financial criteria so that the staff report is now fully positive on all financial criteria.

This project represents the modernization of our over-50-year-old flagship hospital tower and includes the construction of a women's and children's tower. As represented by the support letters listed in Appendix A of the staff report, the public comments presented to you today by community leaders and many elected officials, as well as the other letters of support and petitions in this project file, this investment to improve our health care in Rockford, in the Rockford region, is vitally important.

We have overwhelming local and statewide support for this project. At the public hearing in May of last year, there was one opposing

organization, but they were opposing a different project and a different application. At the time we also had pending an exemption application for a 10-bed neonatal intensive care unit, and the public hearing on that project was held back-to-back on the same day at the same location as the public hearing on this project.

The opponent was there to oppose the NICU application and spoke at both hearings, but they made clear that it was only the NICU and not the modernization that they were opposing, and that is noted in the staff report today.

Interestingly, that organization has remained silent until today, when they once again are attempting to link these projects with flawed logic. Our separate NICU application was approved by this Board last June, and since that approval until today no one has made any objection to this project.

When we modified the project in November in response to the intent to deny, your staff published an opportunity for a second public hearing on the modified project, and no requests for hearing were submitted.

No letters of opposition have been submitted, as indicated in the staff report, and the agenda today shows that this is an unopposed project. The fact that today's opposition was apparently organized at the 11th hour and again attempts to link the modernization project to the NICU exemption suggests an attempt to confuse, create distraction, and stifle competition rather than to provide a thoughtful, organized opposition based on arguments and merit.

You have a project before you now that is better than when you saw it last September.

I wanted to thank you again for your time and attention to our project. I respectfully ask for your support of this revised and worthy hospital modernization project to better serve the people of Northern Illinois.

I now want to ask our CON counsel, Dan Lawler, to address the negative findings in the staff report.

MR. LAWLER: Thank you, Dr. Born. My name is Dan Lawler, L-a-w-l-e-r.

Sorry for not doing that before. I should know better -- and no tutorials now.

(Laughter.)

MR. LAWLER: You're a wise man.

VICE CHAIRMAN SEWELL: Old.

MR. LAWLER: This is a nonsubstantive project. We are not adding any new categories of service; we are not increasing the total number of beds; we are reducing beds.

We substantially reduced pediatric beds to respond to concerns raised by the Board last September. We currently have 28 pediatric beds; we are reducing that to 10. 10 beds will allow us to just barely cover our historical peak census of pediatric patients, so the reduction leaves us with the minimum number of beds to continue serving our historical caseload.

As the staff report indicates on page 16, we are projecting to be at target utilization by the second year of operation, as the criteria requires.

The negatives in the staff report relate mainly to department sizes and utilization. We have 14 different clinical departments involved. The total square footage in those 14 departments is just 0.2 percent above what the State standards

would allow in total for all those departments. That is less than 300 square feet in a project that is well over 200,000 square feet.

We were way under the State standard for many departments. We were over in some. But when you add them up, we are very, very close to the total that would be allowable. Please note that most of the areas in -- clinical areas -- in which we were over the standard are in the existing building.

Almost 90,000 square feet of this project is remodeling a 50-year-old building. Now that I'm in my 60s, a 50-year-old building doesn't seem as ancient to me as it used to be, but we're still talking about 1960s hospital design, and that was before this Board was created and before the State standards came into existence. We can only work within the constraints they made for us 50 years ago.

In the new construction, in the women's and children's tower, we meet most of the department sizes. Where we weren't constrained by the existing structure, we did everything we could to meet your standards.

One area where we were over -- and it was the largest overage -- was the special-care nursery. There's a good reason for that.

My firstborn twins were in a special care nursery for five weeks, not at Swedish but in a Chicago-area hospital. I'm sure that unit met the State standard because it was so packed with incubators and monitors and pumps and panels and cabinets that there was hardly anyplace to walk.

The State standard essentially requires all incubators to be in a single room. There has been much literature -- and it's referenced in our application -- promoting single rooms for mother and baby, and this has been clinically proven to produce better outcomes. The neonatologists and clinicians are advocating for this now.

SwedishAmerican serves a population with a high percentage of at-risk mothers who tend to deliver premature and underweight babies, and that is why we designed this special-care nursery as we did.

Regarding the utilization negatives, the concerns and questions raised at the last meeting focused on pediatrics, and we have addressed these

with the modification to the project. The other areas we've previously explained, and they are noted in the staff report.

With all the talk we heard about NICU this morning, one might think that we were asking the Board to approve a new 10-bed NICU today. We are not. We already have a 10-bed NICU. It's not operational but it was approved by this Board last June. We have been working with the Department of Public Health since last June to -- in connection with the licensing of the NICU.

The only reason that the NICU was even mentioned in this project is that, when the new women's and children's tower is finished, we are going to move the existing NICU -- that's already been approved by this Board -- into the new tower. And whether there was a new tower or not, we are still going to have the NICU.

The vote today has nothing to do with whether or not SwedishAmerican has a NICU. The vote today is only going to determine whether that NICU will be in a new, modern, state-of-the-art building or whether it will be in a 50-year-old structure.

We believe the project substantially complies with the criteria, and we respectfully request your approval.

Thank you.

CHAIRWOMAN OLSON: Thank you.

Questions from Board members?

Mr. Burzynski.

MEMBER BURZYNSKI: Thank you.

Mr. Lawler, pretty well, I think, summed up the difference -- or the concerns relative to the NICU.

But just from a staff standpoint, does that pretty well summarize what we're doing here this afternoon?

MR. CONSTANTINO: Yes.

MEMBER BURZYNSKI: Okay. Thank you.

I think it's interesting, you know. I used to serve the Rockford area and served SwedishAmerican Hospital, Rockford Memorial Hospital, Saint Anthony's Hospital.

And, you know, for many, many years I've seen a lot of this going on. (Indicating.)

And it's frustrating to me because I would hope that all of us have a tremendous amount of

concern for the community and for the patients that you represent. And, certainly, you know, when we have these squabbles -- and this is more than a squabble. It's a brawl. It is not very -- it doesn't speak highly of the area, let's put it that way. So I hope that we can cease and desist from that and some of the attacks and -- personal attacks, et cetera -- that we've seen in the past.

You know, having said that, I'm sure that you-all have looked at the NICU very closely. You are -- from the comments I heard today, you will proceed with that regardless. It's just a question of whether it's going to be in an old building or whether it's going to be in a modern facility.

Having said that, I do know that you-all have expressed and have certainly been a leader in the community relative to development of the community and support for the community.

I commend you for that. Mr. Lawler basically answered my question relative to the NICU.

So thank you.

CHAIRWOMAN OLSON: Mr. Sewell.

VICE CHAIRMAN SEWELL: One of the things

I'm not real clear on is -- what's the relationship between this proposal and the Level III perinatal system that we have? And maybe Mr. Dart might have something on that.

Doesn't IDPH sort of manage that, the Level III system?

MEMBER DART: Well, the department certainly approves those.

VICE CHAIRMAN SEWELL: But there's no concerns about this project?

MEMBER DART: It's been proceeding as indicated since July so -- not that I'm aware of.

VICE CHAIRMAN SEWELL: Okay.

Any comments on that?

MR. LAWLER: No. We'll just add that the day after we were approved last June, we were in meeting with Director Shah and Shannon Lightner at IDPH, and we've been working with them since as we progressed with the NICU project.

VICE CHAIRMAN SEWELL: Okay.

DR. GANTZER: And at this -- sorry.

And at this point we have our designation survey scheduled for October 24th, 2018.

CHAIRWOMAN OLSON: Yes.

MEMBER MC NEIL: So in terms of services, room, all of that, the only new thing proposed are new bricks, mortar, electrical, optical -- physical things that are 50 years old or that have been repaired for 50 years; is that true?

MR. LAWLER: That's correct, yeah.

CHAIRWOMAN OLSON: Other questions or comments?

(No response.)

CHAIRWOMAN OLSON: Seeing none, I would ask for a roll call vote.

MR. ROATE: Thank you, Madam Chair.

Motion made by Mr. Sewell; seconded by Ms. Hemme.

Senator Burzynski.

MEMBER BURZYNSKI: As I stated before, I'm very familiar with Swedes, and I know that they are very civic-minded, pro patient, and I'm sure that they're going to do what's in the best interest of their patients and of their base of patients right there in the Rockford area.

So I vote yes.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: I also deal a lot with the Rockford area hospitals as an employer in the area, and I will say that I'm always impressed with Swedes.

And so I vote yes so that you can modernize your building.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: I vote yes. I can see no reason not to.

MR. ROATE: Thank you.

Mr. McNeil.

MEMBER MC NEIL: I vote yes. I know nothing about you.

(Laughter.)

MEMBER MC NEIL: I go through Rockford. However, from the report and your responses, I voted yes.

MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: I vote yes based on the testimony and the explanations for the negative findings.

Good luck.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: I vote yes for the reasons stated by Ms. Murphy.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: The Chair finds it necessary to abstain from this vote.

MR. ROATE: Thank you.

That's 6 votes in the affirmative; 1 abstaining.

CHAIRWOMAN OLSON: The motion passes.

Congratulations.

DR. GANTZER: Thank you.

DR. BORN: Thank you.

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CHAIRWOMAN OLSON: Okay. Under new business, I would like a motion to keep the executive meeting transcripts closed.

May I have a motion.

MEMBER BURZYNSKI: So moved.

CHAIRWOMAN OLSON: And a second?

MEMBER MURPHY: Second.

CHAIRWOMAN OLSON: All those in favor say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: Ann, a legislative update?

MS. GUILD: Hi. I'm going to be very brief here.

This doesn't -- I did a handout for the Board members, so you-all have it. And if anyone has any questions, please feel free to give me a call.

For those in the audience, the bills on the list are House Bill 4645, 4891, 4892, 4949, and 5069.

4892 is an HFSRB initiative. All of these bills are still in rules. There's a few bills where I might want some feedback.

Senate Bill 33, Senate Amendment 1, is a bill that prohibits Planning Board staff or Review Board staff from providing advisory opinions on potential changes of ownership, stating that they're not reviewable. There's some additional process things in the bill that we would have to go through.

There was a hearing on February 20th, in subcommittee on business entities, and Jeannie and I both testified. It's now postponed in judiciary.

But from the conversation that came out of that meeting, the -- we were -- with legislators -- we were thinking that it might be appropriate -- there was a lot of discussion about transparency -- to post advisory opinions on our website.

And I guess if -- we would do that unless any Board member has any objection to that.

CHAIRWOMAN OLSON: I think it just goes along with transparency, and I would agree with that.

So does anybody have any objections to posting?

MEMBER GOYAL: Madam Chair -- Madam Chair.
CHAIRWOMAN OLSON: Yes.
MEMBER GOYAL: No objections. My objection wouldn't count anyway.
But my suggestion is that you update the website maybe once a year, once every six months, because my fear is that at some point in time what information is there would become obsolete.
MS. MITCHELL: Well, we update our website realtime. Maybe not exactly realtime but very frequently, almost on a daily basis.
MEMBER GOYAL: Oh, okay.
CHAIRWOMAN OLSON: Thank you, though.
MS. GUILD: The next bill I'm going to talk a little bit more about is Senate Bill 1773, House Amendment 4 -- well, today, House Amendment 8.
It is a bill to extend and change the hospital assessment program, which brings about $3 1/2 billion in to the State of Illinois through a Federal match.
There was a provision in there that created a hospital transformation review committee within HFS and would exclude projects that are

approved by that Board from the purview of our Board.

I don't anticipate that there would be that many of those projects, but the goal is to -- for struggling hospitals -- to create a mechanism -- and there's also a pool of money attached -- for them to transform into something other than a hospital that will still continue to help meet community needs.

Anyway, there were some issues with the bill from our perspective because they -- some terminology. They didn't understand that our -- what we call an exemption is different than "exempt" in Webster's dictionary.

There was no clarity in it that, once a project is done with its transformation -- once there's a transformation project that's complete -- it still has to -- anything else it does in the future will still be subject to Board jurisdiction and that they had to report to us if they made any changes in beds and services.

Everyone was quite willing to make those changes, and today that bill came out of committee unanimously, and it includes the changes that we

wanted to see.

CHAIRWOMAN OLSON: Good.

MS. GUILD: So -- and then the last bill on the list is Senate Bill 3230, which is the same as House Bill 4891, and it's in Senate assignments so nothing's happened yet.

CHAIRWOMAN OLSON: I have a question on that.

So change the requirement for a quorum to four members. How do you get 5 votes if there's four people?

MS. MITCHELL: It would change from 5 to 4.

MS. GUILD: You won't need 5 votes.

CHAIRWOMAN OLSON: So any project would only need 4 votes to pass?

MS. GUILD: It's a bill to address concerns about if we have vacancies or members who have conflicts and we don't have a quorum.

CHAIRWOMAN OLSON: Yeah, I understand that. I don't have any problem with that. But I just was worried about the 5 -- about the 5 positive votes if you only have four people.

MS. GUILD: The proponents characterized it as a placeholder on the last call that we had,

and I don't know whether they're going to go forward with it or try to change it.

MS. AVERY: They're going to -- they're possibly going to hold it --

MS. GUILD: Right.

MS. AVERY: -- but haven't really determined. Because of the appointment with our new members and being at full capacity, it may not even go forward.

MS. GUILD: Right.

CHAIRWOMAN OLSON: Okay.

Corrections to profiles?

Do you have one?

MEMBER GOYAL: Madam Chair, could you have this HB5069 explained a little bit?

MS. GUILD: Sure.

This is an Illinois Department of Public Health initiative, and they want to repeal the Illinois End Stage Renal Disease Facility Act and rely upon certification, Medicare and Medicaid certification.

They -- there was a drafting error that, basically, could give us a gap. If this were to pass before June 1st, 2018 -- and, as you know,

that's fairly unlikely -- there could be a gap in our coverage of ESRD facilities; not likely but possible.

I have talked to the department's legislative liaison to see if we could get an amendment done quickly to fix that problem and seemed amenable but had to run it up the flagpole so we'll see.

But that's what that bill is about.

MEMBER GOYAL: Thank you.

CHAIRWOMAN OLSON: Other questions?

(No response.)

CHAIRWOMAN OLSON: So there's one profile change.

May I have a motion to change the HSHS St. Joseph's Hospital, Breese, to correct their 2015/2016 profile.

To accept that correction, a motion?

MEMBER BURZYNSKI: So moved.

VICE CHAIRMAN SEWELL: Second.

CHAIRWOMAN OLSON: All those in favor say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: Motion passes.

Do you want to tell us what's up with the financial report?

MS. AVERY: Yes.

So we were receiving the financial reports from IDPH for each meeting. In the discussion with Kim Palmer, who handles those, she asked if we could do them on a quarterly stance.

So we will receive those reports for March at the April meeting, for June at the July meeting, and the closing report in September. And in October -- in September we'll receive the first quarter report for FY19.

So she'll have them on a quarterly schedule in accordance with our meeting dates, but if we need any information prior to that or if anyone wants them in a different form, she will be willing to do that for us.

But it was just easier for her to do it on a quarterly time period in accordance with some of the reportings from the comptroller's office.

CHAIRWOMAN OLSON: Questions?

(No response.)

CHAIRWOMAN OLSON: Okay. And our next meeting is April 17th, 2018, again back here,

which is a change from initially. It was going to be in Springfield. It is now here.

May I have a motion to adjourn.

VICE CHAIRMAN SEWELL: So moved.

MEMBER MC NEIL: Second.

CHAIRWOMAN OLSON: All those in favor?

(Ayes heard.)

(Off the record at 3:44 p.m.)

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.

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MELANIE L. HUMPHREY-SONNTAG

NOTARY PUBLIC IN AND FOR ILLINOIS

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