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Transcript of Open Session - Meeting

Date: April 30, 2019
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

OPEN SESSION - MEETING

Bolingbrook, Illinois 60490

Tuesday, April 30, 2019

9:18 a.m.

BOARD MEMBERS PRESENT:

MARIANNE ETERNO MURPHY, Acting Chairman

SENATOR DEANNA DEMUZIO

MICHAEL GELDER

JULIE HAMOS

BARBARA HEMME

JOHN MC GLASSON, SR.

RON MC NEIL

Job No. 223747

Pages: 1 - 511

Reported by: Melanie L. Humphrey-Sonntag,

CSR, RDR, CRR, CRC, FAPR

EX OFFICIO MEMBERS PRESENT:

ARVIND K. GOYAL, IHFS

ALSO PRESENT:

COURTNEY AVERY, Administrator

JEANNIE MITCHELL, General Counsel

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

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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

CHAIRMAN MURPHY: Good morning.

Can we take our seats, please.

Good morning. I'd like to call the meeting to order.

Before we do a roll call, I would like to welcome our two newest Board members, Michael Gelder and Julie Hamos.

Welcome. Thank you.

(Applause.)

CHAIRMAN MURPHY: George, can we have a roll call, please?

MR. ROATE: Thank you, Madam Chair.

UNIDENTIFIED AUDIENCE MEMBER: You need a louder mic.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Present.

MR. ROATE: Michael Gelder.

MEMBER GELDER: Present.

MR. ROATE: Julie Hamos.

MEMBER HAMOS: Present.

MR. ROATE: Barbara Hemme.

MEMBER HEMME: Present.

MR. ROATE: John McGlasson.

MEMBER MC GLASSON: Yes, sir.
MR. ROATE: Dr. McNeil.
MEMBER MC NEIL: Present.
MR. ROATE: Marianne Murphy.
CHAIRMAN MURPHY: Here.
MR. ROATE: Thank you.
Chairman Sewell is absent. Seven in attendance.
CHAIRMAN MURPHY: Thank you.
Okay. May I have a motion to go into closed session pursuant to Sections 2(c)(1), 2(c)(5), 2(c)(11), and 2(c)(21) of the Open Meetings Act.
MEMBER DEMUZIO: Motion.
MEMBER MC NEIL: Second.
CHAIRMAN MURPHY: Motion and second.
We are adjourned. Can you please clear the room -- I'm sorry. Not adjourned.
We're going into executive session, if you could clear the room for --
MS. MITCHELL: 20 minutes.
CHAIRMAN MURPHY: -- for about 20 to 30 minutes.
///

(At 9:19 a.m. the Board adjourned into executive session. Open session proceedings resumed at 9:50 a.m. as follows:)

CHAIRMAN MURPHY: Thank you.

All right. We're going to proceed to Agenda Item No. 4.

MS. MITCHELL: May I have a motion to approve the consent agreement for University of Illinois Medical Center at Chicago, HFSRB 17-03.

MEMBER MC NEIL: So moved.

MEMBER DEMUZIO: Second.

MS. AVERY: Sorry, George.

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

MR. ROATE: Thank you, Madam Chair.

Senator Demuzio.

MEMBER DEMUZIO: Present.

MR. ROATE: Mr. Gelder.

MEMBER GELDER: I'm recused on this matter.

MR. ROATE: Thank you.

Mr. Hamos -- Ms. Hamos.

MEMBER HAMOS: Present.

MR. ROATE: Ms. Hemme.

MEMBER HEMME: Present.

MR. ROATE: Mr. McGlasson.

MEMBER MC GLASSON: Present.
MR. ROATE: Dr. McNeil.
MEMBER MC NEIL: Present.
MR. ROATE: Madam Chair.
CHAIRMAN MURPHY: Present.
MS. MITCHELL: We're taking a vote. So is everybody --
MS. AVERY: Yes, yes. Yes, yes.
CHAIRMAN MURPHY: Can you do it again?
MS. MITCHELL: Can you do it again?
CHAIRMAN MURPHY: We're voting on a motion. This isn't roll call.
MEMBER DEMUZIO: I thought she said "roll call."
MS. AVERY: I did.
MR. ROATE: One more time.
MEMBER DEMUZIO: My apologies.
MR. ROATE: Senator Demuzio.
MEMBER DEMUZIO: Yes.
MR. ROATE: Mr. Gelder.
MEMBER GELDER: Still recuse.
MR. ROATE: Thank you.
Ms. Hamos.
MEMBER HAMOS: Yes.

MR. ROATE: Thank you.
Ms. Hemme.
MEMBER HEMME: Yes.
MR. ROATE: Mr. McGlasson.
MEMBER MC GLASSON: Yes.
MR. ROATE: Thank you.
Dr. McNeil.
MEMBER MC NEIL: Affirmative.
MR. ROATE: Thank you.
Madam Chair.
CHAIRMAN MURPHY: Yes.
MR. ROATE: That's 7 votes in the affirmative.
MS. AVERY: Thank you.
MS. MITCHELL: And then on that matter again, can I have a motion to approve that the administrator be the signatory on the amended consent agreement in the absence of a Board Chair?
CHAIRMAN MURPHY: So moved.
MEMBER DEMUZIO: Second.
MR. ROATE: Senator Demuzio.
MEMBER DEMUZIO: Yes.
MR. ROATE: Mr. Gelder.
MS. AVERY: Recuses.

MEMBER GELDER: Recuse.
MR. ROATE: Ms. Hamos.
MEMBER HAMOS: Yes.
MR. ROATE: Ms. Hemme.
MEMBER HEMME: Yes.
MR. ROATE: Mr. McGlasson.
MEMBER MC GLASSON: Yes.
MR. ROATE: Dr. McNeil.
MEMBER MC NEIL: Yes.
MR. ROATE: Madam Chair.
CHAIRMAN MURPHY: Yes.
MR. ROATE: 7 votes in the affirmative.
MS. MITCHELL: Next up, can I have a motion to refer to legal Provident Hospital?
MEMBER MC NEIL: So moved.
CHAIRMAN MURPHY: Second?
MEMBER DEMUZIO: Second.
MR. ROATE: Senator Demuzio.
MEMBER DEMUZIO: Yes.
MR. ROATE: Mr. Gelder.
MEMBER GELDER: I'm sorry. This is on what motion?
MS. MITCHELL: Provident Hospital.
MR. ROATE: To refer Provident Hospital.

MEMBER GELDER: Yes.
MR. ROATE: Thank you.
Ms. Hamos.
MEMBER HAMOS: Yes.
MR. ROATE: Ms. Hemme.
MEMBER HEMME: Yes.
MR. ROATE: Mr. McGlasson.
MEMBER MC GLASSON: Yes.
MR. ROATE: Dr. McNeil.
MEMBER MC NEIL: Yes.
MR. ROATE: Madam Chair.
CHAIRMAN MURPHY: Yes.
MR. ROATE: 7 votes in the affirmative.
MS. MITCHELL: That's all I have.
CHAIRMAN MURPHY: Thank you.
May I have a motion to approve the April 30th, 2019, meeting agenda.
MEMBER DEMUZIO: Motion.
MEMBER HEMME: Second.
CHAIRMAN MURPHY: All in favor?
(Ayes heard.)
CHAIRMAN MURPHY: Any opposed?
(No response.)
CHAIRMAN MURPHY: Thank you.

May I have a motion to approve the March 5th, 2019, meeting transcript.

MEMBER MC NEIL: So moved.

CHAIRMAN MURPHY: Second?

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: Thank you.

All in favor?

(Ayes heard.)

CHAIRMAN MURPHY: Thank you.

Any opposed?

(No response.)

CHAIRMAN MURPHY: Okay. Motion carries.

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

CHAIRMAN MURPHY: Okay. I would like to ask the Board to amend today's agenda.

I would like a motion to move the Westlake-only public participation to in front of the Westlake litigation discussion, so taking that part of the public participation before Agenda Item No. 7.

Can I have a motion for that, please?

MEMBER HEMME: So moved.

CHAIRMAN MURPHY: Second?

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: Is there any discussion on that motion?

(No response.)

CHAIRMAN MURPHY: George, can I have a roll call?

MR. ROATE: Thank you, Madam Chair.

Senator Demuzio.

MEMBER DEMUZIO: Yes.

MR. ROATE: Mr. Gelder.

MEMBER GELDER: Yes.

MR. ROATE: Ms. Hamos.

MEMBER HAMOS: Yes.

MR. ROATE: Ms. Hemme.

MEMBER HEMME: Yes.

MR. ROATE: Mr. McGlasson.

MEMBER MC GLASSON: Yes.

MR. ROATE: Dr. McNeil.

MEMBER MC NEIL: Yes.

MR. ROATE: Madam Chair.

CHAIRMAN MURPHY: Yes.

MR. ROATE: Okay. 7 votes in the affirmative.

MS. MITCHELL: Okay.

- - -

MS. MITCHELL: We're going to get ready to start public participation.

Speakers will be called up in groups. Please quickly make your way to the table when your name is called. The people in your group can speak in any order. You do not have to speak in the order in which your name is called.

You will be limited to two minutes for your statement. Given the number of speakers today, we will strictly adhere to the two-minute limit. If you are still speaking at two minutes, at the two-minute mark you will be instructed to conclude your comments.

At the beginning of your remarks, please state and spell your name for the court reporter. If you have written remarks, please leave them -- leave them at the end of the table, and this is the table which you will come up and speak at.

First up, Dr. Glenn A. Kushner, Igor Sokolowski -- I apologize if I'm butchering names -- Representative Chris Welch, and Ari Scharg.

Please come up to the table.

You may begin. Please don't forget to

state and spell your name.

DR. KUSHNER: Yes. I am Dr. Glenn Kushner, K-u-s-h-n-e-r, president of the medical staff of Westlake Hospital.

In the world -- in the words of Elton John, "We're still standing, yeah, yeah, yeah. Once we never could hope to win, the threats you made were meant to cut us down. You know we're still standing better than ever, looking like a true survivor. We're still standing after all this time, picking up the pieces of our hospital without you on our mind. We're still standing, yeah, yeah, yeah."

There's one reason: At Westlake Hospital we love our patients and are committed to this community, to all people, regardless of their protected or unprotected status or their ability to pay.

Westlake Hospital is the only hospital in the area to offer OB and psych. Our psych unit is necessary to a broad community. Chronic psych patients run out of lifetime Medicare days and, therefore, cannot go to a freestanding psych hospital such as Riveredge. These patients, who

are real people, need our help. We offer electroshock therapy, commonly called ECT, which no area hospital offers. We offer treatment for opioid addiction, needed more now than ever.

We don't stand alone. There are others that have expressed an interest in not only keeping us open but taking us into their family. I have personally spoken to more than one CEO who have expressed interest and wish to know when the financials will be available to a potential owner.

This hospital began as a community hospital and needs to stay in the community. It's a lighthouse and beacon of hope for all in our community and the surrounding communities. Please don't shut out the light that shines from above.

Thank you.

(Applause.)

DR. SOKOLOWSKI: Good morning, everybody.

My name is Dr. Mark Sokolowski, S-o-k-o-l-o-w-s-k-i. I'm an orthopedic and spine surgeon at Westlake Hospital and I have been for 12 years.

Pipeline would have you believe that Westlake's services are limited in scope and

redundant. In fact, we routinely perform complex spine surgeries at Westlake. I'm on staff at five hospitals in Chicago, but I choose to do many of my complex cases at Westlake because the surgical team is excellent and so are our outcomes.

Westlake provides services not readily available elsewhere in the community, including at West Suburban Hospital. The same anterior lumbar spine fusion Tiger Woods had before his win is available even to the nonfamous residents of Melrose Park and routinely performed by me and my colleague Dr. Ivankovich at Westlake. Our surgical team is fully intact. In fact, we have a complex spine surgery scheduled at Westlake tomorrow morning.

I'm also past president of the medical staff and current chairman of the peer-review committee at Westlake. I assure you safety is our primary concern. Safety has never been compromised at Westlake, is not now compromised, and will not be under my watch. Because no physician leadership from Pipeline has ever attended any of our peer-review meetings, I am not surprised by their inaccurate assessment of safety

at our community institution.

Westlake is a critical resource for Melrose Park. Closure will have a significant and negative impact upon the health and well-being of Melrose Park's residents. I implore you to vote to defer Pipeline's discontinuation application until arrangements can be made to preserve these vital services in this community.

Thank you very much.

(Applause.)

MR. SCHARG: Good morning.

My name is Ari Scharg, S-c-h-a-r-g. I'm special counsel for the Village of Melrose Park.

As the Board is aware, we have filed litigation against Pipeline and all the entities that are a part of the application to the Board to close the hospital.

That litigation claims that Pipeline and the Applicants have engaged in a fraudulent scheme and conspiracy to obtain the hospital under false pretenses and to close it down, in violation of statements they made to this Board and to the community and to the State and to the Village of Melrose Park.

The discontinuance application is the product of fraud. Full stop.

What I want to talk about is not just, though, the fact that under the Board's rules the consideration of the application must be deferred until a later date -- because it absolutely requires that. And what's very relevant with respect to the Board's rules is that there are actually two separate rules for dealing with exemptions and permits.

When dealing with an exemption that is the subject of litigation, it's -- the rules, Section 1130.560(b)(2), requires -- it says that the HFSRB will defer consideration.

With a permit, on the other hand, 1130.655(c) -- excuse me -- 1130.655(b)(5) states that the HFSRB may defer a consideration. That is a significant difference in terminology.

With a permit, discretion is given to the Board; with an exemption, discretion's taken away.

MR. ROATE: Two minutes.

MR. SCHARG: I want to add one more thing.

There's been new evidence that has come out recently. There was an in-court hearing --

MS. MITCHELL: Two minutes.

CHAIRMAN MURPHY: Please conclude your remarks.

MR. SCHARG: May I have 10 seconds?

There was an in-court hearing two weeks ago where the CEO of Pipeline admitted under oath in court that he made the decision to close down the hospital before he purchased it, which means that there was an alteration made to the exemption that was issued --

CHAIRMAN MURPHY: Sir, can you please conclude your remarks?

MR. SCHARG: -- and the permit is -- the exemption is, therefore, void.

Thank you.

(Applause.)

REPRESENTATIVE WELCH: Good morning.

My name is Emanuel "Chris" Welch, and I am State Representative of the Seventh District. I have also served as chair of the Westlake Hospital board since October of 2009.

I want to first begin by thanking all of you for your service to this Board and to our state.

Next, I want to ask you a question: How do you want to be seen as a Board? How do you want to be seen? Because all eyes are on you.

How you handle the Pipeline application is important because those eyes are on you. What message does this Board want to send to all those that are watching and paying attention? Is it okay to lie and deceive this Board? Is it okay to lie and deceive communities in this state?

Pipeline Health swore under oath, under penalties of perjury, to keep Westlake Hospital open for at least two years when they filed an application for change of ownership before this Board in September of 2018.

Pipeline Health swore under oath not to make any changes to the charity care policy for at least two years when they spoke to this Board in that application in September of 2018. They did this in September of 2018 fully aware of the hospital assessment that they're now publicly critical of, knowing that it had been voted on six months prior to them ever signing any documentation before you.

Now we know that, after swearing under

oath before you in September of 2018, that in December of 2018 Pipeline's CEO, Jim Edwards, said that they privately decided to close Westlake Hospital but, yet, they continued the lying and deceiving of the community. They went in the press. They called elected officials like myself and the Mayor of Melrose Park and other elected officials and continued to lie and deceive the community all the way through their purchase of the hospital in January of 2019.

This Board should not want to be remembered for rewarding lying and cheating.

MR. ROATE: Two minutes.

REPRESENTATIVE WELCH: We are here to ask you to officially request that the Attorney General get involved on your behalf and investigate Pipeline Health for fraud and misrepresentation.

We also ask you to defer any decision on their application until all litigation is complete and the Attorney General has investigated their fraud and misrepresentation.

I thank you kindly for your time.

(Applause.)

MS. MITCHELL: Next up, Daniel Ivankovich, Raimundo Aguilar, Charles Allen, Kelly Anthony, and Virginia Arrajo.

Please come up when your name is called.

That is Virginia Arrajo, Kelly Anthony, Charles Allen, Raimundo Aguilar, and Dr. Daniel Ivankovich.

MS. AVERY: You can start, sir.

MS. MITCHELL: You can start.

DR. IVANKOVICH: Greetings. Daniel Ivankovich, I-v-a-n-k-o-v-i-c-h.

I want to thank you all for allowing me to speak. I am an orthopedic trauma and spine surgeon.

I've been practicing and licensed in Illinois since 1995. I've seen over 120,000 patient visits, performed 14,000 procedures, and we have created programs for the medically underserved of Chicago. We have orthopedic and musculoskeletal programs that exist in underserved communities and serve many of the safety net hospitals in Chicago. For this me and my colleagues have been awarded Chicagoan of the Year, Illinois Citizen of the Year, CNN Hero,

and Red Cross Hero.

Dr. Mark Sokolowski is my colleague. We perform complex spine surgeries together. In 2007 we picked Westlake Hospital as a facility that could serve the full needs of complex joint replacement, spine surgery for patients throughout Chicago. I bring patients from all over the city that are medically comorbid and need these surgeries that are not routinely offered at safety net hospitals.

And we have a tremendous staff, people with 20 to 30 years of experience that are in our surgical team that are not only empathetic and compassionate but they're amazing.

I served as vice chair of the department of surgery from 2015 to 2017. My job was to review clinical data and outcomes, and I was very shocked when the people of Pipeline said that the hospital was unsafe. Dealing with a complex and comorbid population, Westlake Hospital has outstanding outcomes.

I think that we have never seen a Pipeline medical director come. I've never been questioned; no one has inquired. But I think that

it was abrupt, that it was incorrect to say the hospital was unsafe. It's anything but.

This will affect not only patients in Melrose Park --

MR. ROATE: Two minutes.

DR. IVANKOVICH: -- but orthopedic patients throughout the city that require these surgeries.

I urge you to defer decision on this and, for the people of Melrose Park, keep Westlake Hospital open.

Thank you.

(Applause.)

MS. ANTHONY: Good morning. My name is Kelly Anthony.

I am a unit secretary at Westlake Hospital. I've been there for a total of 19 years. I've had both of my children in Westlake Hospital. It couldn't get any safer than that.

To go to a place where you can work and trust every physician, every anesthesiologist, every secretary, every PCT, every RN, every housekeeper, every security and know that they are

trusting in you as a patient to treat you like you were one of their children -- they supported each other. They support each other. It's the safest place you would want to go. There's no way I would work there and say that I would go and have my children there.

I must love this place. I love Westlake. It is the safest, the best staff members in the world. I couldn't ask for anything more.

But for what Pipeline is doing, underhanded and dirty, lied to us in our faces, told us about what they were going to do, walked up to the floor, introduced themselves and said, "We're going to make you grow; we're going to show you the best -- we're going to expand you," and then turn around a month later and hand -- and find out, in the news, that they're going to close you, now, that's heartbreaking.

Thank you.

(Applause.)

INTERPRETER MARIN: I'm going to translate for Raimundo.

MS. AVERY: Wait a minute. Why don't you move to that mic so there's not a delay in passing

it back and forth. Is that okay?

INTERPRETER MARIN: Yeah.

MR. AGUILAR: (Speaking Spanish.)

INTERPRETER MARIN: My name is Raimundo -- Raimundo Aguilar, R-a-i-m-u-n-d-o A-g-u-i-l-a-r, and I'm a Melrose Park community member, and I have been there since 1985.

My children were both born there, and I am surprised that this is happening to Westlake Hospital.

MR. AGUILAR: (Speaking Spanish.)

INTERPRETER MARIN: I do not know if Westlake Hospital will close or not, but it is a very important hospital, especially for the elderly in the community. And I please urge you to not let Westlake Hospital close.

Thank you.

(Applause.)

MS. MITCHELL: When your name is called, if you could quickly make your way to the table, we do have a lot of speakers, so we need to keep it moving.

Next up are Mari Collins, Tamara Dey-Venturella, Dr. B. Eshaghy, Anna Marie

Falcone, and Liz Figueroa.

I really apologize for butchering names.

MS. AVERY: You can go ahead and start.

MS. COLLINS: Mari Collins.

MS. MITCHELL: Please use the microphone.

MS. COLLINS: Mari Collins, RN --

MS. MITCHELL: Closer.

MS. COLLINS: -- and resident of Melrose Park.

Westlake Hospital is as much as what the others have said for the orthopedic services for the behavioral health services, for the services we provide for high-risk infants; however, the World Health Organization and Healthy People 2010 asked for access to care. They discussed access to care and providing for the underinsured or uninsured.

Westlake has been doing that for all the years that I've been there. In addition to all the medical programs that Westlake provides, it's important in the community because they also do a lot of community service. They give free seminars about health topics to our community. They provide backpacks with school supplies for

our children in the district. They do health screenings on a routine basis. Our doctors speak free of charge to the community about issues in our -- health issues in our area.

They -- people who have come to our hospital recognize all of us because we've been there a long time, and our community needs the hospital to continue to provide the services that they provide.

Thank you.

(Applause.)

MS. FALCONE: Hello. My name is Anna Marie Falcone. I am from Schiller Park. I am a unit secretary at Westlake Hospital.

I started working when the west wing was built in 1983. Myself, as many other employees, are life-timers of the hospital. We're more like family to each other. We trust our doctors that care for us and our family. Two of my children were born there, six of my grandchildren were born there, and most of my family does attend Westlake Hospital when they are in need of medical care.

They are like family. Doctors, nurses, secretaries, everyone in the hospital everyone

knows. We trust our family's health to our coworkers that we are there with.

We are in need, also, of the psych unit. There's really no other psych unit in the area, it has been said in the past by others. Babies, we've delivered many. I worked yesterday; I heard our little ringer going off. That's when a baby's born. We have the need for both of those in the area.

We are also a stroke center. And in the past, while we've been told that there's no need for us, other hospitals have gone on bypass and -- where would those patients go if we weren't there? There would be no care for the patients.

You know, every second counts. From birth to death, every second counts. And if Melrose Park is -- the hospital in Melrose Park is taken from -- if Westlake is taken from Melrose Park, where will all these patients go?

Thank you.

(Applause.)

MS. FIGUEROA-SERRANO: Good morning.

First and foremost, I'd like to thank you for the opportunity of addressing my insight and

knowledge to you, pleading that Westlake does not close its doors.

My name is Liz Figueroa-Serrano, and I'm the advocate and community partners coordinator at Sarah's Inn domestic violence organization. I'm also a resident in Proviso Township, and Westlake is my hospital of choice.

For many years Westlake has provided incredible medical attention to underserved populations within the district and beyond. Westlake has been and is the most favored hospital in our community, providing access to trustworthy medical services. Within walking distance for many patients has been vital and continues to be vital. Westlake has always remained patient centered, and positive feedback from the communities are always provided.

As a representative of Sarah's Inn, we thank Westlake for their ongoing support throughout 16 years, undoubtedly supporting the mission and the work that we do, advocating for victims and survivors of domestic violence and their children. Despite the changes in administration, Westlake has sustained its

services as a safe haven for facilitating ongoing weekly support groups.

Closing the doors of Westlake will unsympathetically affect the women and children that we serve. The women have vocalized their distrust with the news that the hospital may potentially close. Many have shared their children were born at Westlake and continue to receive ongoing medical attention at Westlake.

The staff has always been supportive and know the clients as they come in and out. This has always been a safe haven that our clients have come to. Providing culturally sensitive care is indispensable to this group of people. Beyond our clients, Sarah's Inn is eternally grateful to the staff at Westlake.

Is there anything that you, as a Board, can do to stop the shutdown, a shutdown that will be detrimental not just to the community but to many other communities --

MR. ROATE: Two minutes.

MS. FIGUEROA-SERRANO: -- a hospital that has displayed care that is unmatched for people of color?

Thank you.

(Applause.)

MS. MITCHELL: Next up, Dr. Jen Furm or Furn, Anthony Garrison, Dr. Richard Goldberg, Maria Gomez, and Irma Hernandez.

MS. HERNANDEZ: Good morning.

My name is Irma Hernandez. I am married and have three children of 18, 15, and 6 years old.

Me and my family have been in the Melrose Park area for 15 years until now. I have been a volunteer in the area for 15 years. My family and I have been attending the hospital, Westlake, for 15 years, and I am here to ask do not close the hospital, please, since my two daughters were born here and the service was excellent.

I find Westlake Hospital convenient due to it being very close to my house and has me less worried for when an emergency can occur. Here in the hospital is also the doctor who reviewed my two daughters when they were born 15 and 6 years ago.

Growing up in Mexico with no hospital is very scary due to the fact that if someone got

very ill and needed medical attention as soon as possible, the nearest hospital would be an hour driving or more, which by that time a person would have passed away, depending on the situation.

I feel that having this hospital is a true blessing. We have to build, not destroy. I ask you, before you think about money, think about the lives you can keep saving. For Hispanics, African-Americans, and all of us in this -- in this hospital --

MR. ROATE: Two minutes.

MS. HERNANDEZ: -- shutting it down means death or life.

CHAIRMAN MURPHY: Ma'am --

MS. HERNANDEZ: Thank you.

(Applause.)

MS. GOMEZ: (Speaking Spanish.)

(Applause.)

INTERPRETER MARIN: Good morning. My name is Maria Gomez, M-a-r-i-a G-o-m-e-z.

I am a leader with the PASO organization and I -- West Suburban Action Project -- and I have lived in the community of Melrose Park for more than 15 years.

I am here today as a PASO leader and as a member of my community to express my disagreement in closing Westlake Hospital. The hospital for me is very important because my grandchildren have been born there, emergency surgeries have been done there, and my family and I have been there on several occasions.

Those of us who go to this hospital are mostly like me, people of color, Latin, and blacks with few resources, and it is not fair that companies like Pipeline want to close the hospital.

I also have a daughter with special needs, and the people of Westlake Hospital have always helped me in all the processes I have to do for her, including translation so I can understand the doctors about my daughter's care.

The hospital is minutes from my house. I sometimes walk to go to my consultations. And if they close, it means that I as a person -- as a senior citizen with a sick daughter -- would not be able to have the resources to continue receiving care in case of illness because I do not have a car to get around.

I ask Pipeline and I ask you, the Board, to not only think of me as a senior citizen but also my neighbors who live near the area and do not have the resources to move freely to meet our needs.

Thank you.

(Applause.)

MS. MITCHELL: Next up, Gabino Huerta, Dr. Hamid Humayun, Manuel Iglesias, Anne Igoe, Yelena Ishua- -- Ishahun.

MR. HUERTA: Good morning. My name is Gabino Huerta.

I live in Melrose Park. I'm against discontinuation for many reasons.

(Speaking Spanish.)

INTERPRETER MARIN: So one of the reasons I'm worried about closing Westlake Hospital is because of -- all the community of Melrose Park and the communities around will be affected.

We will be moved -- have to move our care over to West Suburban Hospital and West Suburban Hospital will become overcrowded and we will not be able to receive the care we need.

Thank you.

(Applause.)

DR. IGLESIAS: Hi. I'm Dr. Manuel Iglesias, I-g-l-e-s-i-a-s. I have been at Westlake since 1978, 41 years.

I have been providing gastroenterology services to the community. I'm proud to say that I have three generations of patients actually there, and they are really upset about this particular situation. I get calls every day from confused patients not knowing what to do, and this is something that I think is pretty bad.

I urge you to advise not to close Westlake Hospital. We need it. The community of Melrose Park needs it for many, many years.

Thank you.

(Applause.)

MS. IGOE: Good morning. My name is Anne Igoe, I-g, as in "George," -o-e.

I serve as the vice president for SEIU Healthcare Illinois and Indiana. We represent 90,000 hospital health care -- and health care workers, specifically thousands of union members who live and work in the Melrose Park and Maywood area.

We stand with workers and community members to call a Code Blue on this action. We're calling a Code Blue for the closure of Westlake Hospital and the closure of any hospital that serves a community of color anywhere in this state.

We call on the Board to defer this decision and allow for the State to take action to keep Westlake Hospital open so as to provide charity care and care to those served by the State Medicaid program.

Pipeline claims that the hospital is underutilized and they will be losing money under the new hospital assessment program. We feel that the 10,000 days of care provided to patients covered under Medicaid is hardly underutilized. What it sounds like is that Pipeline just can't make a profit on Medicaid and charity care.

SEIU Healthcare is calling on the Board and the State to step in and stand up for the community that is served by the hospital. We cannot make decisions on keeping a hospital open based only on the opportunity to make a profit.

While on paper 47.68 percent of the

patients are on Medicaid, what doctors, nurses, and other employees know is that this number is much higher. When taking into consideration the current denial rate for claims, the hospital is serving a much higher Medicaid population.

Westlake Hospital is a safety net and should receive recognition by the State and receive the appropriate level of funding. In 2015 the Illinois Hospital Association pressed legislators to pass Public Act 99-0154, which amended the Illinois Health Facilities Planning Act to make it easier for hospital operators to close facilities and eliminate services.

As the lawyer from Melrose Park stated, this Board has been limited in its ability to make decisions concerning the care for the community. We think that is wrong.

We're calling on the hospital Review Board to defer this decision and allow the closure of the hospital --

MR. ROATE: Two minutes.

MS. IGOE: -- and in support of greater oversight so the decision to buy, sell, open, and close a hospital have greater oversight by the

State so that decisions are not based solely on profit.

Thank you.

(Applause.)

MS. MITCHELL: Next up, Mary Kateeb, Anna Marin, Dr. Ray McDonald, Sandra Melendres, and Dr. -- sorry, not Dr. -- Renae Meruz.

You may begin.

MS. MARIN: Hi. My name is Anna Marin, A-n-n-a M-a-r-i-n, and I'm the organizing director of PASO - West Suburban Action Project.

PASO is a community-based social justice organization that works to engage community members to address issues that affect them, their families, and neighbors with a mission to build stronger communities where all residents can live dignified lives regardless of their race, gender, sexual orientation, socioeconomic, or immigration status.

PASO is based in Melrose Park, Illinois, and serves the surrounding west Cook County suburbs and some of DuPage County. Ever since Pipeline first announced the closing of Westlake back in February, PASO has come together with

community members in opposition.

Days after the announcement, PASO stood alongside the immigrant African-American low-income mothers and children and families in front of the hospital in solidarity with the nurses and doctors and staff of the hospital, religious leaders from neighborhood churches, elected officials from mayors to State representatives to Congresspersons to tell Pipeline how critical Westlake Hospital is to our community. We hoped they would do the right thing.

PASO brought together community members to testify against the closing of the hospital, both in front of State representatives and in front of this Board during a public hearing held in Melrose Park. We endured Pipeline's representatives trying to placate our community with empty gestures of bussing women in labor to another hospital and substituting critical services to clinics miles away when many patients walk to Westlake Hospital for lack of transportation. And we hoped they would do the right thing.

PASO brought community members downtown to speak to the media outside the courtroom as Pipeline tried to defend its flagrant violation of the law in systematically shutting down sections of the hospital to illegally render it useless and placing the emergency room on bypass status for days at a time, putting our community in danger for lack of access to local medical services. And we still hoped they would do the right thing.

PASO gathered over 300 letters and postcards from concerned -- no, enraged -- community members, hospital employees, church patrons, grandparents, workers, single mothers and delivered them to the office of this Board in person in Springfield, imploring --

MR. ROATE: Two minutes.

MS. MARIN: -- that action be taken to keep Westlake Hospital open. Now we hope you do the right thing.

Thank you.

(Applause.)

DR. MC DONALD: Hello. My name is Raymond McDonald. I've been on the medical staff of

Westlake Hospital for 45 years.

I've had almost every job at the hospital, including being the ER director, but for 42 years I've been the medical director of the Belleville Developmental Center, which is a home for severely challenged patients. These patients have cerebral palsy, Down's syndrome, autism, quadriplegia -- you name it, they have it.

And Westlake Hospital has done a terrific job for handling these type of patients. I've been on many other medical staffs and never have I seen such a dedicated physician and nursing staff that will, with care, take care of these very complicated patients.

The other thing I want to make is a second point. I've been on the board at Westlake Hospital for many years and know a lot about the past history.

Historically, Westlake Hospital sold to Resurrection Health Care 20 years ago for $70 million. Currently the new owner bought Westlake Hospital, West Suburban Hospital, Weiss Hospital, and the beautiful River Forest Medical Center for the same $70 million at a very

depreciated dollar rate.

I think to replace these four functioning health care institutions today would cost well over a billion dollars. And as I said, the current owners purchased all four of them for $70 million, about 7 cents on the dollar for irreplaceable facilities that I think should never have been sold to the private sector in the first place.

I hope in the future that the State of Illinois does not allow the transfer of any strategic, valuable, public properties to the private sector lest they disappear forever and are no longer available to future generations.

Thank you.

(Applause.)

MS. MITCHELL: Next up, Bess Mocek or Mojek, Tatiana Munoz, Richard Paduch, Dr. Kathy Papazian, and Dr. Shobhana Patodia.

You may begin.

MS. MOCEK: My name is Bess Mocek, M-o-c-e-k. I've been a nurse and a nurse manager from 1981 to 2016 at Westlake Hospital. Both of my children were born there.

I grew up poor. I know firsthand what the people who live in Bellwood, Maywood, Melrose Park are up against. My parents both worked to feed us and put a roof over our head, but there was no money for preventative health care or seeing a doctor. My mom died at the very young age of 48 because of this.

I was over a $5 million budget for two big nursing units. I went to monthly budget meetings starting in 2000 -- 2000. We -- our numbers of uninsured and, therefore, doing it out of the kindness of Westlake's heart to take care of these people -- we will, by shutting down Westlake, put those communities who have no insurance, no money, have -- will have no access to health care.

What happens is what happened to my mother. You can't afford to see a doctor. The day comes when you are so sick you feel like you're going to die. You walk on over to Westlake's ER. We have two cath labs. We stop your heart attack from happening. We stop you from having a full-blown stroke. Your baby has fetal distress, we do an emergency C-section.

I personally -- as a State of Illinois

taxpayer all of my 62 years, I'm pissed. And the reason I'm pissed is I and my fellow Illinois residents are going to be paying a lot more in taxes to take care of the people who have a weak heart because their heart attack wasn't getting their coronary arteries opened right away in the cath lab.

MR. ROATE: Two minutes.

MS. MOCEK: I am going to be paying a lot more on Medicaid to keep them in a nursing home after their big stroke for 10 or 20 years.

And the baby. If you're against abortion --

MS. MITCHELL: Please complete -- conclude your remarks.

MS. MOCEK: -- how much will it cost this State to, on Medicaid, take care of children with brain damage because they didn't get out when they had fetal distress?

I think the Health Review Board has to understand. I've been there --

MS. MITCHELL: Please conclude your remarks, ma'am.

MS. MOCEK: -- I understand these

communities. You need to keep Westlake open two years --

MS. GUILD: Ma'am -- ma'am, you have to --

MS. MOCEK: -- there will be changes in the health care system federally and there would be hope.

If you close them now --

MS. MITCHELL: Ma'am, please conclude your remarks.

MS. MOCEK: -- all of the people in that community will have no hope and the deaths of the children will be on our heads. And it's not the right thing to do.

MEMBER HAMOS: Thank you.

(Applause.)

MS. MUNOZ: Hello. My name is Tatiana Munoz, and I am a community organizer with PASO - West Suburban Action Project, and I oppose the closing of Westlake Hospital.

The health of the community depends on this hospital, and it provides many services that are readily available to everyone. Nursing students from my school, which is 15 minutes away from the hospital, had clinicals at Westlake, and

even students were impacted by Pipeline's actions of pausing services.

The students in this situation were relocated to other hospitals, which ended up being a little bit further of a commute for them, and in that transition students lost hours and had to make those up on their own time. Students who work, have families, need to spend time had to make up hours because of decisions made by Pipeline.

I also have classmates that live in the area and have been affected by the situation at Westlake with lack of services for themselves and for their families.

As a community organizer I have heard stories from various individuals about the benefits of having a hospital so close and one that cares about the well-being of the community and one that identifies so closely with the community.

PASO has brought some of those individuals here for you today, and you have seen their faces. You now have faces to remember when you make your decision, and I urge you to remember the

individuals and the stories that they have told you today because it's very simple to forget that there's human beings being impacted. So we brought them here for you to remember their faces, and I urge you to please remember them when making your decision to keep Westlake open.

Thank you.

(Applause.)

DR. PAPAZIAN: Good morning. My name is Dr. Kathy Papazian, P-a-p-a-z-i-a-n. I am an attending ER physician at Westlake -- and have been for the last 10 years -- and a new resident of Melrose Park.

I am on the front lines --

MS. MITCHELL: It's a little difficult to hear you, ma'am.

DR. PAPAZIAN: I can talk up.

I am on the front line in emergency medicine. I am the front door to Westlake. I can tell you that, when we were on bypass, we were still seeing patients. We were boarding them in the emergency room because Pipeline would not let me admit them upstairs despite the fact that I had nursing upstairs, despite the fact that I had

a lab that could take my MIs and strokes.

I have the unique experience of actually practicing in both hospitals in Melrose Park. I will tell you for a fact, when they go to the opposite hospital, you will not see a nurse until they figure out how you're going to pay for the visit.

Case in point: We had a 5-year-old that came into the other hospital that had a fever. They did -- asked the patient, "How are you going to pay for this?" That patient walked that child a mile down to Westlake Hospital. By the time that child got to Westlake, he was in a coma from DKA.

That's the reality of Melrose Park. People do not feel comfortable going to West Sub or the other hospital in Melrose Park. They come to Westlake because we understand them. We make it comfortable for them. There are patients that I see on a regular basis that I know their medical history better than they do.

So I urge you, please defer your decision and let the Court take its course.

Thank you.

(Applause.)

MS. MITCHELL: Next up, Veronica Perry, Dr. Neil Rosenberg, Sylvia Saenz, Dr. Nabil Saleh, and Dr. Lyndon Taylor.

DR. ROSENBERG: Good morning.

My name is Dr. Neil, N-e-i-l, Rosenberg, R-o-s-e-n-b-e-r-g.

I'm board certified in internal medicine, pulmonary medicine, and critical care medicine and the medical director of the ICU and respiratory care services. I want to give two brief experiences and then I'll address the ICU.

One, I was sitting in the doctors lounge about two months or three months ago, and an individual from Pipeline joined us and expressed his desire of how he was looking forward to working with us, building the hospital, setting up new programs, and giving us every indication that the hospital is going to stay open, and we were looking forward to working together with him.

I have an office in the professional building, and every day my patients come in almost crying, "What am I going to do when the hospital leaves? What are you going to do? Who's going to

take care of me? How am I going to continue with the services?"

As far as the ICU, we work the same protocols that you see elsewhere in the country. Right now we have an individual with a heroin overdose -- you've heard on the news recently -- we have an alcoholic going through alcohol withdrawal symptoms; and as of yesterday we had an 80-year-old gentleman admitted through the emergency room with an acute ST-elevated myocardial infarction, a heart attack.

He received the same care he would receive anywhere. EKG showed this, the cardiologist was called, he was taken to the cath lab, the stent was placed, the artery opened, and he's being transferred to the telemetry unit in stable condition today.

There was a reported comment by Mr. Edwards that the care in the ICU was not of the quality that he expected because we had agency nurses participate in the care of the patients. This is a standard thing in every ICU around the city. This is another demonstration of his lack of knowledge of how care is administered.

The ICU can have 2 patients one day and 12 the next. Staffing problems can often be a difficult situation, and agency nurses are well-qualified in our electronic medical record.

MR. ROATE: Two minutes.

DR. ROSENBERG: They proceed with the same protocols that you see everywhere.

We have a stroke center that's certified. We have the same protocols that you do with sepsis from the -- in the entire country, and the care they're provided is what you would see in a standard anywhere else.

And I hope that you will continue to let us proceed and thank you for giving us the opportunity to talk to you.

(Applause.)

DR. SALEH: Good morning, Board. Thank you for allowing me to talk today.

My name is Nabil Saleh, N-a-b-i-l S-a-l-e-h. I'm a pediatrician. I've been practicing in the area for 40 years. I'm a past medical staff president and past chairman of the department and a current member of the board of trustees.

Aside from everything that was said about the services we provide from maternity, drug rehabilitation services, kidney dialysis, a dialysis unit which is the biggest unit in the area, aside from the fact that we take charity work and charity patients without asking about the choice they have, aside from the fact that Pipeline says that there is overbedding in the hospitals in the area, I want to tell them that this is not one size fit all. It all depends on the demographics; it all depends where the hospital is located; it all depends how the patients' access to the hospital and the health care in that area is.

I'm a pediatrician. My patients walk to my office in the professional building at Westlake Hospital with three or four kids, whether it's rain, shine, or snow, because they don't have the facilities or the means to get a Lyft or Uber or taxi or private cars. Hardworking, middle class, local people who hardly have one car for the husband to go to work; the mothers walk to my office.

Last week I discharged a baby from the

nursery, premature, that required resuscitation, required IV, was not feeling well, and had sepsis. The mother had to walk three or four -- every three hours to nurse that baby, to cuddle the baby, and to be with that baby in the crisis. And great event, fortunately, that the baby went home fine last week.

Pipeline came to --

MR. ROATE: Two minutes.

DR. SALEH: -- Westlake with the promise that they would work with us. One day prior to our meeting to -- one day prior to their entry of deciding to close the hospital, they were meeting with us to tell us how wonderful we are and what programs we can work with.

Instead of coming with deceit and lack of transparency, they should have come to talk with clarity and honesty with the Board, the Village, the legislators, and with everyone that's concerned.

I invite the Board to come to Westlake. Please do come to Westlake. Talk to the patients, talk to the doctors and nurses, and you will find people who are really proud to serve this

community --

MS. MITCHELL: Sir --

DR. SALEH: -- and will continue --

MS. MITCHELL: Sir --

DR. SALEH: -- to do so.

Thank you.

(Applause.)

CHAIRMAN MURPHY: Thank you.

MS. SAENZ: Hi. Thank you for having me. My name is Sylvia, last name Saenz. I'm a certified nursing assistant for 23 years at Westlake.

I grew up in Melrose Park, and I -- actually, I know ancestors of the people that actually built the hospital. Those people were farmers. They worked very hard to build a hospital for the community that -- they were growing their vegetables and fruits and everything that feeds us because those things are the things that keep us healthy. They knew that that foundation was going to keep us going for many, many, many generations, and that's what they wanted to give us, an inheritance.

And this inheritance, we need to pass it

along to other grandchildren and great grandchildren because, honestly, there is a lot of love at Westlake, and you see it every day.

We have patients coming to Westlake from all over the place, and it's not just the black and Hispanic thing. I see all races coming to our hospital.

I work in same-day surgery, and I see doctors sending in their patients to us that are billionaires, millionaires, other doctors, lawyers, police officers, firemen. Why do they send them to our hospital? Because they know that we are safe. We take good care of them, and we know how to take good care of them.

So I urge you to please help us to continue this fight because it's not just about us. It's about everybody. We're all included, your -- your brothers, your sisters, your nephews, your nieces.

I also work in the emergency department, and I have seen a lot of tragic situations where people from affluent neighborhoods are coming to our areas and to the surrounding vicinities and are overdosing on heroin. Heroin and fentanyl is

killing everyone. And guess what? It could be your relative, your child, your nephew, your niece.

And what is happening? We are saving their lives, and I have to go home crying because we saved some rich person's child.

MR. ROATE: Two minutes.

MS. SAENZ: Guess what? They're all a part of us. It's not just a Hispanic thing. It's not just a black thing. It's everybody sticks together because we have a lot of love in our hearts.

MR. ROATE: Two minutes.

MS. SAENZ: Thank you.

(Applause.)

MS. MITCHELL: Dr. Mark Tomera, Estela Vara, Ana Maria Villarreal, Kathleen Ward, Rosemary Williams, and Marianna Woosley.

MS. AVERY: Go ahead and start.

Doctor, go ahead.

DR. TOMERA: Okay.

MS. VARA: Good morning.

MS. MITCHELL: Please state and spell your name -- sorry.

MS. VARA: My name is Estela Vara. E-s-t-e-l-a V-a-r-a.

I am a community activist with PASO - West Suburban Action Project. I have been a member of the area for more than 14 years, and I'm here today to express my absolute rejection of the closure of West Hospital [sic].

I went to Westlake Hospital for the first time when my son Francisco had a pain in his stomach seven years ago, when he was a child, and he had an emergency operation for appendicitis. I feel very blessed to have a hospital five minutes from my house because this time was critical for saving my son's life and because the hospital and staff made me feel safe and like my family. That day was the first time of many times that my family and I visited the Westlake Hospital.

As a member of my community and organizer with PASO, I am here today to tell the Pipeline Health company that we'll continue organizing and we work with the legislators in the area, with the City of Melrose Park, religious leaders, institutions, and community members to avoid

closing the hospital. I ask you guys, for the community, to keep Westlake Hospital open.

Thank you as --

(Applause.)

MS. VARA: -- as a mother.

DR. WARD: My name is Dr. Kathleen Ward, K-a-t-h-l-e-e-n W-a-r-d. I'm currently the chair of the department of internal medicine at Westlake Hospital.

When I was up last night trying to think about what I wanted to talk about here, it was a little perplexing because I talk a lot about Westlake Hospital.

But, basically, I came to the conclusion that your Board is really responsible to the people of Illinois, not to anybody else, and it's your responsibility to be certain that the closure of a hospital, which is a gigantic undertaking, will not negatively impact that community, the patients, and the society at large.

And I take issue with the closure of Westlake Hospital. I'm a cardiologist by trade. We are interested in rapid diagnosis and care. And if you look at the medical literature, all of

our care is becoming faster and faster and faster because cardiovascular disease and neurovascular decease, if it is not diagnosed and treated expeditiously and quickly -- and we're talking about minutes -- you have death and devastating complications. Similarly, critical care patients suffer the same fate.

Now, if you look at the American Hospital Directory, which is available online, the 4/4/19 data -- I went through the data last night, and I found that, if you compare Oak Park Hospital, West Suburban Hospital, Gottlieb, and Westlake -- if you close this hospital, 12 percent of cardiac admissions will be affected by this. 12 percent.

If you look at the number of beds in those same hospitals, we will lose 17 percent of the critical care beds in our community, and this is really big. If you look at the neurological admissions, 24 percent of neurological patients will be affected.

Now, why is this important? Well, because the distance from Westlake Hospital to the other surrounding hospitals -- all you have to do is look it up on IDOT -- I said this before.

MR. ROATE: Two minutes.

DR. WARD: The average time to get these patients to the hospital is 17 extra minutes. That's 17 extra minutes that can result in death, heart failure, respirators, and paraplegia.

MR. ROATE: Two minutes.

CHAIRMAN MURPHY: Ma'am --

DR. WARD: So I ask you to please refer this to Kwame Raoul and to stay the closure of Westlake Hospital.

Thank you.

(Applause.)

MS. VILLARREAL: Good morning. My name is Ana Villarreal V-i-l-l-a-r-r-e-a-l.

I'll just give a short testimony this morning about what the Melrose Park hospital, Westlake Hospital, means to me.

I have been in the community for more than 20 years. Westlake Hospital is part of my life; one of my two children was born there. I always use the hospital when I need it. All my medical records are there. I cannot imagine Melrose Park without the hospital.

I always receive very good treatment.

I find very good people to help me, what I need. I pray for not close the hospital. The community of Melrose Park needs it and all the communities around.

Thank you.

(Applause.)

DR. HUMAYUN: I'm Dr. Hamid Humayun. I'm one of the nephrologists, and I've been on staff at Westlake for over 35 years. I've been in all capacities. I've been chairman of emergency and at the present time I'm vice chair of medicine.

Westlake Hospital is a very good hospital, and the way it is in this shape is because of the poor management on the part of the administration. It is as good as any other hospital, and I don't really see any reason why it should close because it provides quality care.

The staff is interested in keeping it running, the physicians are interested, the community is interested, and so it is the hospital which I think is badly needed for the community, and I really don't see any reason why it should close. I mean, it is as good or better than most

of the neighboring hospitals.

Thank you.

MS. MITCHELL: Next group -- there are individuals who signed up and had numbers on their sheets, so I'm going to call you up now.

So those with Nos. 1, 2, 3, 4, and 7, please come up.

And please leave your sheets on the table when you're done and don't forget, at the beginning of your remarks, to state and spell your name.

MAYOR SERPICO: I guess I'm one.

My name is Ron Serpico, S-e-r-p-i-c-o. I'm the Mayor of the Village of Melrose Park. I appreciate the challenge that you have before you today.

I'm not going to reiterate all the things that happened with the hospital and what they serve, but I can tell you my own personal opinion, a bunch of docs that came up that were taking care of my father, my father-in-law, and my family. And as you heard from the times that they were here, there's a serious commitment to the hospital.

I was asked why the Village took on this, and we took it on because it's the most vulnerable. And if we didn't do it, obviously, we wouldn't be here today. Pipeline would have trampled over us. They've been disingenuous from the beginning.

And you have a challenge and a charge today to take seriously the lies that they've continued to perpetuate. They're disingenuous. They knew from the beginning what they were buying. I don't think someone's going to spend $70 million without doing their due diligence.

They were losing a million dollars a month, $2 million a month, and at the last court hearing $600,000 a day. And, quite frankly, I don't have a computer or calculator to add that up.

So it's a series of lie after lie after lie, and I think you have a charge today to defer on this action to allow them to close because, as Christians, we have a responsibility to the most vulnerable, and I hope you take that seriously.

And that's what I have to say. Thank you.

(Applause.)

MS. STIMSON: Hello, everybody. My name is Arielle Stimson. I'm here with Golden Years Retirement Home.

THE COURT REPORTER: Could you spell your name, please.

MS. STIMSON: Yes. It's A-r-i-e-l-l-e. Last name, S-t-i-m, as in "Mary," -s-o-n, as in "Nancy."

THE COURT REPORTER: Thank you.

MS. STIMSON: Yes.

So as I said, I'm here with Golden Years Retirement Home, and I am in support of keeping Westlake Hospital open.

We brought many of our residents here with us today who are actually Westlake Hospital patients, and they choose to have Westlake as their primary hospital versus other hospitals in the area for many reasons, but one of the main reasons that they tell us is they truly get the attentive care that they need from the nurses and the doctors, whether it be in the emergency room or the surgical room or -- even some of our patients, you know -- in the mental health unit, as well.

Not only is it the attentive care that they report back to us but it's also -- they feel like they're an individual when they go there and not just a number, such as how they felt in some of the larger hospitals that they've experienced.

So some other things that they also mentioned to us is when they go to Westlake Hospital not only is the care extremely important to them but they're also -- they don't have to worry about getting lost in the hospital and have to walk a mile from one room to another. That fear is gone when they go to Westlake.

So overall, on behalf of myself and all the residents that I brought here with us today -- you know, bussed over and everything; it was a whole big ordeal to bring everybody over here today -- on behalf of myself and them, we think that closing Westlake would be a huge mistake.

Thank you.

MEMBER HAMOS: Thank you.

(Applause.)

MR. MEHTA: Good morning. My name is Tushar Mehta -- that's T-u-s-h-a-r; last name, M-e-h-t-a -- from Broadway Medical Center.

And we would like to represent ourselves as a small business in the community in the village of Melrose Park. We have been an integral part of Melrose Park for approximately 17 years. If we feel we have an impact of ourselves in the community, then imagine what Westlake has an impact on the part of the community, which is many times larger than us and providing essential care such as emergency and life-threatening services to the underserved area.

Being located in the underserved area, it still goes to great state-of-the-art care for adults, pediatric, psychiatry, and cardiac care, just to name a few, actually. We also are staffed with top-notch providers, practitioners in the Westlake Hospital who provide excellent, safe, quality care for our community patients.

I suppose the largest concern or threat that we impose without the hospital being in existence is the life-and-death situations that would need to be addressed within minutes to our highly sickly patients that we have in our community. Without the hospital there and the travel time taken to the next nearest hospital

will make a difference in the person's survival.

Support us at Broadway. We know this also gives us the opportunity to continue care with our patients that are sent to this hospital on a regular basis. This broken link may not allow us access to these patients without vehicles, elderly patients, newborns, toddlers, just to name, again, a few.

Coming from a health care provider, the whole meaning of taking over a business like a hospital is not just the financial part of it. We all experience the downs in the industry, especially in the recent times, due to these insurance companies. But above that it is the nature of our profession. It is to take care of our community and our patients with no financial barrier that should come between us, especially in taking into consideration a big hospital like this. Our profession is to serve and to take care of --

MR. ROATE: Two minutes.

MR. MEHTA: -- of the patients, especially the needy and the community within -- that is defined to us. We just want to, again, make a

little -- think of Pipeline to say please keep it open for our community and our people.

Thank you.

(Applause.)

MS. MITCHELL: Is there anybody who signed up to speak for Westlake Hospital whose name has not been called or whose name has been called and didn't come up?

Come on up.

Please state and spell your name for the court reporter.

MR. THOMAS: Good morning. My name is Wellington B. Thomas -- W-e-l-l-i-n-g-t-o-n -- B. Thomas, II, and I've been an EMT for 16 years, an ER tech for 13 years, and also one of the leaders of SEIU for over 6 years, and I'm here to stand against the closure of Westlake Hospital.

The time it takes from injury to operation is called the golden hour. Time to transport emergency patients to other facilities would cost the patient their lives due to longer transport times. I experienced this firsthand when I was speaking with a patient in the back of an ambulance after an injury that actually passed on

the way to the hospital after passing an actual closed hospital.

Once again, lives will be lost due to the longer transport times with medication that could be given at a hospital that's nearby but, unfortunately, postponed because they're closed.

The services provided the Melrose Park community does need from Westlake, if taken away would destroy the community, especially with the hospital in the middle of the community with people of color.

It should not be closed, as the hospital like the one I served at Loretto Hospital serves as the community base. It provides the services needed for that particular community with monetary resources, should not be an option.

The hospital is a survivor, and we should be helping the hospital instead of destroying it. This closure is by design, and the IHA has the capacity to stop this and to ensure that people of black and brown skin are given the care that they deserve and they should have -- they -- the care that they deserve and that should be a right.

I stand with Westlake Hospital as we urge

to defer this decision to protect against the loss of life.

Thank you.

(Applause.)

MS. MITCHELL: That concludes the public participation for Westlake Hospital.

CHAIRMAN MURPHY: We're going to take a 10-minute break. When we come back, we're going to resume with Item No. 7 on the agenda.

(A recess was taken from 11:09 a.m. to 11:24 a.m.)

CHAIRMAN MURPHY: Please take your seats.

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

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MS. MITCHELL: Next on the agenda is the Westlake litigation and potential deferral.

Can we get the Applicants for the Westlake closure hospital to come to the table.

MS. AVERY: And they have to be identified and sworn in.

MS. MITCHELL: Are they in the room?

MS. AVERY: There they are.

MS. MITCHELL: Sorry. I didn't see you.

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

(Four witnesses sworn.)

THE COURT REPORTER: Thank you.

MS. MITCHELL: Okay. First, we're going to begin. I'm going to make a statement.

The Applicants in Exemption E-004-19 submitted a discontinuation exemption application on February 21st, 2019, proposing to close Westlake Hospital in Melrose Park.

A few weeks later -- sorry, Melanie.

A few weeks later the Village of Melrose Park initiated a lawsuit challenging the proposed closure of the hospital, alleging fraudulent misrepresentation and violations of

Melrose Park's Municipal Code in addition to other allegations.

The Village asserts that the Applicants made misrepresentations to the Board and the community to secure the change of ownership in Westlake Hospital. Part of the relief that the Village is seeking is injunctive relief.

Earlier this month the Applicant submitted a letter to the Board stating that they were going to temporarily suspend services at Westlake Hospital. The Village challenged any cessation of services, seeking a temporary restraining order.

The Court granted the temporary restraining order. The Applicants challenged the temporary restraining order but it currently stands. The Court ordered the Applicant to maintain service until May 1, 2019, assuming that the Board would render a decision on its discontinuation application by that time.

Generally, the Board must approve an exemption application when an Applicant submits all of the required information; however, in this case there's pending litigation, and Section 1130.560 provides that HFSRB will defer

consideration of an application for exemption when the application is the subject of litigation until all litigation related to that application has been completed.

My legal interpretation of this rule is that the discontinuation application is so significantly related to the pending litigation that it warrants the Board to defer consideration of the application. The pending temporary restraining order and request for injunctive relief is proof that the litigation stems entirely from the Applicant's application to discontinue Westlake Hospital. If it were not for the discontinuation application, there would be no lawsuit.

Therefore, legal recommends that the Board defer consideration of Exemption E-004-19 until all litigation related to the application is completed.

And we'll open it up for the Applicants to provide a statement, but I want to tell everybody this -- the portion of the meeting right now is only to discuss potential deferral in light of the litigation. That is it. We're not discussing the

exemption to close; we're only discussing whether to defer the exemption consideration because of litigation.

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

CHAIRMAN MURPHY: Can the folks at the table please identify themselves and be sworn in to testify.

MR. SAFER: We've been sworn.

MS. AVERY: Sorry.

CHAIRMAN MURPHY: Is there a motion on the Board to defer Exemption E-004-19?

MEMBER HEMME: So moved.

MEMBER MC NEIL: So moved.

MEMBER DEMUZIO: Second.

MEMBER HEMME: Second.

CHAIRMAN MURPHY: Did you get it? Did you get it, George?

MS. AVERY: Did you get it, George?

MR. ROATE: I did. I'm going to go ahead and call the motion. I'll say Dr. McNeil --

MEMBER HAMOS: When do we have discussion?

MR. ROATE: -- made the motion --

CHAIRMAN MURPHY: We will.

MR. ROATE: -- Ms. Hemme seconded.

CHAIRMAN MURPHY: Yes.
MS. AVERY: Okay.
MEMBER HAMOS: When do we have discussion?
CHAIRMAN MURPHY: Okay. We'll now have discussion on the motion.
MEMBER HAMOS: Are we going to hear from --
CHAIRMAN MURPHY: Yes, yes.
MS. AVERY: Yes.
MEMBER HAMOS: Could we hear from them?
CHAIRMAN MURPHY: Would you like to make a statement?
MR. SAFER: I would. I would. Thank you.
My name is Ron Safer, and I'm litigation counsel for the Pipeline companies and the individuals named in the Melrose Park litigation now joined by the State.
I appreciate the opportunity to address you this morning.
I will briefly describe how -- contrary to the opinion you were just given -- the litigation is unrelated to the application for certificate of exemption that is before you and how the complaint lacks any merit and, therefore, the Board should

grant the application and consider the application for discontinuation today.

We are aware of the just-quoted rule regarding litigation, a rule that was issued before the Act was amended to require the Board to approve an application once it is complete. That suggests that the Board may defer consideration of an application when the application is the subject of litigation. That rule has no application here.

First, the statute requires the Board to act to approve our complete application. The statute trumps the regulation.

Second, Melrose Park's complaint is completely unrelated to the application for exemption that is before the Board today. Melrose Park's complaint, as you heard from their attorney this morning, is based solely upon events in and around the change of ownership application.

The complaint asserts that the application's statement that Westlake's charity care policies would remain unchanged for two years, as required by the statute, was a promise to keep the hospital open for two years. The complaint asserts that you were defrauded by

that promise, and those are charges that were repeated before you this morning.

Of course, you and your staff know that you were not defrauded, and you appropriately approved the change of ownership application.

First -- as you well know but the complaint ignores and the testimony this morning ignores -- the Review Board cannot require a guarantee of continuation of services in deciding whether to grant an application for change of ownership. Indeed, the statute sets forth the material terms of a change of ownership application. Continuation of services is not a material term as set forth by this statute.

Second, guidance was sought from your staff, which is commonly done, before you considered the application. The staff was told that closing Westlake was under consideration, and, in accordance with the clear directive of the statute that continuance of operations could not be considered and is not a material term of the application, the staff's guidance was that Pipeline's consideration of closing Westlake need not be raised at the October 30th, 2018, hearing.

So the entire lawsuit rests on a faulty premise, a premise that you know is simply untrue. You were not defrauded in any way. It would be the height of injustice to defer consideration of Pipeline's application because of the pendency of litigation that is unrelated to this application and so clearly baseless.

To put this in perspective, here are the facts regarding the change of ownership application: As Nick Orzano will tell you, the Applicants, both Pipeline and Tenet, fully expected Pipeline to operate Westlake Hospital indefinitely into the future when the change of ownership exemption applications were submitted on September 6th, 2018.

In the third week of September 2018, Pipeline received from Tenet financial information that showed a dramatic and unexpected downturn in financial performance at the three Chicago hospitals, especially at Westlake.

After consideration of this new data and internal deliberations, the Pipeline team began to doubt whether Westlake could be viable. And it was simply not a matter of, as you heard this

morning, whether Westlake provided services that were meaningful and proper. They do. It was whether it was viable at the dramatically reduced utilization rate that the hospital has experienced.

It was then that Pipeline reached out to the Board staff for guidance, in full transparency, and was told that there was no need to discuss potential future plans to close Westlake.

In the months following the Board's approval of the change of ownership application for Westlake Hospital, Board staff were consulted for guidance at several points along the way, as it became clearer that an application to discontinue Westlake Hospital was almost certain to be filed by Pipeline shortly after the transaction closed.

At each of those turns, the Applicant was advised by Board staff that affirmative disclosure of these plans to the Board was not necessary prior to the filing of the discontinuation application itself. And at one point, indeed, we sought advice from staff concerning a contemplated

action, and staff advised that would require an amendment of the application, so Pipeline decided not to do it. There was no fraud.

I will not belabor the other inaccuracies in the lawsuit, but they are many, and they were repeated before you this morning, some of them.

The complaint -- some of the highlights: The complaint repeatedly claims and the Court was told orally that Westlake is a safety net hospital. Of course, it is not.

The complaint repeatedly claims and the Court was told orally that Westlake has an inpatient substance abuse program. Of course, it does not. You heard this morning about opioid treatment. Beyond emergency room treatment, that treatment is available only if the addiction is a secondary diagnosis to psychiatric issues.

Westlake does not have a certified substance abuse treatment program. And no matter how many times it is repeated that it does and that doing away with it would harm the community doesn't make it true.

The complaint repeatedly claims and the Court was told orally that no other hospital in

the area serves uninsured persons who are without the ability to pay, and, of course, you know that's not true.

These are but a few of the highlights -- or lowlights -- in the complaint. There are many more.

One thing you did hear from the general counsel that is absolutely accurate is the Courts expect the Board to act today. They said -- the TRO was extended to May 1st, anticipating, as the general counsel just said, that the Court -- that this Board would act. Both Judge Reilly and Judge Jacobius expressed their expectation that the Board would act on the application on April 30th multiple times over the course of multiple hearings.

The Cook County State's Attorney's office recently intervened in the litigation and, in doing, so expressed its expectation that the Board would act on the application on April 30th. The Court and the State's Attorney understandably expect the Board to fulfill its statutory obligations under the Act.

We respectfully urge you to fulfill those

obligations to consider Pipeline's certificate of exemption application to discontinue Westlake Hospital today.

Thank you.

MS. MITCHELL: Are you still continuing with statements?

MS. MURPHY: We are. We're going down the line.

Thank you very much for hearing us today. My name is Anne Murphy, A-n-n-e M-u-r-p-h-y, and I am outside regulatory counsel to Pipeline and its affiliated entities in Illinois.

As you heard from Ron Safer, we are here today to respectfully request that the Board fulfill its legal obligation to consider Pipeline's certificate of exemption application to discontinue Westlake Hospital.

I'm going to present the statutory case for the Board hearing us today, some of which you already heard from Ron.

Then Nick Orzano, president of Pipeline Health, will explain why time is of the essence in approving the application from a financial perspective and will rebut the notion that there

may be a viable buyer for the hospital.

Finally, Roz Lennon, chief nursing officer at Westlake Hospital will share the increasingly intensive challenges she is experiencing in clinical and other operations, which only serves to underscore the patient safety mandate for allowing for an immediate and orderly wind-down of the hospital.

Taken together, we believe both the law and the facts require approval of our application today.

So turning first to the statutory obligation to act: The COE application for discontinuation, as Ron indicated, was filed on February 21 and was deemed complete by Board staff within days after its submission.

Section 8.5(a-5) of the Illinois Health Facilities Planning Act requires the Board to approve a COE discontinuation application when all the information required by the Board has been submitted. Specifically the Act requires that an exemption shall be issued upon a finding that the application is complete. This statutory mandate is clear, it is nondiscretionary, and cannot be

superseded by regulation.

Indeed, the statute's legislative history clearly demonstrates that this section of the Act was promulgated for the express purpose of streamlining the regulatory process of closing a health care facility.

Board staff has already deemed the COE application ready for approval. The report previously issued by Board staff specifically found that the Applicants have provided all the information required by the State Board. The report goes on to acknowledge that State law requires that an exemption shall be approved by the Board when all of the information required by the Board has been submitted. This condition plainly has been met. We urge the Board to follow the law and act now.

Moreover and as Ron addressed, we believe the litigation is irrelevant to the COE application and is baseless. We understand that the Board's rules suggest that the Board will defer consideration of an application when the application is the subject of litigation; however, any regulatory interpretation that allows the

recent litigation brought by the Village of Melrose Park to halt the Board's action on our COE application is clearly inconsistent with the law.

First and as has already been indicated, the statute requires the Board to act to approve our complete application, and this statute, to use Ron's phraseology, trumps any regulatory provision that is inconsistent with it.

Second, even if the rule applied, the COE application for discontinuation is not the subject of litigation, nor is the Board named as a party.

We also must point out that the litigation is meritless and is a blatant attempt to interfere with the regulatory process that is the subject of this Board's jurisdiction. The Village's lawsuit alleges violation of the Melrose Park Municipal Code, alleges misrepresentations relating to the purchase of the hospital, and alleges that the closure of the hospital constitutes a public nuisance. All of its claims are absolutely baseless, and none of its claims relate to the COE application in the first instance.

The Village's claim seeking a declaratory judgment is the only claim to even mention the Planning Act. That claim involves the change of ownership process, not the COE application.

If the Board delays action today, Westlake will be caught between a Board that refuses to fulfill statutory obligations and a court system that is awaiting the very action that the Board refuses to undertake, and it is not at all clear when that process would end. To hold the hospital hostage would be unfair, unreasonable, and contrary to law. To do so when the underlying litigation is based on a false narrative would subvert justice.

Due to low occupancy and continuing staff attrition, it is in the best interests of patient care to close the hospital. Neither the State nor private litigants should be permitted to force a private party to continue to operate a nonpublic hospital under circumstances that may lead to patient safety concerns.

We ask that the Board meet one of its core purposes, as laid out in Section 2 of the Planning Act, which is to assure that the reduction or

closure of services or facilities is performed in an orderly and timely manner and that these actions are considered in the best interests of the public.

Section 2 goes on to say that evidence-based assessments, projections, and decisions will be applied regarding capacity, quality, value, and equity in the delivery of health care services in Illinois, evidence-based assessments.

We respectfully urge you to fulfill your statutory obligation to consider today Pipeline's certificate of exemption application to discontinue Westlake Hospital based on the abundant evidence supporting this action that was provided in the application and deemed complete by staff.

Thank you for your time and attention.

MR. ORZANO: My name is Nicholas Orzano, N-i-c-h-o-l-a-s; Orzano, O-r-z-a-n-o.

Members of the Board, thank you for the opportunity to testify before you today. As stated, my name is Nick Orzano. I'm the principal and copresident of Pipeline Health.

For nearly two decades I've worked in finance in health care, most recently helping to turn around community hospitals, including ones that are either in bankruptcy or on the verge. We are very familiar with operating hospitals in disadvantaged communities. In Los Angeles approximately 65 percent of our patients are on Medicaid, and predominantly those hospitals serve Hispanic and African-American communities.

If you're looking for one reason today as to why the Board should hear the application, it's this: We're out of time.

Delay in decision will not provide better health care to the region, nor will it stop the powerful industry trends that have been set in motion and have hobbled Westlake Hospital for years.

Many have offered their opinions as to why Pipeline applied to close Westlake and when it made the decision to do so, but few have accurately portrayed those facts.

Here they are: When we submitted our application to the Board on September 6th, 2018, to transfer the three hospitals from Tenet to

Pipeline, we believed that we could turn around all three of those facilities.

After many months of diligence, we developed a plan that was going to eliminate the 10- to $12 million annual loss at Westlake. We submitted our application with what was our plan at the time. We can corroborate those exact details with a slew of emails and materials that we presented to our financial partners.

On September 24th, 2018, Tenet contacted us and informed us that the losses at that hospital had nearly doubled over a two-month period. After further review we began to doubt whether there was any path for Westlake to continue. Our initiatives, putting those in place, would no longer allow that facility to even come close to breaking even.

Over the next several months we negotiated with Tenet on how we could move forward, including options where Pipeline would not purchase Westlake Hospital. During this time we sought guidance on how we could proceed, and such guidance was provided and helped to provide the decision-making path that we took.

Although there are several factors around those financial losses, the biggest one was acceleration in the loss of patient volume, lower ER traffic, fewer inpatient admissions, and less surgeries. The year-over-year decline was dramatic. Many want to believe that these volumes will rebound and patients will return to Westlake, but as my colleagues on this panel will describe, the sheer magnitude of the losses and the severe overbedding in and around Westlake make that near impossible to overcome. To tell you that's possible is either naive or not true.

What has been lost in this conversation is that the community around Westlake has been voting with their feet for years. On average, Westlake is 70 percent empty on a daily basis, a trend that was in place well before we took over the facility. The numbers don't lie.

Local leaders have argued forcibly that there's another legitimate buyer who would want to own and operate the hospital. We've spoken to or attempted to speak to each of the buyers that have come forward. We've yet to see a buyer come up with the financial wherewithal to not only cover

the current operational shortfall but to also be acceptable to the mortgage holder of the property.

Additionally, a quick review of the recent ownership of the hospital demonstrates that holding out hope for a new buyer is futile and would only disappoint further. The prior owner of Westlake, Tenet, had been trying to sell Westlake, West Suburban, Weiss, and MacNeal for more than two years. MacNeal, the larger tertiary facility, was sold in January 2018 to Loyola, leaving the three remaining community hospitals.

If it took over two years for one of the largest hospital companies in the country to find a buyer for those hospitals, at a time when Westlake losses were only 10- to 12 million, it defies logic that there's a legitimate buyer interested in buying Westlake given its current annual loss of more than $25 million.

Not only that, but the equipment and facility upgrades are in the millions. Westlake has an electronic health records system that is no longer supported after December of 2019.

Although there have been letters of interest and intent from various companies,

there's a stark difference between showing interest and being able to successfully execute a transaction like this.

With Westlake operating on a nearly -- or more than $2-million-a-month deficit, the capital that was raised to transform Westlake is gone. Contrary to popular belief, Pipeline does not have an endless supply of cash, nor is raising additional capital an option. No investor will provide capital to a facility when it's abundantly clear it cannot be saved.

As Ron Safer and Anne Murphy noted, Pipeline was completely transparent during the entire acquisition process. We submitted the application for change of ownership with the facts that were present at the time, and we asked for and followed guidance from the Board as soon as those facts changed.

For this reason and the others I've outlined, we believe the Board should hear the application. We are out of time.

Again, thank you for the opportunity to underscore why the Board should hear our application today.

MS. LENNON: I'm Roslyn Lennon, R-o-s --

MS. AVERY: Pull the mic closer to your mouth.

MS. LENNON: Roslyn Lennon, R-o-s-l-y-n L-e-n-n-o-n.

To members of the Board, thank you for allowing me to testify today. My name is Roslyn Lennon, and I serve as the chief nursing officer for both West Suburban Hospital and Westlake.

I've been a nurse for over 35 years, and the conditions we're managing at Westlake are by far the most demanding that I've faced in my career. The clinical and operational challenges that I will detail here speak loudly and clearly as to why a timely hearing on Westlake's application for discontinuation is necessary.

I face each morning uncertain about the difficult decisions in the day ahead to ensure that we're providing safe, quality care for our patients, and I lay in bed at night worrying about what-ifs and worst-case scenarios.

To understand how we arrived at our current challenges, it's important to revisit the time line. Staffing shortages on off shifts and

in certain departments began in the weeks after the application for discontinuation was filed. House manager coverage was limited for the off shifts, as well, due to an FMLA. The hospital went on ambulance bypass due to insufficiently staffed intensive care beds for the number of patients they were caring for at the time.

These alarming developments were what ultimately led to Westlake's decision to instate a temporary suspension so that further attrition wouldn't inadvertently lead to an unsafe environment for patient care.

The staffing declines that began with the application for discontinuation continued upon the issuance of the WARN notices. Longtime staff began moving to other facilities or simply retired, and a number of departures go into effect this week and next.

As a result, Westlake now faces increased staffing shortages across nearly all critical units, including the intensive care, emergency department, the acute rehab unit, obstetrics, and behavioral health and even the department that literally keeps the lights on at Westlake.

To underscore the extent of the loss we're grappling with, I received notice last week that our quality analyst, one of our most trusted staffers, has accepted another position, leaving the hospital with lack of infection control monitoring, medical record extraction for specific patient conditions, and reporting of key quality data to regulatory agencies.

We are left to piece together a plan to cover all that she does, from reporting out on infections to abstracting the medical records for quality data that are reported to the regulatory agencies, and interfacing with doctors, directors, and staff.

Meanwhile, several building engineers and security staff have resigned, causing my colleagues who manage the hospital's facilities to assess how the hospital would be covered, necessitating extending hours and stretching shifts.

The losses are compounded by the recent court orders requiring reinstatement of certain medical services. The last-minute planning to cover absences has devolved to embarrassing simple

but critical questions: How many patients can our limited staff handle at any one moment? Where do we put the patients? Should they be in the ICU or on a floor? For example, the medical, surgical, and behavioral health departments have each consolidated their units. Beginning next week there's an insufficient number of rehabilitation nurses to care for those specialized patients.

To cover for shortages, the hospital does rely on agency staffing with nurses affiliated with outside agency covering shifts. The hospital currently has three six-week contracts with agency nurses in addition to using -- utilizing per diem agency nurses, as available, to cover absences. The behavioral health unit has also contracted for an agency social worker since that unit has only one of three positions filled.

There are inherent drawbacks with this staffing model, as outside agency nurses aren't immediately familiar with the hospital and its policies and procedures and, therefore, are not a viable long-term alternative.

Select staff from West Suburban are utilized to cover at Westlake; for example, in the

radiology department for imaging services. But if I were to provide more support from West Sub, this would create a domino effect, requiring us to employ agency staff at West Suburban to fill gaps and compromise the availability and timeliness of care to patients at West Suburban. Further, because we are holding approximately 60 positions open at West Suburban for Westlake employees, this is a limited approach for filling gaps in Melrose Park.

Of the existing staff, nurses in some departments are gaming the staffing system. They alternate from calling in sick one week and filling in the following week to cover shortages, allowing them to collect $10-an-hour bonuses and additional overtime pay. To give you a sense of the uptick of this practice, sick calls from nurses at Westlake doubled from 58 in February to 116 total in March.

We've utilized medical/surgical services to cover in the postanesthesia care unit and ICU, and nurses are being requested to change their established shifts for extended periods in order to better cover shifts with less coverage. In

surgery, staff have inconsistent volumes, with some days seeing 8 to 11 patients and other days with no patients.

These circumstances are bringing out the best and worst in Westlake's employees. Prior to issuing the temporary suspension, the emergency department director extended her day to over 24 hours to support her department because of a call-in where she would have had only one agency nurse for the night shift.

Meanwhile, staff discontent has allowed a culture of anything goes to bubble to the surface. The environment of uncertainty from the political controversy created by local officials has emboldened staff to act without fear of retribution.

For instance, I learned that a medical staff doctor recently called a secret all-staff meeting, urging employees to contact their congressional representatives about the application for discontinuation, begging the question who was taking care of the patients during this session.

Another physician has been rounding on

units telling nurses not to leave and not to let management know that he's talking to them because the hospital will stay open.

Distrust has grown so much that I now require unit directors to sign off on the daily operations report, certifying that they're staffing their units at a coverage level that ensures patient safety for that shift, and that's ultimately what this cost boils down to, assuring safe, quality care.

While you've just heard from my colleagues about the legal merits and financial constraints necessitating today's hearing, I implore that you put the patients above all else. The operational and clinical conditions that we are contending with at Westlake are, quite frankly, not sustainable. Please agree to consider the application today in the interests of putting patients and the staff caring for them first.

Thank you again for the opportunity to testify today, and I'm happy to answer questions.

CHAIRMAN MURPHY: Thank you.

MS. MITCHELL: The Applicant argued that the Board does not have authority to defer the

discontinuation exemption application -- can you hear me?

UNIDENTIFIED AUDIENCE MEMBERS: No.

MS. MITCHELL: That's not usually a problem. Can you hear me now?

UNIDENTIFIED AUDIENCE MEMBERS: Yes.

MS. MITCHELL: Okay.

The Applicant argued that the Board does not have authority to defer a discontinuation exemption application.

The statute -- pursuant to the statute, the Board cannot deny an exemption application if all the required information is submitted, but it does not limit the Board from deferring an application. It does not state that the Board cannot abide by its own rule and defer consideration of an exemption application when there is litigation. In fact, the statute is silent on that.

Furthermore, the statute provides that the State Board shall establish by regulation the procedure and requirements regarding issuance of exemptions. The Board has established a rule to allow for deferral of an application when there's

pending litigation.

CHAIRMAN MURPHY: Thank you.

I'm going to take questions from the Board members. But, first, there have been a lot of statements made today about discussions with and assurances from the Board staff, so I would like to hear from our Board staff about these discussions. And specifically I would like information about the legal advice that you sought about the rule.

MS. AVERY: The statement that was made regarding Board staff advising the Applicant not to address the disclosure is not accurate. And I have to say I was greatly disappointed when I learned that this is the way in which this information would be presented.

In October, yes, I was approached by Ms. Murphy; we had a discussion about the possibility of Pipeline closing Westlake Hospital. It was a possibility; it was not a fact.

Looking back, yes, I probably should have advised when Ms. Hemme asked a question that was not answered about the plans for Westlake Hospital. I should have probably said something

at that point, but, again, it was not a factual statement that this would occur.

We were contacted later on about the possible restructuring of the change of ownership plan -- well, let me go back.

I did say that, if this happens, it may be a compliance issue, I'm not sure. At that point I asked the general counsel, Jeannie Mitchell, for her input on it, and we said, "Look. We'll address that if we get to that point. It does not have anything to do with the change of ownership at this time in October."

There were further discussions that came about regarding a restructuring, which we advised that there will be a change of ownership and that will require a new application.

But I did not want to leave it that Board staff advised solely not to speak on the discontinuation. At that point, again, it was not factual information; it was a probability that it would occur due to incorrect numbers -- as you heard from the Applicants -- that were submitted by Tenet Hospital.

In addition --

MS. MITCHELL: I'm sorry. I thought you were done.

MS. AVERY: Sorry.

In addition to that, I would say that another issue is, when we had these discussions, we probably should have had it, again, with our reviewers. But, once again, it was not something that was factual at that point when we discussed it in October.

We did start providing assistance before the application was provided for the discontinuation in probably December on to January and then to the point that we received the application for this closure in February.

MS. MITCHELL: And there was advice sought from the Attorney General's office, as well --

MS. AVERY: Use your mic.

MS. MITCHELL: There -- we sought advice from the Attorney General's office as far as the application of the deferral language in our rules, and they agree with our characterization.

CHAIRMAN MURPHY: Are there questions from Board members?

Yes, Ms. Hamos.

MEMBER HAMOS: Yes. I would -- I guess I'd like to make a statement about what I'm hearing today. This is my very first hearing, so I'm learning on the job.

And, first, I'd like to thank the 33 -- by my count -- people from the community who came forward today to give us very thoughtful and compassionate and honest testimony about your feelings about this closure.

So as a brand-new Board member and also as a former legislator for 11 years -- and I mention that because I'm reading the statute as a legislature -- as a legislator -- I do believe that we have a statutory obligation in this case.

Now, when this law was changed in 2015, Public Act 99-0154 -- and this is a section of the Planning Act that has to do with exemptions, and it does say -- respectfully, I disagree with the general counsel.

It does say "An exemption shall be approved when information required by the Board by rule is submitted." It doesn't say "except" -- I mean, I've written a lot of legislation during my years. And it might have said "except as

provided in subsection B below," and subsection B might have said "except when there's litigation."

But there is no litigation exception in the law, and that's why the legislature -- which clearly intended to provide for this expedited or streamlined procedure for discontinuation of a category of service or discontinuation of a health care facility -- did intend the Board to approve it when the information is provided.

Now, again, the legislature did not see any litigation exception, and if they had in 2015 they might have said, "Well, wait a second. That sounds like a loophole. We'd better deal with that because anybody can bring litigation."

Now, that's my first point.

The second point -- so I think that we do have a statutory obligation.

My second point is I know the legislature did not see that language because this spring, right now, they are trying to repeal this part of the law, and that's in House Bill 123. So they're trying to take away those two circumstances by which exemptions would be provided in the future if it passes and is signed into law.

But this law, this bill, does say, "If there is a pending lawsuit on the closure of a health care facility for which an application for an exemption is under review, the Board shall suspend any pending action involving that application until the resolution of the lawsuit."

That would make it the law, but this doesn't have law. This is -- I would argue that, in fact, in 2015 when the legislature added those two circumstances, it superseded that section on pending litigation that was found in the administrative rules. And, really, at that time the Board or the Board staff might have said, "There's an inconsistency here."

So the third point I would make is that this litigation exception really makes no sense in the context of what the law was trying to do in 2015. So the two -- you know, the reasons were -- for this exemption -- were added to the law, and it didn't intend for the Board, then, to get all the information and cede our authority to the Courts.

I mean, we wouldn't even be allowed to look at -- it was no longer a permit process where

we would look at all the information in front of us, consider the need, get public input. We would simply say, "Oh, there's litigation. The Courts can handle it."

That doesn't make any sense on the face of it and what this section of the law was really trying to do. That -- really, it is a huge loophole, and it runs counter to what I'm -- the other point I'm going to make.

But I would tell you that I looked this up. There are 91,000 lawyers registered in Illinois, and I would suggest that anytime from now on that an exemption would be pursued by someone wishing to close a facility, there would always be a litigant and one lawyer who would bring litigation, so this would completely subvert the whole intent of this law.

And the fourth -- the 2015 law.

And the fourth point I want to make is that this also creates a precedent that really runs counter to all the trends in the nation and in our state to help transform the health care industry and the health care service delivery system.

The Illinois legislature and the administration are following national trends, that hospitals do need to transform, and there will be a lot of exactly this kind of activity in, I would suggest, the next 5 to 10 years. It's not two years away, as one of those witnesses suggested. It's here right now.

And that's why last year the Illinois legislature and Governor set aside a $263 million fund called the Hospital Transformation Fund, because there is a general understanding that, because of medical advancements and technology, they are resulting in declining inpatient utilization rates and, therefore, the need for beds. And that's why Westlake today stands 70 percent empty. 31 percent occupancy is what I saw in the application.

That's a national trend and, because of that, there's more focus on hospitals transforming and providing those kind of services as outpatient services.

The transformation -- no transformation will be easy for any community, and I think what we heard today, very heartfelt and honest

responses, we will hear over and over every single time a hospital wishes to transform. That's going to be from well-meaning mayors and legislators and unions and employees and doctors and everybody else up and down the line.

But this Board should really embrace that trend and understand that we are really on the cusp of a very significant change in our health care system. And instead of ceding authority to the Courts to say "Let them decide," we should not -- we should really embrace this, and that is not the -- our role -- and that is not the position we should take today.

So that precedent really will be huge because the word will go out that anytime there is an exemption application filed and a community is distressed about a closure, all they have to do is get one litigant and one attorney and this Board is willing to wash our hands and let somebody else deal with it.

So I would argue against this motion to delay.

CHAIRMAN MURPHY: Thank you.

Are there any other questions or

statements from Board members?

Dr. Goyal -- let's work our way down the line.

MEMBER GOYAL: Thank you, Madam Chair.

My name is Arvind Goyal. I represent Medicaid on this Board. And you are safe because I don't have a vote, but I have some questions, if I may.

One, could you indicate, based on your investigation or your data, what percentage of your population is currently Medicaid and what percentage is uninsured?

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

MR. ORZANO: I don't want to misspeak. I don't have those numbers off the top of my head.

MEMBER GOYAL: I think that adds to a reason for deferral, but I would not influence the Board's work on this.

Let me also make two comments, if I may: One is I find it unbusinesslike to not have a full financial picture before somebody starts buying something.

(Applause.)

MEMBER GOYAL: If you got the information

three weeks after you owned the facility and you did not look into what the financial picture was, I do not know if it's a buyer's remorse or if it is --

UNIDENTIFIED AUDIENCE MEMBERS: Yes, yes.

MEMBER GOYAL: -- really something you should have known at the time you bought it.

(Applause.)

MEMBER GOYAL: And let me make one other comment and then I'm done.

And that is, if -- it appears to me that the debate here is between profit or loss versus service.

I want to be sure that this Board takes into account the fact that there are questions based on issues raised by the community members and representatives, et cetera, today that we do need to look into the service method, regardless of what the Courts decide.

And my final line is I'm also aware, because of what I do in my daily life as medical director of Medicaid, that Pipeline has three hospitals in the area at this time and you want to close one of the three.

I just would like for you to know that the hospital ownership, hospital management -- hospital service, most importantly -- is based on trust. How would you do it at the other two hospitals is certainly in your court.

Thank you.

MR. SAFER: So, Doctor, I appreciate your question and comments.

With regard to the knowing -- the due diligence, obviously, there was much due diligence done before this transaction was entered into, and we had real insight into what was given to us for the first half of the year.

But as you have seen, what could not have been given to us until it happened was the fact that those losses significantly accelerated in the second half of the year, and that's not -- you know, as you know better than -- than anybody sitting on this side of the table, certainly, that the revenues are affected by people, that all that reflects is a dramatically declined census, a dramatically declined demand for those services.

And it is because of that and because of a desire to serve this population, to serve it with

viable entities, with outpatient investments, just as a Board -- as the prior Board member said, that Pipeline is motivated to do this.

And it is serving the community. They want to serve in the community. They have invested. They did due diligence. But you cannot anticipate the rapid decline in the financial picture. That is what led, for the first time, the owners to think -- the expected new owners -- to think, "Is this viable?" and they raised that question.

MEMBER GOYAL: Thank you.

CHAIRMAN MURPHY: Before we go on, can I just make a statement?

I understand all of the passion surrounding this issue, but I would ask that audience members please refrain from reacting to any of the comments made here in the interest of a timely proceeding.

Thank you.

MS. MURPHY: There are two disparate points that I would like to make with the Board's indulgence.

One, I believe that the application itself

included Medicaid information and uncompensated care, charity care information, and I believe, in fact, with respect to the Medicaid statistics, we submitted a supplemental set of information because the original calculations had been incorrect.

So I believe in the application materials themselves there are those statistics, although I don't remember them precisely off the top of my head. Certainly, that supplemental piece should be readily accessible.

The second point I want to make goes back to the question of what was discussed on October 30th. And I do want to --

CHAIRMAN MURPHY: Could you speak into the mic?

MS. MURPHY: Oh, yes. Sorry.

I do want to clarify for the record that the disclosure to Courtney was one of a possible closure. It was not a definitive closure decision. And so the advice that I believe I received was that the possibility of closure need not be communicated to the Board during the public session.

And so to the extent that there was any mischaracterization of that, I do want to clarify that.

I will say, however, that I do not believe that I was informed that it would be a potential compliance action. That may have been a discussion with counsel, but I do not believe that I heard that on October 30th.

So I wanted to -- I wanted to clarify those two points.

CHAIRMAN MURPHY: Thank you.

Mr. Gelder, do you have comments?

MEMBER GELDER: Okay. Yes. Thank you very much.

I realize I'm coming into a movie here in the -- in the middle. This is my first Board meeting, too, as Member Hamos had described previously.

UNIDENTIFIED AUDIENCE MEMBERS: We can't hear you.

UNIDENTIFIED AUDIENCE MEMBER: Speak up.

MS. AVERY: Directly into the mic.

MEMBER GELDER: Okay.

MS. MITCHELL: Directly into the mic.

MEMBER GELDER: Okay. Directly into the mic. Sorry.

All right. I was just saying how new I am to this and the feeling as if I've come into a movie without fully understanding all the plot and the character development that may have happened over the last several months. But that is the nature of boards and, with the new Governor and new appointees, there are some new members.

I was moved by Member Hamos' reference to health system transformation since my former position was, indeed, director of the Governor's Office of Health System Transformation for Illinois, and that is the milieux, that is the environment, that's the context within which I think we have to look at everything that we are asked to do on this Board, at least it's the context that I will be using.

I think all the good doctors that we heard from today as well as the nurses and the medical staff personnel are aware better than any of us about how medical practice has changed. The person who was coming in for a heart attack isn't going to stay for a month, stay perhaps for a

few hours for the cardiac catheterization, be transferred to a telemetry unit, and will be out.

That's the way it should be, but that's not the way it was when Westlake and dozens of other Chicago-area hospitals around the country -- that wasn't how medical practice occurred when those hospitals were built.

And so I'm not -- I'm not, by my vote here, saying I believe one side or another. I've spent most of my career working with community organizations and social service agencies and community health centers to make sure health care's accessible in their communities.

But what communities need more than anything is access to high-quality primary care and access to emergency care within specified time frames. And we do need hospitals, and they are going to be with us forever, hopefully, because that is the best place for certain types of care, but it's no longer the place for many types of care that was common even 10 or 15 years ago.

And so I would -- I see my role as very important in this context, as well, to support the

rule of law and not to be swayed by emotions and sincere beliefs that are brought before us.

That is great; that is your right; that's our obligation to hear. But then we have to decide, make our votes based on what we think the law says and not on what's convenient or helpful to try to kind of, perhaps, kick a can down a road.

So I appreciate everybody's comments today, and I will be voting on these motions accordingly.

CHAIRMAN MURPHY: Thank you.

MEMBER HAMOS: Marianne, may I speak?

MS. AVERY: Going down -- two more people.

CHAIRMAN MURPHY: Mr. McGlasson and then Ms. Hemme.

MEMBER MC GLASSON: First, let me say that I am not an attorney and I don't understand the -- don't know the process of temporary restraining orders. But I do have what I think is an important question.

You mentioned that the temporary restraining order was granted through tomorrow. My question is, when the request was made for the

restraining order, did they request that it go through tomorrow, or did the people that granted the request indicate tomorrow on their own volition?

MR. SAFER: You know, I don't recall exactly the answer to that, but I will tell you that the Court was made aware of the fact that the Board would be considering the application on April 30th, and the Court, therefore, granted a TRO to allow the Board -- said "Maintain the status quo" -- maintain what was going on at the hospital -- "until the Board can consider and vote on April 30th."

MEMBER MC GLASSON: Thank you.

MR. SAFER: Thank you.

CHAIRMAN MURPHY: Ms. Hemme.

MEMBER HEMME: I don't know where to start.

THE COURT REPORTER: Pull your mic close, please.

MEMBER HEMME: Sorry.

When this came before the Board in October, several criterion were presented by you as being met. I have that transcript -- or your

application -- in front of me.

You said, under Criterion 1130.520(b)(3), charity care policies, that your charity care policy will remain in place for no less than two years following the consummation of the transaction.

UNIDENTIFIED AUDIENCE MEMBERS: That's right. That's right.

UNIDENTIFIED AUDIENCE MEMBERS: Yes.

MEMBER HEMME: Second of all, when we voted on this, you stated, Criterion 1130.520(b)(4), benefits to the community, "Following the transaction Westlake will continue to operate for the benefit of the residents of Chicago and the greater Chicago area, including serving poor and underserved individuals through Westlake's charitable activities."

Under Criterion 1130.520(b)(9), scope of service changes or charity care changes, "The transaction set forth in this COE will result in no changes to the scope of services offered at Westlake. Following the transaction, SRC will be implementing a charity care policy at Westlake. The SRC charity care will not be more restrictive

than the current charity care policy at Westlake and will remain in effect for at least two years after the transaction."

That's your application. That's your words.

UNIDENTIFIED AUDIENCE MEMBERS: Yes.

MEMBER HEMME: And when we voted as a Board, you told us you were meeting all of that criterion, which is why we approved the sale.

Now you come before the Board, less than six months later, and say, "We want to close this hospital." I'm having a problem with that because your own words said "we will not" upon this sale.

Second of all, I'm an accountant. I can't believe that you didn't do due diligence in a merger and acquisition.

(Applause.)

MEMBER HEMME: Even if it's within the past six months, there's always a final review before the papers are signed, and I know this because I've participated in acquisitions before.

So you're sitting there telling me that you were unaware, but you still have a final check before you signed on that dotted line --

UNIDENTIFIED AUDIENCE MEMBERS: Yes.

MEMBER HEMME: -- and I feel that the Courts need to review that particular thing.

The third thing, I've heard from our two new members the latest buzzword, which seems to be "health services transformation." That seems to be on your mind, as well. If we have an underserved area, why not produce health services transformation, keep Westlake open, and, instead, try to provide the services that they do need?

I do know exactly where Westlake is. I drove past it maybe two weeks ago. There is unlimited -- there is not unlimited bus service there. They're not in Chicago. They're on North Avenue.

And if you would just take the time to drive down North Avenue -- just drive down it almost anytime except at midnight -- you will find that it's at least a 15-minute ride to Gottlieb Hospital. It is not within walking distance. There is not public transportation.

So why not, instead, let this go through the court system, let us defer this vote until it gets through the court system, and then, instead,

keep your word and do something called health services transformation? Keep the building open and provide what the community needs. It may be beneficial to you as a corporation.

The last thing is I did notice that your corporation says "We turn around hospitals in trouble." I read that further back in the application.

So are you a company that will turn around this particular location to provide good, solid health care services for this area?

MR. SAFER: So thank you -- thank you.

With regard to the --

(Applause.)

MR. SAFER: -- the court -- the first thing I would say, with regard to "Let's let the court system sort this out" -- and I understand the appeal of that -- the problem is it's not going to work that way.

The court system takes years to work through. The money for this hospital will run out in weeks, months, not -- you know, days, not years.

So if you are going to say "Go through the

courts," the hospital will eventually -- sooner rather than later -- run out of money, and there will not be an orderly process that will follow. It will be a disorderly process.

With regard to the statements made, there -- as the statute requires, you know, you have to pledge to maintain the charity care. That pledge was 100 percent accurate when made. It was absolutely carried out.

What was not anticipated -- what was anticipated at the time was that the hospital would be open indefinitely. That was not a pledge to keep the hospital open for two years. Indeed, as you know, the statute forbids that, a continuation-of-service pledge in consideration of a change of ownership, and that certainly, in that application, was not such a pledge.

It was a pledge for -- that we believe that this hospital is going to stay open and, if it does, for two years we will not change the charitable care. That's what was intended. If it was inartfully said, then that is our fault, not yours, but that was what that section says.

With regard to why not -- you know, why

serve the community? I mean, here -- here is the reality: Are we prepared to turn around these hospitals? As many as we possibly can, but there is a finite amount of money.

And so the decision was made that Westlake's -- because of the utilization, not because of a desire not to serve the community but because of a desire to serve the community -- that what we would do is invest in outpatient centers -- right there, right in that same location -- invest in capital, invest in treatment, invest in the services, the equipment, the technology but not invest in a building that was -- that is grossly underutilized by the -- this very community but, rather, give them the patient care that they so richly deserve and turn around the other two hospitals in that underserved area.

That is exactly what we're trying to do, and that is exactly what -- why Pipeline has come in and invested in the community in real -- with real money, but that real money is not unlimited, and Westlake's money is running out quickly.

MR. ORZANO: I'll just add to what Ron

said.

We did diligence. We're acting as if this is a static situation and things don't change. As a physician on the end, I'm sure you can appreciate the fact that on one day you may take vitals from a patient, he may be doing fine, and two weeks later things could change.

And when we made those pledges, we did think the hospital was doing fine. All of our diligence pointed to the fact the hospital was doing fine.

We're sitting here on April 30th, with the benefit of hindsight, knowing that it did, in fact, not do fine since then. That was not under our ownership. It was prior to us. We're trying to do what's best with what's available to us.

Facts change. We're trying to make decisions as those facts change. And if Westlake was operating the way it was on June 30th and the 12 months prior to that, it was only losing 10- to $12 million, we would absolutely think we could turn it around and keep it open. It's not. It's losing $25 million now.

Those facts change. It's not a savable

facility. It just isn't. I wish it was. There's no benefit to us of shutting down this hospital other than saving -- saving money for the other facilities.

UNIDENTIFIED AUDIENCE MEMBER: Really, they knew that.

UNIDENTIFIED AUDIENCE MEMBER: Do the transformation for --

MS. MITCHELL: If we can please limit the outbursts.

MR. ORZANO: The only other thing I'll add that Ron mentioned is we did put in our proposal that we did want to spend money on outpatient services in that community, so we did want to transform services. We put that in our statements of what we were going to do.

MS. MURPHY: At the risk of underscoring it one more time, it was precisely during the due diligence process that the abrupt decline in the financial performance of Westlake was discovered.

So that due diligence process was ongoing. And when that was discovered, there was an intensive effort to address that, to find out more information from Tenet, and to figure out what the

path forward was from there.

CHAIRMAN MURPHY: Thank you.

Are there any other questions -- yes.

MEMBER HAMOS: So we've made some statements about health care transformation. Mr. Gelder and I, I think, both look at issues like this from that lens.

I guess we had -- in the ideal world, I think that the new owners would be talking to the Mayor and to the community members to figure out what other health care needs there are in that community to really do health care transformation.

You've made a commitment, as I read it, to provide outpatient services and to make an additional investment in the very excellent FQHC on-site, and you're going to keep an office building to have outpatient services.

But maybe there's utilization for the building -- not a hospital -- that is not health care transformation to keep a hospital -- but it's inpatient acute beds that are really going down in their utilization. That's really where the need is only 30 percent, and that's not, you know, sustainable for anybody.

So in the ideal world, you, Mr. Orzano, would make a commitment to work with the City to really do health care transformation. Maybe substance use disorder treatment, to become a certified treatment center is an important use for that community. So there are other uses for buildings. Would you commit to really working on that?

Unfortunately, I feel like this is going to go downhill from here. You're going to be languishing and losing precious resources, health care resources, in the courts instead of working on a problem-solving -- in a problem-solving way to really get to understand the real needs of that community.

MR. ORZANO: To answer your question, yes. I mean, we will -- we are absolutely committed to trying to find an appropriate operator for that facility.

We -- as I'm sure the accountant can appreciate, we --

MS. AVERY: Bring the mic a little closer.

MR. ORZANO: I'm sorry.

As I'm sure the accountant can appreciate,

we don't -- we have a lender on that property, and so that lender needs to be satisfied. But as soon as it is -- I mean, we have -- we will absolutely try to sell that to somebody that can operate that facility.

CHAIRMAN MURPHY: Are there any other -- are there any other questions?

MEMBER GELDER: Yes.

CHAIRMAN MURPHY: Yes.

MEMBER GELDER: I would maybe approach that -- just underscore it -- probably not a different approach at all but -- one of the problems that I see so clearly just from the first three or four hours I've put in on this Board is that this becomes an adversarial process.

I mean, it's very common because of our jurisprudence system; it's not something we're surprised about as Americans. But health care should be a cooperative venture. Health care is not something about which there's two sides, a pro and a con, a for or against, a buy or sell.

It's a process of helping communities achieve -- and individuals in those communities and families within those communities -- achieve

their highest level of health and functioning so they can be -- they can participate in society. And you -- it's -- really, it's unbelievable that we sit here adversarially trying to approach this.

So, you know, underscoring what Julie Hamos just said, I think the best that this -- the best outcome that we can reach, I think, is for the community and the owners, the current owners of the hospital, to figure out what are the best uses of that campus and how can health care be improved in that community and then set about applying the resources that were going to be devoted to the -- operating a defunct, antiquated facility -- and I'm sorry; I can't strike that but I don't mean those words as hurtful to any of the people who work there or people getting their care there, people that have been born there and had their kids there -- but many hospitals are no longer needed, and beds in those hospitals are no longer needed.

So if we could work towards a collaborative effort to improve health care and looking at what role that campus might play if -- it could be the outcome I would love to see from

all of this effort.

CHAIRMAN MURPHY: Yes, Dr. Goyal.

MEMBER GOYAL: Thank you, Madam Chair.

I just wanted to respond to your comment about vital signs.

I don't think there is an excuse in the health care system for not doing initial assessment on any sick patient. And then if the vital signs change because you did not do your due diligence right at the beginning, when the patient was first evaluated, I think it's a problem, and that's exactly what I was saying.

CHAIRMAN MURPHY: Are there any other questions or comments from Board members?

Dr. McNeil.

MEMBER MC NEIL: The only comment I will make: We're dealing with a business decision versus a human decision, something that has lasted a long time.

From Pipeline's standpoint, you bought -- you found out you were losing over $2 million a month. No matter what we say otherwise, that cannot continue, even if it's a million and a half a month or, even in the statements, a million a

month. So from a transition standpoint -- we're not talking about a transition. We're talking about a turnaround.

Now, you take that and what we've been presented with from all the 30-some people this morning -- they have a need. And what we see constantly is that gap between the business and the outflow of cash that becomes an emergency -- the checkbook will be empty -- versus the human need and those two sides getting together -- and it's been brought up -- on how we can resolve some issues to offer good health care the best we can and to provide those services.

You can't continue forever. You're a privately owned company. In El Segundo, California, where you're headquartered, you've bought a lot of these hospitals, so you've had a huge outlay of cash, not only this 70 million but Dallas and other places. I've read about it.

So from a business standpoint, there's an issue the community faces no matter what happens. No matter what happens, that's a business decision in the sense of the loss. And then there's a human side of how we can sort of bring that

together.

So those are the issues that I see. And as a Board, we have decisions to make according to our rules and the way we have to do things.

CHAIRMAN MURPHY: Thank you.

Are there any other comments or questions?

(No response.)

CHAIRMAN MURPHY: There is a motion to defer Application -- Project E-004-19.

Barring any other comments or discussions, George, can you please call the roll vote?

MR. ROATE: Thank you, Madam Chair.

Motion made by Dr. McNeil; seconded by Ms. Hemme.

Senator Demuzio.

MEMBER DEMUZIO: Yes. I vote yes to defer the issue on the table.

And just in passing, I'd like to make a quick comment. I hope you do try to bring the community and your company together at some point. I think it would be advantageous.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: No.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: No.

For all the reasons I've stated, I do not feel this is within the statute for us to be able to do this.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, I vote for deferral.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: No. I vote no based on the testimony here.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: I vote yes based on the testimony, transcripts, and the need to work out some issues.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: I vote yes for deferral based on the interpretation provided by the Board's general counsel.

MR. ROATE: Thank you.

That's 4 votes in the affirmative, 3 votes in the negative.

CHAIRMAN MURPHY: The motion to defer fails.

We will be taking up the application, the exemption application, at that part in the agenda.

So now we are --

MS. AVERY: Questions?

MS. MURPHY: At the risk of asking a stupid question, I -- I actually thought the motion passed.

MEMBER HAMOS: It takes 5 votes.

MS. MITCHELL: It takes 5 votes.

MS. AVERY: It takes 5 votes.

MEMBER HAMOS: It's not a plurality.

MS. MURPHY: That's right.

CHAIRMAN MURPHY: We're going to break for lunch.

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

CHAIRMAN MURPHY: What do you mean, "What happened?"

MS. AVERY: Let's explain it, Jeannie.

MS. MITCHELL: Okay. So it takes --

THE COURT REPORTER: Hold on. Hold on.

MS. MITCHELL: It takes 5 votes -- it takes 5 affirmative votes for any motion to pass. The vote was 4 to defer and 3 not to defer, so the motion did not pass.

So the Board will consider the discontinuation application where it is stated in the agenda.

MS. MURPHY: Thank you very much.

CHAIRMAN MURPHY: And now we're going to break for lunch. We will be back in -- at 1:15, 30 minutes.

(A recess was taken from 12:45 p.m. to 1:34 p.m.)

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CHAIRMAN MURPHY: Good afternoon.

We are going to continue on the agenda with public participation, which is No. 8.

Please keep in mind we still have a lot of folks that want to comment about various applications, about 60. So at two minutes apiece, you can see where that would take us until forever. I hope you brought your sleeping bags.

MS. MITCHELL: Please --

CHAIRMAN MURPHY: Please keep your comments to two minutes or less. I will not be as polite as I was this morning. You will be asked to halt at two minutes.

So we are going to start now with public participation, and Jeannie is going to call folks up.

MS. MITCHELL: All right. First group, remember to state and spell your name at the beginning of your remarks for the court reporter. And if you have handwritten -- not handwritten -- if you have written comments, rather, please leave them at the table.

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

MS. MITCHELL: For Project 19-003,

Dr. Samuel Ohlander.

Is he here?

For Project 18-047, Anshu Chawa -- Chawla -- Drew Bell, Vince Brandys, Johnny Estrada.

MS. AVERY: Go ahead.

DR. OHLANDER: My name is Dr. Samuel Ohlander, O-h- --

MS. AVERY: Mic to the mouth.

DR. OHLANDER: -- -l-a-n-d-e-r.

I'm a urologist, fellowship-trained in male infertility. I'm here today to ask you to support the proposed River North Center for Reproductive Health, Project 19-3, which is a proposal for a specialized surgery center which will focus exclusively on treating male and female infertility.

Last week was Infertility Awareness Week. Across social media they were all sorts of posts emphasizing how common infertility truly is. It can be emotionally and physically draining on the couples that we treat.

Traditionally infertility was thought to be due to female factors alone, but now it is better understood that infertility is not just a

female problem and a male factor is solely responsible in about 20 percent of the infertile couples and contributory in another 30 to 40 percent.

Male factor infertility is not just a diagnosis but something that oftentimes may be treated to improve chances of natural conception or improve the success of assisted reproductive techniques.

Years ago the only surgical intervention for male infertility was microsurgical reanastomosis of the vas deferens, more commonly known as a vasectomy reversal. At that time men with severe dysfunction in sperm production were unable to father their own biological children. Now, with our surgical and technological advancements in reproductive medicine, this doesn't have to be the case. Microsurgical sperm extraction coupled with in vitro fertilization makes conceiving a child possible.

Furthermore, we have the opportunity to harvest and utilize testicular tissue as a viable means of preserving fertility in men undergoing chemotherapy or radiation in other complicated

cases. Research is moving toward similar strategies in prepubescent children in hopes of preserving the fertility of boys with childhood cancer.

I have been working with the Fertility Centers of Illinois physicians for sometime now, but we have not had the opportunity to share the same surgical treatment space until this project was conceived.

Currently my procedures are done at an IDPH-licensed site where the patient is under general anesthetic and harvested tissue is then transported to the FCI embryology lab for processing and cryopreservation.

With this new center infertile couples will now have access to the state-of-the-art treatment of both male and female fertility problems in the same center.

MR. ROATE: Two minutes.

DR. OHLANDER: Communication will be immediate between the embryologists and myself.

Please approve this River North Center for Reproductive Health. Thank you.

CHAIRMAN MURPHY: Thank you.

Go ahead.

MR. BELL: Drew Bell, B-e-l-l.

MS. MITCHELL: Bring the mic closer to you.

MR. BELL: Drew Bell, B-e-l-l.

My name's Drew Bell. I'm vice president for operations for the Chicagoland region for Surgical Care Affiliates.

I'd like to thank the Review Board members for the opportunity to share a few comments regarding my and others' opposition to Project 18-047, the Ophthalmology Surgery Center of Illinois in Itasca.

This application is constructed with the intent to pull all of Dr. Kevin Kovach's surgical volume from six identified area facilities that he currently operates in, and he is the lead surgeon at the Kovach Eye Institute practice listed on the application.

Three of those six facilities are ASTCs, and across those three sites he already performs 90 percent of his total surgical case volume, and those three facilities are all listed as losing 100 percent of that case volume to this proposed ASTC.

And two of those ASCs, Midwest Center for Day Surgery and Naperville Surgery Center, are facilities that we are partnered with and operate. And, additionally, Dr. Kovach is a board member and partner at Midwest Center for Day Surgery in Downers Grove, where more than 50 percent of his cases are currently performed.

As you can imagine, approval of this project would lead to a substantially adverse impact on those ASTCs, creating very difficult dynamics around staff reductions, reduced accessibility for patients, and decreased capability for us to continue to invest in the centers.

Both of the ASTCs we operate have substantial amounts of capacity for additional cases should their practice grow, and we see no need for this project or justification for it. It would simply be a redundancy of services and materially adverse impact on all of these ASTCs in the market, so I would encourage the Review Board to deny this project.

Thank you very much.

MS. GARDINER: Dr. Chawla had to leave.

Can I read his statement for him? Is that --

MS. MITCHELL: No. Sorry. Our rules don't allow anyone to read somebody else's statement.

MS. AVERY: Do you have statements of your own?

MS. GARDINER: I'm sorry?

MS. AVERY: Do you have statements of your own?

MS. GARDINER: I do. Can I read his instead of mine?

MS. AVERY: You read yours. You're going to have to read yours.

The rules don't allow for that. You're going to have to read yours.

MEMBER HAMOS: You can call it yours.

MEMBER GELDER: Yeah. Read his and call it yours.

MS. AVERY: Yeah.

MS. GARDINER: Okay.

MEMBER HAMOS: If you agree with it.

MS. GARDINER: Yeah.

MS. AVERY: Okay.

MEMBER HAMOS: Okay. That's okay.

MS. GARDINER: Gardiner, G-a-r-d-i-n-e-r.

Hello. I'm Deborah Gardiner, director of operations at Surgical Care Affiliates, and a facility in my region is Midwest Center for Day Surgery in Downers Grove. I would like to express my opposition to the proposed Project No. 18-047.

Contrary to assertion in the application for permit, the proposed surgery center will have a devastating economic impact on Midwest Center for Day Surgery.

Dr. Kevin Kovach from the Kovach Eye Institute has been on our surgery center's medical staff since 2009. For the last 10 years, Midwest Center for Day Surgery has enthusiastically supported and invested in all of Dr. Kovach's new ventures and surgical procedures. When he expanded his scope of practice in February 2016 by bringing on a retinal specialist, the surgery center invested $125,000 in specialized equipment required for these procedures. The center has purchased three microscopes at his request within the past two years totaling over $120,000. All of these and other capital equipment expenditures directly contributed to the growing and broadening

scope of Dr. Kovach's ophthalmology practice.

Our satisfaction results validate that Dr. Kovach's patients are extremely satisfied with their experience at Midwest Center for Day Surgery, especially with our talented and specialized ophthalmology nursing staff. Nearly all patients return to our surgery center.

As a result of our unflagging support of his practice, the Kovach Eye Institute surgical case volume at Midwest Center for Day Surgery during the last five years has grown to represent 34 percent of our total case volume.

Withdrawing this volume will create a huge void in the utilization of the surgery center, which will be difficult to replace as our service area is already saturated with ASTCs. An additional consequence of the loss of this volume would be the need to reduce staff hours and lay off FTEs.

MR. ROATE: Two minutes.

MS. GARDINER: The Midwest Center for Day Surgery has substantial capacity to accommodate --

CHAIRMAN MURPHY: Ma'am -- ma'am --

MS. GARDINER: -- additional growth --

CHAIRMAN MURPHY: -- ma'am, could you please conclude your remarks?

MS. GARDINER: Absolutely.

The application states they are opening a new center to accommodate Medicaid patients. Are they --

CHAIRMAN MURPHY: Ma'am, could you please conclude your remarks?

MS. GARDINER: I respectfully request you deny the project.

CHAIRMAN MURPHY: Thank you.

THE COURT REPORTER: Leave your remarks if you would, please.

DR. BRANDYS: Good afternoon. I'm Dr. Vincent Brandys, B-r-a-n-d-y-s. I'm a senior director of government and internal affairs at the Illinois College of Optometry and staff director at the Illinois Eye Institute, the clinical division.

Dr. Toseef Hasan from Addison and Glen Ellyn was here earlier, but he could not stay as he had to get back in the clinic. These remarks are mine, but I wanted to let the Board know that there was another optometrist here in

support of this project.

I support 18-047 because of access to care limitations. The Eye Institute is the largest Medicaid eye practice in the state. We have cataract patients who are waiting more than a reasonable amount of time to get surgery.

I think the level of care that Dr. Kovach has given all these years has been impressive, and for us to continue to provide that care, the site in Itasca would be paramount for us to have our patients not wait.

For those of you who may not know what a cataract is, it's a cloudiness of your lens. Whether you're the CEO or the janitor of a corporation, you need to be able to see to do your job. And having to wait to have a cataract done -- and specifically with the managed care organizations having 70 different plans, in order to accept all those, surgeons have to go through considerable hoops.

I think Dr. Kovach has shown over the years his support of optometry and ophthalmology working together, providing very quick turnaround of patients who have cataracts to

get back to their normal daily activities.

I support 18-047 and ask that the Board does, as well.

MR. ESTRADA: Thank you. My name is Johnny Estrada, and I'm here to oppose 18-047, Center for -- Ophthalmology Surgery Center.

As of 2019 Dr. Kovach and his group have already pulled their cases and have stopped performing cases at Naperville Surgery Center. As a result, Naperville Surgery Center is already facing financial downfall as a result of his removing all of his cases that were budgeted based on his group.

If this continues, we will have a shortfall of over 300 cases for the year, over 2,000 hours of OR utilization time that will not be utilized, and a net revenue shortfall of over $300,000.

In addition, teammates of Naperville Surgery Center are no longer getting consistent hours, causing hardship, financial hardship, to them and their families.

And I ask this: If Dr. Kovach is not performing cases at Naperville, with the

opportunity to have all the OR time that he has available to him, where are these patients receiving services?

Thank you.

MS. PREPHAN: Hello. My name is LuAnn Prephan; that's P-r-e-p-h-a-n. I'm a director of operations for Surgical Care Affiliates in Chicago. I'd like to thank the Review Board for providing the opportunity to speak in opposition of this project.

I'm here today to oppose Project 18-047, the Ophthalmology Surgery Center of Illinois, Itasca. I'm responsible for the operations of Naperville Surgery Center, which is one of the locations where Dr. Kevin Kovach currently performs ophthalmology procedures. I'm also responsible for Golf Surgical Center, which is mentioned in the Applicant's State Board response. The approval of this project would mean a loss of a large number of these procedures at the Naperville ASC.

We're very concerned that the approval of the project would lead to a significant impact to Naperville operations and would create the need

for staff reductions as well as limit the access to care for patients in the Naperville area.

Additionally, we currently provide a large ophthalmology service line that allows us to provide the latest equipment and technology, which leads to better patient outcomes. A decrease in volume puts the center at risk of not being able to continue to provide this high level of care to the patients that we serve.

It is also important to point out that surgery schedule access in this market is not an issue. At the Naperville Surgery Center, upwards of 50 percent of our current surgery schedule is open and available for scheduling on a daily basis. Contrary to the Applicant's response statement, Golf Surgical Center is an option for scheduling ophthalmology cases, as well. At Golf approximately 40 percent of our current surgery schedule is open and available for scheduling.

In the interest of ophthalmology patients in our market, I strongly encourage the Review Board to deny the project.

MR. CONSTANTINO: May I please have your comments.

MS. MITCHELL: Next up, for Project 18-047, Sohila Parsinejad, LuAnn Prephan -- I think she just went. Right?

LuAnn Prephan, did you just go?

MS. AVERY: Was that LuAnn?

MS. MITCHELL: Okay. Go ahead.

MS. PARSINEJAD: I'm the only one?

Hi. My name is Sohila Parsinejad, P-a-r-s-i-n-e-j-a-d.

I am the manager director at --

MS. AVERY: Bring the mic closer.

MS. PARSINEJAD: I'm sorry.

I am the managing director at CIBC, which formerly operated as The Private Bank in the market. I'm here to express CIBC's support for the approval of this project.

CIBC is backed by a 150-year-old Toronto-based, global financial institution with our headquarters here in Chicago. We invest in our businesses, our clients, and people in our communities.

I'm pleased here -- I'm pleased to be here today to discuss our planned financing of this surgery center, which will be a great benefit for

everyone but especially Medicaid patients with access issues.

We've been working with this organization, with Dr. Kovach and his -- or the organization's leadership for the past several months, with expectation that CIBC will be financing -- will be the financing partner for this project. We have reviewed the key financial elements of the deal based on the pro forma statement prepared by a well-respected, independent accounting firm specializing in health care and other key information about the planned surgery center, and we're committed to funding this project as set forth.

Subject approval of the certificate of need -- subject to approval of the certificate of need for this project, our summary financing would include a loan of $1.5 million for capital improvements to the site and to finance equipment purchases. It would be a 66-month note, 6 months -- and the first 6 months would be interest only, and it will convert to a term note.

We are pleased to be the financing partner for this proposed surgery center and look forward

to the committee's approval of the certificate of need, as required.

Thank you.

MS. MITCHELL: For Project 19-003, Jim Draths, Annette Escobar, Richard Greenberg, Kim Grikis, and Monica Varri.

Again, please state and spell your name for the court reporter. And if you have written comments, please leave them at the table.

You may begin.

MR. DRATHS: My name is Jim Draths -- that's D-r-a-t-h-s -- from Lake Forest Bank & Trust Company, part of Wintrust Financial Corporation.

I'm pleased to be here in support of the certificate of need approval for Project 19-003, River North Center for Reproductive Health, to be located in Chicago.

We've been working with the physicians of River North and their financial team for the past several months as we hope to be their financing partner for this project. We have reviewed the proposed lease agreement, budgets, operating budgets, and assumptions as well as the historical

financial information, and we are excited and supportive of the opportunity. Moreover, we are very comfortable with the financing requirements to complete the project as outlined to the HFSRB committee during the application process.

Subject to the approval of the certificate of need for the project and on receipt of the final construction documents, our summary financing structure would include a leasehold improvement loan to fund the medical equipment and facility build-out requirements. This facility will be structured as a nonrevolving line of credit for one year during the construction period and convert to a six-year fully amortizing term loan upon completion of construction and opening of the surgery center.

Secondarily, we'll provide a line of credit to support the working capital needs for River North Center for Reproductive Health, which will be fully available to the borrower upon completion of construction and opening of the facility. The line will be structured as a two-year tenor and supported by a blanket lien on business assets, primarily accounts receivable of

the surgery center. Monthly payments of interest would be required, and for both of those facilities the approximate rate would be about 2.5 percent as of today's date.

We're very pleased to be the financing partner for the proposed surgery center and look forward to the committee's approval of the certificate of need, as required.

Thank you.

MR. GREENBERG: Good afternoon, members of the Board.

My name is Richard Greenberg, G-r-e-e-n-b-e-r-g. I am here to speak in support of the application of River North Center for Reproductive Health, Project 19.3.

Thanks to the assistance of this Applicant, my wife and I have a child, Lucas, who could not otherwise have been conceived. Having our son required in vitro fertilization and the use of an egg donor, which these reproductive experts facilitated and made happen.

Lucas brings us a tremendous amount of joy. He's a special child who has completed our family. I think that the new frontiers opened in

health care and in reproductive technology in particular are quite important and have materially enhanced the lives of so many families.

For example, technologies are now available to freeze unfertilized eggs to permit prospective parents to time pregnancies when it makes the most sense to them. This did not exist when we were trying to conceive Lucas.

I understand that IVF providers can now even assist prospective parents by extracting sperm from testicular tissue and using that to conceive a child. These and other truly amazing advances help otherwise childless parents build a family.

Our process to conceive our son was truly an ordeal. It took us four years from the time my wife's fertility was diagnosed to the birth of our son. We had to go through several cycles involving, among other things, waiting for eggs to mature and embryos to develop. At the time people and friends suggested our goal of having another child was not worth the effort, but our IVF team was compassionate, professional, and encouraging in using their expertise to make our dream come

true. Now everyone sees what a miracle it is to have Lucas. We cannot imagine our lives without him.

I'd like to thank the Board for listening today to my story. I would ask that you please approve the River North Center for Reproductive Health project so that other families like mine can be helped.

Thank you.

MS. ESCOBAR: Hello. My name is Annette Escobar, E-s-c-o-b-a-r, and I'm here to share a friend's fertility story. The remarks are mine but I'm sharing her story. I appreciate the opportunity to share their experience.

They found out about five years ago that they had fertility issues. They were referred to FCI for a consultation. The workup showed that her husband did not have any sperm in the sample he produced. They struggled with the news but found so much reassurance once they met with Dr. Rapisarda that they still had options for achieving their dreams of having children.

He needed to have a surgical procedure called a TESE to find out if he had -- produced

sperm at all. The doctor recommended a urologist at a different facility to perform the procedure and see. If he had any sperm that was found, it would be saved and transferred to FCI.

The anxiety they experienced venturing out to a new facility with staff they had never met before was overwhelming. He experienced so much emotional stress. Dealing with male infertility is very personal and a sensitive topic, and he was having to explain to everyone why exactly they were there.

He was awake for the entire procedure, wasn't given any choice or warning. He has posttraumatic stress from this procedure. A physician who he had met one time performed the delicate and sensitive procedure while he was awake.

She witnessed him mentally break down and cry in the car as he could not stop reliving the experience. This traumatizing procedure actually negatively impacted the future potential to have biological children.

The plan had originally been for him to take medications to help his body naturally

produce sperm and then undergo another TESE procedure to extract any sperm that would have been created. He confessed to her, sobbing, that he could never go through that procedure again.

At FCI they learned that TESE could be done with anesthesia. The separate clinic never offered this option to us. They chose FCI to -- they chose FCI due to its reputation of excellence and the patient communication and high standard of care; however, due to there not being a surgery center to perform the procedure, he underwent one of the most sensitive and private procedures with complete strangers.

They finally got a positive pregnancy test and were overjoyed.

MR. ROATE: Two minutes.

MS. ESCOBAR: Unfortunately, it was an ectopic pregnancy and she again was slated to go through another surgical procedure.

CHAIRMAN MURPHY: Ma'am, could you please conclude your remarks?

MS. ESCOBAR: I firmly believe that FCI needs a surgery center to provide continuity of care throughout this -- throughout the entire

process of fertility.

Please approve the surgery center. Thank you.

MS. VARRI: Hi. My name is Monica Varri, V, as in "Victor," -a-r-r-i.

I support the North Center -- River North Center for Reproductive Health center surgery for IVF and child conception, Project No. 19-3.

Thanks to the expertise of the physicians affiliated with this project, I have two beautiful daughters, Sophia and Gabriella, who could not have been conceived without in vitro fertilization.

The world has changed in many ways, and, for me, advancement in medicine has given me the opportunity to have children. As a woman plans her life's journey, starting as a little girl, she creates expectations for what her life is going to be like. That vision for most women involves a clear expectation of having children and being part of her own family, leaving a legacy and sharing her love, energy, and values with the next generation. I was one of those girls.

By the time I felt like I was in the right

place professionally to have kids, I learned it was difficult for me to get pregnant without the help of a fertility specialist. We have gone so far in society to bring gender quality to the workplace, allowing women to participate in interesting and fulfilling careers, but as a society we are still figuring out how parenting fits with a woman's career. For me, it meant delaying having children, which meant I became a patient of the Fertility Clinic of Illinois.

The IVF process was complicated. For a successful egg retrieval, there were injections, a lot of early morning monitoring appointments, and I was never quite sure what day I would have procedures because it depended on the timing of the egg maturation and the growth of the embryos to the stage when they would be ready for transfer. The physician overseeing my care was on-call every day to be ready for my procedures.

This is a specialized group recognized for high quality and success rates all over the Midwest, the nation, and the globe. Please help other people like me have a chance to build a family. Please approve this surgery center.

THE COURT REPORTER: Please leave your remarks.

MS. MITCHELL: For Project 19-016, Mark Silberman and Juan Morado, Jr.

You may begin.

MR. MORADO: Thank you.

Not often do you see two former generals counsel to the Board appear before you and offer public testimony. We're here today to raise concerns about the Village at Mercy Lake [sic], Project 19-016, on behalf of our client Heritage.

Our client has been providing care in this community for years, respects this Board, respects its process, and expects its competitors will be judged by the same standard it was held to in establishing its facilities. There are a series of procedural irregularities regarding this project that bring us pause and we hope will inspire this Board to also take pause, as well.

Those issues include the costs for this facility are higher than any other long-term care project approved over the last two years. The SAR summarizes four deficiencies when there appear to be at least six. The SAR claims that it is

projecting a seven-bed need but this project seeks to add seven more beds than the projected need. The Applicant's own market study does not justify 40 beds, only 24.

None of the referral letters included in the application are compliant. There is no bank letter regarding financing arrangements, and the application cites to a letter that is not there. The Applicants criticize the quality of existing facilities but have their own issues and do not cite those, either.

Not all the necessary Coapplicants appear to be included in this application, and the Applicant has failed to show that they have control of the site wherein they hope to establish a facility.

For all these reasons, we hope you take pause and ask the appropriate questions of the Applicant when they appear before you.

Thank you.

MR. SILBERMAN: Good afternoon.

My name is Mark Silberman. I'm here on behalf of our client Heritage in opposition to Project 19-16, the Village of Mercy Lake.

The biggest issue with regards to this project is its overall posture. The Board needs to consider that this -- there was a different project that was approved at the last Board meeting, establishing a facility at this exact same site. It was approved on the promise that that facility -- that another facility was going to give up 40 beds to justify the need, but that did not happen.

Now, that project was approved by the Board and remains a valid, open project. It has not been abandoned, nor has there been any relinquishment that's filed that's available on the website.

If the posture of this project is an alteration of that project, then it's not properly positioned as an alteration. If it's its own new project, then this project shouldn't be able to move forward until that project has been resolved because relinquishment of an application under the Board's rules requires filing an application, filing a fee, appearing before the Board, and receiving approval.

And the failure of that to have taken

place is not a failure of the Board, it's not a failure of the staff, but it is something that the Applicant should have to address because relinquishment of the permit cannot take place after the fact.

This project, inexplicably, is moving forward very quickly. I think it's important for the Board to consider. This new application was filed on March 27th, 2019, and here we are, 32 days later, and it is being heard by the Board.

The project that was filed right after this project, on March 29th, is currently scheduled for September 17th, the Board meeting in September of this Board. The project that was filed immediately before this project, on March 21st, is scheduled for August 6th, 2019.

There's no reason for this project to proceed so forward so quickly because, at the end of the day, we do believe that there is a very serious legal issue if this Board is to have two applications that it has approved to establish different facilities at the exact same site.

MR. ROATE: Two minutes.

MR. SILBERMAN: For that reason, we would

ask you to take that into consideration in evaluating these applications.

MS. MITCHELL: Next up, for Project 18-042 --

THE COURT REPORTER: Leave your remarks, please.

MS. MITCHELL: -- Quincy Medical Group Surgery Center, Maureen Kahn, Julie Brink, Laura Kent Donahue, Dave Boster, Lisa Neisen, and Lexie Davis.

You may begin.

MS. KAHN: Okay. I'm Maureen Kahn, K-a-h-n.

I'm Maureen Kahn, Blessing Health System. I'm the CEO. At our last Board meeting, we took to heart the comments of Chairman Sewell, Senator Demuzio, and Dr. McNeil and have done everything in our power with QMG on the existing surgery center that we own and that QMG manages.

QMG sold that facility to us in 2006 when they were having financial difficulty, and our two organizations together have made it viable. QMG wanted to buy it back, and we offered them in February a 40 percent interest in that center.

After our March meeting the Blessing board approved a pure 50/50 collaboration with equal ownership and representation on the ASTC Board.

Representatives from our two boards met just two weeks ago to discuss our proposal. I thought it was a productive meeting, and yet here we are again today, meeting for approval on a second unneeded surgery center in Quincy. Our 50/50 joint venture is still on the table.

Also, we have addressed all of the issues which QMG has raised with regard to what they say are deficiencies with the existing surgery center, and with QMG's cooperation I believe these issues can be resolved. After all, QMG is still the facility's manager. The Quincy community wants QMG and Blessing to collaborate on the existing surgery center, and we want that, too.

I affirm to this Board on behalf of Blessing that if this project is denied, we will not pull the offer because we are better together, and I ask the Board to deny Project 18-042.

Thank you.

MS. BRINK: Hi. I'm Julie Brink, B-r-i-n-k.

My name is Julie Brink, and I'm a member of a family-owned construction and trucking company with more than 100 employees in Quincy and serve as the chair of the Blessing Hospital Board.

I was here at your meeting in March and was greatly encouraged to hear a majority of this Board express a strong desire for Blessing and QMG to work together in the best interest of the community. I can affirm that Blessing and the Quincy community and most employers want this collaboration.

In response to the comments we heard from you last month, we offered QMG a pure 50/50 joint venture. Our Board believes this is what's best for the Quincy community and are behind it.

We offered QMG equal ownership and equal Board representation of the existing surgery center. In addition, consistent with the comments of Mr. Sewell and Dr. McNeil in March, our proposal included a mutually acceptable tiebreaker on the surgery center Board from the employer community.

This is a win-win proposal because a joint venture represents a less costly alternative that

avoids unnecessary duplication, reduces the adverse impact of the proposed project on existing providers that cross-subsidize safety net services, eliminates the patient safety issues inherent in a remote cardiac cath lab, and enjoys support from a large margin of the employer community.

Our collaboration offer is open-ended. We believe this is the best option for the community and the best option for both Blessing and QMG. I respectfully ask that you deny Project 18-042.

Thank you for your time.

MS. KENT DONAHUE: Laura Kent Donahue, D-o-n-a-h-u-e.

My name is Laura Kent Donahue. A lifelong resident of Quincy, I represented Western Illinois in the Illinois Senate for 22 years. I currently serve on the Illini Community Hospital Board of trustees.

Senator Demuzio, Dr. Mitchell [sic], you were right when you said that the fighting needs to stop and Blessing and QMG need to collaborate on the existing surgery center. I know this collaborative approach is what is best, in the

best interest of our community.

Senator Demuzio, you said at the last meeting you were disappointed when you saw some headshaking at the suggestion of a surgery center joint venture on the Quincy-Blessing campus. Let me assure you that those were not Blessing heads shaking. The Blessing leadership, the Blessing board, and the Blessing employees are a hundred percent -- hundred percent behind this collaboration.

The rules of this Board specifically promote joint ventures as alternatives to projects by single Applicants, and they specifically promote ASTC joint ventures that include a hospital partner. Blessing's proposed joint venture with QMG advances the Review Board policies behind this rule.

I know all that Blessing has done prior to the March meeting to reach an agreement with QMG. I also know that QMG has been spinning this in the community and to this Board. Frankly, the only thing that is going to bring QMG to the table is to deny this project, and that is what I respectfully ask you to do.

Thank you.

MR. BOSTER: My name is Dave Boster, B, as in "boy," -o-s-t-e-r.

I'm one of the trustees, all unpaid volunteers, on the Blessing Hospital Board, and I oppose Quincy Medical Group's CON.

Blessing Hospital has served the Quincy area as a not-for-profit, community-owned hospital for 144 years. There are 36 different community members represented on various Blessing boards, and 735 community members serve in other volunteer roles.

We are a caring, committed organization that continually does strategic planning to address the ever-changing needs of our community. The Board recognizes the shift to outpatient care and has been working closely with leadership to transition the organization to best meet the community needs.

For example, Blessing established an employer clinic in 2017 with 25 employers and still growing. We opened three regional clinics and one urgent care clinic throughout the region and have partnered with Hyvee and County Market to

locate additional clinics.

Blessing has partnered with area colleges to provide education opportunities, an investment that is critical to maintaining staffing levels for both Blessing and QMG. We partner frequently with other providers to offer important services to the area, like the EMS system, ambulance restocking, and air evac for helicopter transfer -- transport -- with a pad outside our ER.

It's Blessing's belief we are better together, and that applies to QMG, as well. One financially viable surgery center co-owned by Blessing and QMG is better than two duplicative centers that will inevitably cut safety net and other, less profitable services.

We urge you to deny Project 18-042.

MS. DAVIS: My name is Lexie Davis. I'm a polling director for Remington Research Group, which is a nationally acclaimed polling firm specializing in political and corporate public opinion survey research.

Remington has conducted many thousands of polls over our 15-year history. We were asked to

do an objective as possible baseline poll of attitudes surrounding this proposed project and alternatives, not a push poll.

On a single evening, last Wednesday, April 24th, we completed 405 live interviews of registered voters in Adams, Brown, Schuyler, Hancock, McDonough, Scott, and Pike Counties, a statistically relevant sample with a margin of error of plus or minus 4.85 percent.

We found that both QMG and Blessing enjoy excellent favorable ratings in the 71 to 72 percent range. 3 in 4 responding indicated that they had seen, read, or heard something recently about QMG or Blessing.

Regarding the surgery center matter, we found a clear community preference for collaboration on the existing ASTC over a second ASTC in the Quincy Mall. Collaboration on the current center was the choice of the majority of the public. 50 percent support the center while only 21 percent oppose. This is a net positive 29-point margin in favor of collaboration.

A very unusual thing happened the day after we completed this poll. QMG sent out a

fraud alert to local media and on social media, asking residents not to respond to the poll and report calls to QMG, truly a first for us, but that incident did not influence our already-completed survey.

The favorable ratings for Blessing Hospital are some of the highest we have seen for a hospital, and the poll indicates strong support for the 50/50 proposal Blessing has presented.

MS. NEISEN: Hello. I'm Lisa Neisen, N-e-i-s-e-n, and I'm a 28-year employee of Blessing Health System, and I'm the brand strategy director.

After last month's meeting, our leadership took to heart the words of Review Board members and decided to do our part to set a better tone through our actions and our words in the best interest of the greater Quincy community.

Both QMG and Blessing regularly advertise in both print and broadcast platforms with very similar frequency, and we decided to use our normal ad rotation these past three weeks to acknowledge teamwork.

Our first ad featured a heart attack

victim who was saved through the work of Blessing and QMG doctors. Our second ad, narrated by Senator Donahue, touched on how Blessing and its partners together improve the quality of life in our community.

These ads never once mentioned the surgery center matter. They were not about advocacy; they were a general positive shout-out to all who participate in providing health care in our area. Generalized positive tone, nothing more, just to do our part.

Much of what was said last month did not reflect sentiment or experience in Quincy. I am proud to be a part of a community-owned institution that improves lives -- yes, with all sorts of partners -- and I'm proud to be associated with its positive tone.

Thank you.

MS. MITCHELL: Next up, Steve Hathaway, Mark Schmitz, Kent Adams, Ryan Stuckman -- and I remind you, Mr. Stuckman, that you can't read a statement on behalf of somebody else based on our guidelines -- Dr. Randy Tobler, and Adam Booth.

MR. HATHAWAY: Good afternoon.

My name is Steve Hathaway, H-a-t-h-a-w-a-y. I serve as vice president and general manager of the Titan International facility in Quincy. Titan produces wheels and tires for use in the agriculture, construction, forestry, and mining industries and has over $1 1/2 billion in annual sales. With approximately 1,000 employees in Quincy and approximately 7,000 employees overall, Titan is one of Quincy's largest employers.

At your meeting last month, before issuing the intent to deny, a majority of this Board urged QMG and Blessing to find a way to collaborate. To the Board members who offered that advice, let me say this: Your words and encouragement echoed strongly and favorably in Quincy.

My company strongly prefers a collaboration outcome. 13 of Quincy's largest employers submitted a joint letter, which in part says, "Appreciating both the concerns raised by QMG as well as those expressed by Blessing Hospital related to the impact of a shift in health care dollars away from the community benefits and safety net services that Blessing

currently provides, we agree that such effort at collaboration between QMG and Blessing would be in the best interest of the Quincy community, our employees, and the patients served by QMG and Blessing. We believe the Review Board members shared wise counsel and advice."

Similar letters from Quincy University and others were even more forceful.

I respectfully urge this Board to show resolve today by seeing your wise counsel through. Please reward those parties who look to approach collaboration fully and in good faith.

Thank you.

MR. SCHMITZ: Mark, M-a-r-k; Schmitz, S-c-h-m-i-t-z.

I'm the executive director of Transitions of Western Illinois. We're a charitable, not-for-profit agency that provides mental health, rehabilitation, and education services to some 9,000 area residents annually. We have a staff of 175, which makes us a significant employer in Quincy.

Transitions today joins the growing employer-community chorus that wants

collaboration, not necessarily the project before you today.

We believe the message that was sent at the last meeting of the Board was the correct one, encouraging both QMG and Blessing to engage in a dialogue to achieve a solution where both groups can win in the interest of quality care at a reasonable price without jeopardizing other aspects of our health systems of care. This is important to Transitions both as an employer and for our consumers who rely on services from both providers to be quality and strong.

I understand this Board's rules expressly encourage joint ventures. The circumstance before you today, with staff reports indicating findings of unnecessary duplication and adverse impacts associated with a second surgery center in Quincy, calls out for the sort of collaboration and joint venture that's been offered to QMG.

I believe our two premier health providers can and should do better than this proposal. Through their application QMG has brought needed attention to the important issue of how our health care prices in our community are higher than other

similar communities; however, we do need an alternative which both provides lower costs while being financially sustainable for each provider and also that doesn't result in destabilizing our community's safety net services.

Thank you.

MR. ADAMS: My name is Kent Adams, A-d-a-m-s. I'm a partner with Adams & McReynolds Retirement Partners. We consult on retirement, investment, and insurance products for individuals and businesses and are deeply connected to the Quincy business community.

I previously served as chief executive officer with the Moorman Manufacturing Company, which was and still is one of Quincy's largest manufacturers and employers. Moormon today is part of ADM and is now known as ADM Alliance Nutrition of Quincy.

My partner Laura McReynolds and I have a popular weekly radio show in Quincy and the surrounding area, focusing on topics which provided wisdom and guidance for the second half of life.

The record reflects that far more Quincy-

area employers and residents support collaboration than the few who side with the second surgery center.

I, personally, want to see collaboration, not consternation, in my health care, something we know that is possible if both parties come together in good faith. Sometimes a little nudge is required, and I hope this Review Board does so today.

As the medical hub for 50 miles in every direction, Quincy today is fortunate to have wide-ranging medical resources. The staff report explains how that will change, negatively, with a second surgery center. Collaboration will preserve safety net services and those medical services that are not the most profitable to maintain and deliver.

This Review Board tapped into the sentiment in Quincy when it asked that the parties work this out. Blessing's 50/50 joint venture offer has been well received in the community.

MR. ROATE: Two minutes.

MR. ADAMS: Why this matter is up again so soon and --

CHAIRMAN MURPHY: Sir --

MR. ADAMS: -- in this context is puzzling, disappointing --

CHAIRMAN MURPHY: Sir --

MR. ADAMS: -- and disheartening.

Thank you.

DR. TOBLER: I'm Dr. Randy Tobler, T-o-b-l-e-r. I'm the CEO and medical director of the department of ob-gyn of Scotland County Hospital in Memphis, Missouri.

Scotland County is a critical-access hospital in the northeast part of the state. We have had a collaboration agreement with Blessing Health System since May of 2014. This has been an effective partnership in clinical care and innovative approaches that keeps care local to our community and grows relationships with local community business and thought leaders.

Scotland County Hospital and Blessing Health System have shared visions for providing affordable and proximate access to quality health care services in our region. Our organizations have consistently intersected positively in many areas, including a robust cardiology service and

Blessing's recent inclusion of our hospital in a clinically integrated network, which is already delivering value with better quality at reduced costs to the patients served by its physicians.

In our experience with Blessing, they've been open to the community needs to keep care local. It's willing to assist us in achieving our goals and ready to compromise as necessary to achieve the expectations of the community.

My facility currently benefits from the efficiencies of collaboration on clinical programs that have long been successful with both providers here today, Quincy Medical Group and Blessing, and it's clear to me that a collaborative approach to the existing surgery center would be the best outcome from a cost, quality, safety, and outcome perspective.

QMG and Blessing have the opportunity now to take the current ASTC and, together, evolve it for the future needs of the region. Whether it remains in the current location or moves to the hospital campus, as recommended by one member of the Review Board, I encourage and support collaboration on the project. Synergy, not

division, should be the guiding light going forward.

As administrator and physician, it's crystal clear that, for the sake of responsible resource stewardship and the promises of innovation through collaboration, I urge you to join me in recognizing that synergy.

Thank you.

MR. STUCKMAN: I'm Ryan Stuckman, S-t-u-c-k-m-a-n, a former member of Quincy University's basketball team and recipient of both undergrad and graduate degrees from QU.

Our president, Phillip Conover's schedule could not permit him to be here today. In addition, QU experienced a tragic loss of a senior student, which prevented anyone else from QU to attend. In his absence, I'm presenting his comments on behalf of QU, and I adopt them as my own.

I believe that the proposed outpatient surgery center at the Quincy Mall would not be in the best interest of our region. The center would be a duplication of services in our area and ultimately could lead to a loss of much-needed

services that are currently funded by profits from the existing surgery center. These services include a trauma center, the emergency care department, and behavioral treatment services, among others.

I believe that the Facilities and Services Review Board made a wise decision at its March 5th meeting. The member's suggestion that Blessing Hospital and Quincy Medical Group collaborate on ways to make the current surgery center more viable for our community would be beneficial for all.

I am asking that you keep your past admonition on both parties to do what is good for the region and work collaboratively together for the good of our citizens and area.

MR. BOOTH: My name is Adam Booth, B-o-o-t-h. A lifelong resident of Quincy, I am a real estate developer, business owner. I'm here today to speak in opposition to 18-042.

I was here at that Board meeting in March. Long day. Several Board members urged that the parties work together and mend some fences for the benefit of Quincy. I agree. Quincy is far better

when Quincy Medical Group and Blessing can collaborate together and work more on the existing surgery center and avoid this damaging duplication of unnecessary services.

Unfortunately, I don't feel that QMG has put forth a serious and good faith effort into trying to do what the Board members asked. A mere two weeks after the intent to deny ruling, QMG had already requested to reappear before this Board without even meeting with Blessing.

Since the last Board meeting, all we have heard -- all we have seen from QMG is one announcement after another about how they are proceeding with their own ASTC surgery center at the mall and installing banners on the building promoting the new facility, social media videos lauding this unnecessary second surgery center, and the continuing belittling of Blessing in the process.

QMG has been too busy moving forward on this proposed project instead of making a serious effort to explore collaboration. If QMG is allowed to move forward today, what's broken in Quincy will not be fixed. Our community will

lose.

MS. MITCHELL: Next up, Lori Wilkey, Dr. Joe Meyer, Elliott Kuida, Dr. Irshad Siddiqui, and Tim Tranor.

MR. KUIDA: Hello. My name is Elliott Kuida and that's K-u-i-d-a. I serve as the executive vice president and chief operating officer at Blessing Hospital.

Listening to the testimony by QMG at your March meeting, I was struck by the number of issues that were brought up by QMG spokespeople, of which the Blessing team had no prior knowledge.

One example was Dr. Alexandre's testimony, and he spoke about a recent experience at the surgery center where a surgical consent form was in question. He indicated that he felt that he was bullied during this incident, so upon return to the hospital, I reached out to Dr. Alexandre to learn about this incident and to schedule a meeting to discuss it.

The day before the meeting, Dr. Alexandre emailed me to say that it was not a Blessing employee with whom he had interacted and, rather than discuss something that occurred in the past,

he had other pressing issues that he wished to discuss with me and my team, and so we did so.

Since the March meeting Blessing has worked with QMG to expand hours of operation at the existing ASTC. We have also identified future options to add more hours and more rooms across the week to accommodate future demand. Blessing has taken seriously your direction to collaborate for the benefit of our community. We are committed to resolve all issues that we have learned from the previous COPN testimony.

QMG and Blessing have a long history of working together, and Quincy will benefit if we collaborate further through a 50/50 shared ownership of the existing and underutilized ASTC.

I respectfully believe denial of this project, No. 18-042, is warranted.

DR. MEYER: My name is Dr. Joseph Meyer, M-e-y-e-r, and I am vice president of Quincy Anesthesia Associates, QAA.

In January I delivered an impact statement refuting the need for an additional surgery center in Quincy. I testified again in March, and I stand before you today for the same reason.

Each time I have stood before this Board, I've addressed QMG's complaint that the anesthesia department is not providing Quincy Medical Group's surgeons their desire for extended weekday and weekend hours.

After four months of testimony and hearings, I respectfully ask a simple question of the Board I stand before: A certificate of need implies just that, need. Is there a genuine need for another surgery center in Quincy? My answer is an emphatic no, and these are the reasons why:

For the first four months of this year, the Surgery Center of Quincy continues to run as inefficiently as it has in the past. In April 75 percent of the time all operating rooms have finished by 3:00 p.m. Additionally, in April there were 10 days in which one operating room was completely empty.

Nevertheless, in an effort to grant QMG's surgeons the additional OR time they desire, Blessing Hospital and QAA have extended services. As of April 1st we are now providing additional evening hours Monday through Thursday as well as two Saturdays a month. My anesthesia department

is happy to provide extended hours at the surgery center in order to satisfy QMG.

In 2003 there was a need for an outpatient surgery center in Quincy. Today, a second surgery center in Quincy is completely unnecessary, given the fact that the current SC is underutilized. Despite operating rooms sitting empty, Blessing Hospital and QAA have increased coverage to accommodate the requests of QMG.

A second surgery center in Quincy would result in duplication of services and increased health care costs by further increasing inefficiencies.

For these reasons I respectfully request that you deny COPN 18-042 and thank you for your time.

DR. SIDDIQUI. Good afternoon. I'm Dr. Irshad Siddiqui, I-r-s-h-a-d S-i-d-d-i-q-u-i. I serve as chief health information officer for Blessing Health System, here to address medical records access between QMG and Blessing.

The project application said, "QMG physicians do not have access -- immediate access to the complete medical record of their patients

when performing services at Quincy's existing ASTC and, as a result, QMG physicians are required to navigate two electronic medical record systems."

Please know that Blessing has offered on several occasions, starting in December 2015, to deploy a solution called dbMotion to connect the two systems. Throughout the country a great many leading health systems have very successfully linked two medical records systems through dbMotion.

To date QMG's Iowa-based 45 percent owner, UnityPoint, has disallowed this connection, citing some unknown administrative effort that may be needed to maintain such an integration. Please know that full interconnection is immediately possible if only UnityPoint would allow it.

A joint venture opens more possibilities. Blessing and QMG could create a community data asset, providing significant benefits to our patients and our physicians. Pathways to exchange orders, results, documentation, and patient registration information can be created with the use of special health information exchange software. This software can also provide

analytics to improve productivity and efficiency and optimized supply chain.

As an IT expert, I believe this is a better solution, being cooperative and transforming health care together, for the community than creating a second, stand-alone ASTC with a separate Epic medical record.

I respectfully ask that you deny Project 18-042. Thank you.

MR. TRANOR: My name is Tim Tranor, T-r-a-n-o-r. I'm the chief nursing officer of Blessing Hospital.

Your hearing on March 5th was the first time I heard the expressed concerns of Quincy Medical Group. In my experience, both Blessing and QMG physicians have created a positive environment for our employees and patients.

Whenever there are differences that need to be addressed, both QMG and Blessing have multiple avenues to voice concerns or make recommendations. There are multiple operational and administrative committees to deal with any issues that may arise.

After first hearing concerns raised at the

March hearing, I immediately followed up with QMG's newly hired neurosurgeon, Dr. Anderson, who testified that his requested blocks were denied. In conversation he confirmed with us -- just as he had in our initial meeting several weeks prior -- that he is planning to work in the shared neurosurgery block that his QMG partners have until the neuro block reaches a significantly higher utilization. We also recently completed a million-dollar capital purchase in collaboration with Dr. Anderson for equipment to meet the needs of neurosurgery.

Blessing is committed to QMG's growth. Blessing and QMG can both be successful and provide high-quality health care to our community without unnecessarily duplicating services. Working together is the best solution.

I urge the Board to vote no on QMG's application for a new surgery center.

MS. WILKEY: My name is Lori Wilkey, W-i-l-k-e-y. I am the administrative director of surgical services and the cancer center at Blessing Hospital. I oppose QMG's CON request because a second surgery center is a duplication

of services.

As I listened to the testimony on March 5th, I was taken by surprise since it was the first time I had heard many of the comments. I have a positive working relationship with the surgeons at QMG, and they have every opportunity to voice concerns or make recommendations. These surgeons participate in multiple operational committees where any concern can be easily addressed.

Some of QMG's previous testimony specifically referenced a need for expanded hours in the surgery center. On March 11th Blessing Hospital leadership added an agenda item to the medical consultant committee to discuss expanded hours in the surgery center. A week later, at that meeting, we asked the committee, which is comprised primarily of QMG physicians, what the expansion of hours means to them.

While the group was unable to give specifics, we felt committed to move forward with expanded hours and did so effective April 1st, adding an additional two hours per day Monday through Thursday as well as opening two Saturdays

per month. To date, these expanded hours have been minimally utilized.

Blessing leadership, anesthesia, and surgery center staff are committed to further expansion of hours. It is my belief, through continued collaboration with QMG physicians, that, together, we can build the best surgical experience for our community.

Thank you.

MS. MITCHELL: Next up, Justin Hale, Scott Koelliker, Pat Gerveler, Julie Duke, and Tim Moore.

If you have written comments, please either give them to George or leave them on the table.

You may begin.

MR. GERVELER: Thank you.

My name is Patrick Gerveler, G-e-r-v-e-l-e-r. I am the executive vice president and CFO for the Blessing Health System.

I support the staff's negative finding on the financial viability criteria for QMG's application.

There are two major financial issues with

QMG's application. First, QMG does not have the appropriate financial standing to start up a new surgery center. To properly plan for a project of this size, QMG should have improved operating margins and reserved the required levels of days' cash on hand to meet the CON standards for financial viability.

Instead, QMG is now promising to reserve future cash flows of $1.8 million. As the staff report notes, that is only enough cash to cover operating expenses for 4 days, and the rules require 45 days, which is $15 million.

Second, this ASTC will redistribute $40 million annually in net margin from Blessing Hospital to QMG investors. It will skim the most profitable surgery cases while patients who are unable to pay will be left to Blessing.

The $40 million annual loss is real. The staff notes that Blessing will lose 10,658 cases a year to the project by its second year of operation. It's easy to look at the hard data and run the numbers, and they do, indeed, total over $40 million.

This project is a duplication of services

according to the staff report. I respectfully urge the Board to deny QMG's bid for a second ASTC in Quincy.

Thank you.

MR. HALE: Justin Hale, H-a-l-e. I am the director of managed care and decision support for the Blessing Health System. I wish to set the record straight on some comments QMG's consultants made at the March hearing.

One consultant used data from Quantros CareTracks to state that Blessing was higher cost. Blessing has access to the same data, and we looked at the same cost-and-margin analysis. We pulled eight similarly sized hospitals, as did the QMG analysis. Blessing is right at or below the cost of seven of these eight hospitals.

QMG claims Blessing was higher cost than all the other analysis. Blessing contends the data shows that we are not high cost. Not only does the data show we are not high cost, but it also shows that Blessing is in the 92nd percentile in overall quality.

Another claim was that Blessing has 80 percent market share. Blessing utilizes a firm

named Trilliant for market share analysis which captures 95 percent of the claims in our market. In the 27-zip code GSA identified on page 95 of QMG's application, Blessing's surgical market share hovers around 50 percent, not the dominant market position QMG claims.

QMG also claims that Blessing has higher margins than the hospitals they studied. This is not true. Blessing's operating EBITDA is in line with Moody's medians for comparable hospitals.

Finally, QMG continues to base its project on unrealistic growth projections. Market research from Trilliant shows that demand for surgical cases is negative 1.2 percent through 2019. There's simply is no need for an additional surgical center.

MR. KOELLIKER: Good afternoon. My name is Scott Koelliker, K-o-e-l-l-i-k-e-r. I'm the executive vice president for Blessing Physician Services. Four years ago this month, Blessing formally launched a price reduction process that, when fully implemented, will equal if not exceed all proposed price savings in the QMG application.

Our approach has three focuses: First, we

established a population health strategy, which led to an implementation of a clinically integrated network as well as an ACO with plans to explore additional value-based programs.

In just one year we reduced total cost of care by $29 per member per month, while improving quality in five different clinical areas, such as high blood pressure and diabetes management.

Second, we improved our cost structure, resulting in millions of dollars of cost reductions.

Third, we worked closely with our patients and employers to continually understand their needs, especially around affordability of care.

As a result of this planning, among other things, Blessing has rolled out the following price reductions to our community: The existing surgery center in Quincy is now formally moving to a freestanding ASTC. Our pricing will be at or below anything suggested by QMG.

In our 48th and Maine location, Blessing will be offering high-quality radiology and laboratory services with competing pricing in a facility with convenient access to the consumer.

In short, any price reductions suggested in Project 18-042 are already being achieved, and then some, in the existing Quincy Surgery Center.

Thank you.

MR. MOORE: Tim Moore, M-o-o-r-e. I'm the vice president of finance and chief accounting officer for the Blessing Health System.

Quincy Medical Group has been misrepresenting our financial 990 forms, and I wanted the Review Board members to understand these facts if, in fact, it comes up here.

Last Wednesday, April 24th, QMG posted a Facebook video featuring its revenue cycle director. In it she stated that Blessing Hospital had profits of $74 million in fiscal year 2017 and that Blessing Corporate Services had a profit of $13 million, for a combined profit of $87 million, in 2017. That is completely untrue.

The Form 990 is complex, and QMG did not account for Schedule D of the 990, which reconciles the information from page 1 for the tax accounting of the 990 to the actual audited financials of Blessing. Blessing Corporate Services, which includes Blessing Hospital, had a

total operating income of $46 million in 2017.

When that $46 million is reduced by the $41 million negative impact of QMG redirecting 10,658 surgical cases from Blessing to the proposed surgery center, Blessing is left with only $5 million in operating income. Blessing would not meet basic capital spending needs nor be able to pay its annual principal and interest on its debt with that 5 million left over.

Blessing will be forced to reduce jobs by over 400 positions through both layoffs and attrition to be in a financial position to adequately maintain equipment and facilities and fund debt obligations. Blessing would also have to reduce the extent of safety net services it now provides to the community.

Please deny Project 18-042. Thank you.

MS. DUKE: Good afternoon. My name is Julie Duke, D-u-k-e, and I am the administrative director of the revenue cycle for Blessing.

I'm here to address Blessing's pricing. Historically we have utilized provider-based reimbursement. Medicare put this reimbursement model in place because they saw the need for

hospitals to fund safety net services, and we have properly utilized it.

Many hospitals use this provider-based reimbursement option with CMS; however, the world is changing, we fight new containments, and we have adapted. Well before we learned of the CON application, Blessing was moving from hospital-based pricing to an ASTC facility fee at the existing surgery center.

We formally submitted our change request to CMS in February and expect to receive CMS approval soon. With that change, Blessing's ASTC will be charging the exact same fee that QMG's project would offer. Consequently, QMG's recommendation that its second surgery center will lower costs is simply not correct.

What is correct is the adverse impact on both Blessing Hospital and the existing ASTC as found by your staff report.

I respectfully oppose Project 18-042.

CHAIRMAN MURPHY: We're going to take a five-minute break. Don't go far.

(A recess was taken from 2:47 p.m. to 2:53 p.m.)

MS. GUILD: The next people to come to the table are John McDowell, Dr. Eliot Nissenbaum, Brenda Beshears, Dr. Harsha Polavarapu -- sorry -- and Kyle Dixon.

MR. MC DOWELL: I'm John McDowell, M-c-D-o-w-e-l-l. I serve as Blessing's administrative director of psychiatric services with administrative oversight of our 41 inpatient behavioral health beds.

We are the only inpatient provider for behavioral health beds serving ages 5 through adulthood within a hundred miles. I oppose an unneeded second surgery center for Quincy.

This CON threatens the continued viability of the inpatient behavioral health services that my staff and I work to provide every day. It takes away the most profitable areas of the hospital while leaving nonprofitable safety net services like behavioral health without offsetting financial support. To make up for the $41 million in lost annual revenue, behavioral health services would be among the first services to be compromised.

The population that we serve is both

vulnerable and substantial. Studies show a prevalence of mental health disorders in Illinois affecting 16 percent of adults and 13 percent of adolescents. People in mental health crisis come through our emergency room 24/7. In 2018 70 percent of the 2,000 admissions to our facility came through our local emergency room.

Because mental health services are not profitable, we must have support from the profitable areas of the organization to be sustainable. Just a couple months ago, the next closest behavioral inpatient unit in Jacksonville closed its 10-bed psychiatric unit.

Maintaining inpatient care locally gives our patients and their families access to the support systems that are so important for successful treatment.

To safeguard the continued provision of safety net services like inpatient behavioral health, I respectfully urge denial of CON 18-042.

DR. NISSENBAUM: Good afternoon. I'm Dr. Eliot Nissenbaum. I'm a Board-certified invasive cardiologist working at Blessing Health System. I also work at Scotland County Hospital

and the Hamilton Warsaw Clinic, also part of the Blessing Health System.

I wish to address serious concerns regarding the remote cath lab proposed by QMG, which would be the only one in Illinois.

In QMG's application reference is made to two nonpeer-reviewed articles regarding cardiovascular procedures at surgical centers. Please understand that the National Cardiovascular Data Registry reports 1.9 percent adverse events with diagnostic caths and for percutaneous intervention, which are stent procedures, balloon stenting and so forth like that, and that they also have had adverse events reported more than diagnostic caths as aforementioned, including nearly 1 percent dissection of aortas and 2.5 percent bleeding.

Now, with that in mind, what is going to happen when there is an adverse event at this remote cath lab which is over 2 miles away from the nearest hospital? That's very important to consider. Is the patient going to be wheeled through the shopping mall on a stretcher, the shopping mall there? How else are they going to

get to the parking lot? Also, there is not going to be an ambulance just sitting there waiting for them. QMG will have to call one. Will an ambulance even be available? And how long will it take for them to get there?

This has not been thought out thoroughly from a cardiac point of view. Blessing Hospital has repeatedly asked QMG for its procedures and protocols for maintaining patient safety, and QMG has repeatedly ignored these requests. They want a transfer agreement with Blessing, but they will not provide Blessing with even the basic fundamental safety measures they intend to implement to protect patients in the case of an adverse event.

I respectfully say that it would not be responsible to approve this remote cath lab given the unaddressed dangers presented.

MR. ROATE: Two minutes.

DR. NISSENBAUM: I oppose CON 18-042. Thank you very much for your time.

MS. BESHEARS: I'm Brenda Beshears, B-e-s-h-e-a-r-s.

As the president and CEO of the

Blessing-Rieman College of Nursing & Health Sciences, I'm here today to oppose this CON application.

Quincy is not a destination city. It must grow our health care workers from within. That's the reality of rural health care, as those from downstate know from experience.

Blessing spends millions every year educating medical lab, radiology, surgical technicians, nurses, nurse-practitioners, physician assistants, and family medicine physicians. The community and QMG benefit greatly.

A list of education programs that Blessing now supports include the SIU School of Medicine family practice residency, nursing programs at various levels with Blessing-Rieman College of Nursing & Health Sciences, John Wood Community College, which is a collaborator, Culver-Stockton College, and Quincy University, both partnerships; radiology; EMS training program for area paramedic staff; pharmacy, surgical, and lab tech programs; respiratory therapy; and health information management.

Rural health care has always required collaboration to thrive. I feel that QMG has turned its back on collaboration with this CON with long-term negative impacts for the greater Quincy community.

Please deny CON Application 18-042.

DR. POLAVARAPU: Hi. My name is Dr. Harsha Polavarapu, P-o-l-a-v-a-r-a-p-u. I am a colorectal surgeon, and I also serve as the chairman of the department of surgery at the Blessing Hospital.

I would like to bring the Board's attention to two things that we have done since the last March hearing.

Blessing Hospital has continued to work with QMG and its surgeons to improve the operations of the existing ASTC. We have extended the operations of hours in the OR and the GI procedural areas and Saturday morning hours, as well, and we can also add additional rooms and hours of operation as needed.

The second thing we have done is we have converted the ASTC from hospital-based to freestanding ambulatory site status. The plan is

to submit for our accreditation visit in the coming months.

As you're aware, this transition will lower the reimbursement to the surgery center from the hospital-based payment to the freestanding ambulatory payment, a change that will benefit our patients and employers of the region.

Since the March meeting Blessing has been working to enhance the ASTC experience for our surgeons and the patients alike. We're committed to working together with QMG in the best interest of the Quincy community.

I respectfully request that you deny the CON 18-042 based on the standard of duplication of the services. Thank you.

MR. DIXON: Good afternoon. I'm Kyle Dixon, D-i-x-o-n, a captain for Adams County Ambulance.

We do not support or oppose Quincy Medical Group's application; however, it does create concerns for delivering emergency medical services to our community and our response to critical patients at their facility.

We operate six advanced life support

ambulances countywide with three in the Quincy District, and we are the sole provider of prehospital EMS transport services in Adams County.

The two transfer agreements that Quincy Medical Group currently has in place are both more than a hundred miles from Quincy. In the event of a necessary transfer, this would require us to either dispatch an on-duty ambulance or wait 60 minutes for an on-call crew, if not already committed on another transfer.

Good patient care is at stake in both scenarios. Either the patient from Quincy Medical Group waits and loses critical time or the patients calling 911 for an ambulance would have a longer response time throughout the community.

We routinely do interfacility transfers to both Peoria and Springfield and know that our crews are gone for five to six hours for each trip. This is an extended period for an ambulance to be out of district and out of service.

As this Board considers the many issues associated with this CON, I ask you to consider the patient care impact in our community.

Thank you.

MS. GUILD: Next group, Sandy Behl, Barb Richmiller, and John Cooley, and then there's one more group from Blessing after that.

MS. BEHL: Sandy Behl, B-e-h-l. I'm the manager of the emergency medical services department at Blessing Hospital and have an extensive background in emergency medical services. I also serve as the program director for Blessing's paramedic program.

I have serious concerns over the proposed location of this surgery center and the inherent risks for cardiac cath patients who might require emergency ambulance transport to the Blessing Hospital campus.

The proposed site is over 2 miles from the hospital. I'm not aware of any freestanding cardiac cath labs in Illinois, much less one that's 2 miles from the nearest hospital. We have asked QMG for safety data on this and to date have provided -- they have provided nothing.

In an emergency situation the ambulance crew, assuming that they were available, would be traveling with a patient along the busy Broadway

corridor through three high-traffic intersections, which further increases risk.

Blessing has proposed a joint venture with QMG for an ASTC on the Blessing campus and has even discussed a cardiac cath service in the ASTC that would be directly connected to the hospital surgical floor via a pedestrian bridge. This would provide lower costs for cath procedures while ensuring immediate access to the hospital in the case of an adverse event. It's the best of both worlds.

From an EMS and patient safety perspective and from the cost perspective, as well, the proposed Blessing joint venture is a much better alternative to this project.

I respectfully urge denial of CON 18-042.

MR. COOLEY: Good afternoon. My name is John Cooley. That's C-double o-l-e-y.

I respectfully oppose QMG's proposed surgery center and hope instead that QMG will cooperate with Blessing on the existing and underutilized surgery center in Quincy, Illinois.

A lifelong Quincy resident and having volunteered at Blessing Hospital for 17 years,

I wish to share the perspective of many of my volunteers.

Over 735 volunteers donated 64,310 hours in fiscal year of 2018. Volunteers serve 42 hospital departments, including the emergency department, patient floors, and the cancer center. They greet and direct patients. They manage the Blessing Tea Room cafe and gift shop, with profits donated back in the form of surgical equipment and support for the cancer center.

Volunteers provide information and support in our waiting rooms. They visit and deliver flowers and mail to patients. Volunteer chaplains pray with patients every day.

Our community is a hospital in every sense, and giving back is a part of our small town culture. Unlike the Chicago area, there isn't another hospital in Quincy to fill the void if service must be discontinued because a nonprofit service has been redirected away.

The truth is that Quincy Medical Group and Blessing have a long and positive history of working together. Regarding the existing surgery center, Blessing stepped up after financial

pressures forced QMG to sell, and Blessing kept QMG as both manager and landlord. Blessing has stepped up again to bring QMG back into the ownership as a full and equal partner. Our community spirit and, certainly, our volunteers support our -- such cooperation.

Thank you.

MS. RICHMILLER: My name is Barb Richmiller, R-i-c-h-m-i-l-l-e-r.

I've lived in Quincy my entire life and am one of 735 community volunteers who give of our time to Blessing Hospital. I volunteer because I feel strongly about the importance of a strong community hospital and the important work that Blessing does for patients in our area.

That's why I respectfully oppose QMG's application for a second surgery center in Quincy and why I hope QMG will come around to embracing collaboration.

I give back to Blessing because of what Blessing provides our community. It's our hospital, owned by the community. Blessing's mission is to improve the health of our communities, and its volunteers help serve that

mission. Citizen involvement is second nature because it is our hospital.

Giving back takes many forms within the walls of our hospital. We all know what will happen if the more profitable patient volumes, as identified in the staff report, are shifted away from an already underutilized surgery center and hospital. Something will have to give, and, certainly, safety net and other services will be cut back and jobs will be lost.

This Review Board wisely urged that QMG and Blessing find a way to work things out between them, and I do hope QMG comes around and really tries. I believe with further encouragement from this Board QMG can and will come around. That's how life works in smaller towns. It's the Quincy way.

MS. GUILD: The last group from Blessing Hospital is Lance Privett, Lea Ann Eickelschulte, Rick Kempe, Sarah Stegeman, Betty Kasparie, and Dan Lawler.

MR. PRIVETT: Hello. My name is Lance Privett, P-r-i-v-e-t-t, the director of performance excellence at Blessing.

I respectfully urge denial of QMG's application based on the negative staff findings. Review Board staff found that other than shift its CT scanner from one cost line to another, QMG did nothing to materially address the negative findings relating to service accessibility, unnecessary duplication, and financial viability.

The project remains an unneeded duplication of services with significant adverse impact on existing providers. Negative impacts on safety net services remain unchanged.

The project still fails to meet any of the four need factors, literally zero demonstration of needs under the Board's service accessibility criteria. QMG relied on unfounded speculation to claim that patient volume at existing facilities will miraculously double by 2023. Review Board staff refuted and rejected this speculation.

Further, the service accessibility criteria clearly requires current utilization to be at target utilization, making speculation about future utilization irrelevant.

QMG's most recent submission only confirms that Blessing -- that both the existing ASTC and

the hospital are underutilized. By State standards, ASTC surgical hours in 2017 would support less than five rooms while the existing ASTC has six rooms. Hospital surgical hours in 2017 would support less than 8 rooms while the hospital has 10 surgical rooms.

QMG's claim that both facilities are utilized at or above the State's utilization standard is simply wrong and your staff is correct. There is no demonstrated need to support this certificate of need.

Thank you.

MS. EICKELSCHULTE: My name is Lea Ann Eickelschulte, E-i-c-k-e-l-s-c-h-u-l-t-e. I am the chief information officer of Blessing Corporate Services. Based on the negative staff findings, I respectfully request denial of QMG's pending application.

The unnecessary duplication/misdistribution criterion requires an Applicant to document that the proposed project will not lower the utilization of existing facilities. The original staff report found that the proposed project would result in reduced utilization at both Blessing

Hospital and the Blessing ASTC. The report's negative finding stated, quote, "Based upon the staff's analysis, the proposed ASTC will impact the two Blessing facilities," end quote.

QMG's additional information, filed in response to the intent to deny, attacks the staff's analysis under this criteria. QMG claims that volume at the Blessing facilities will not be reduced but, instead, will grow at an annualized 6.5 percent rate between 2017 and 2023. The facts belie this claim.

Blessing's volumes from 2017 to date show our two facilities experienced a 10 percent annual decline in surgery hours. Those numbers are in the record. Review Board staff rightfully rejected QMG's speculation of future volume growth.

With two presently underutilized facilities, compounded by declining volumes, the impacts on our hospital and the ASTC will be severe. This only underscores the wisdom of collaboration as the far better approach and why denial of the application before you is appropriate.

MR. KEMPE: Good afternoon. My name is Rick Kempe. I'm the chief strategy officer for the Blessing Health System. My name is spelled K-e-m-p-e. I've been with the health system for 32 years and very much appreciate your time today.

While we embrace collaboration at Blessing, we must respectfully oppose QMG's proposed second surgery center. The original staff report found that the project failed to meet 15 financial viability measures. Those problems remain. There still is a negative finding on financial viability for QMG's project.

Your most recent staff analysis underscores the cash-on-hand shortcoming, just four days' worth at the end of last year. QMG's additional information submitted after your intent to deny last month does not come close to meeting either historical or projected criteria of this Board.

QMG asks that none of the Board's financial viability ratios should apply, that you, today, create an exemption for QMG because it is a physician group and not a hospital or an ASTC.

Of course, the Board's financial viability

ratios are for an ASTC. Surely, if the Applicant wants to operate an ASTC, it should comply with the applicable Review Board criteria.

Further, the Board's regulations do provide very specific and limited exemptions from financial viability ratios, but being a physician group is not one of those exemptions. There is no good reason to create one today outside of the normal rulemaking process.

As you've heard today, history supports collaboration. After QMG was financially unable to maintain ownership in the existing surgery center in Quincy, Blessing stepped up to buy it, and we did, indeed, keep QMG as the manager and landlord --

MR. ROATE: Two minutes.

MR. KEMPE: -- who are the manager and landlord today.

Thank you very much.

MS. STEGEMAN: Hello. I am Sarah Stegeman, S-t-e-g-e-m-a-n. I'm the innovation manager at Blessing, and I respectfully oppose a second surgery center in Quincy.

Efforts at collaboration have already

addressed what QMG put forth as the basis of its application. In describing its goals, QMG said in its CON application that it wanted equity in the Blessing ASTC. That option is on the table.

More than three weeks ago, Blessing formally proposed a 50/50 joint venture in the existing ASTC. Even before QMG was here last month, Blessing had offered a 40 percent interest to QMG's physicians as a starting point for discussion.

Hospital/physician joint ventures in ASTCs are common in Illinois. They are strongly encouraged by this Board under both its alternatives and service accessibility rules.

The CON application also raised some operational concerns with the existing surgery center, including QMG's first-expressed desire for extended weekday hours, along with Saturday hours of operation. Blessing has responded by extending weekday hours effective April 1st and opening the facility for Saturday surgeries beginning this month. QMG has expressed appreciation.

The other issues raised in the CON application -- related to medical equipment,

medical records, and types of available surgeries -- were discussed by Blessing and QMG at a regularly scheduled medical consulting committee meeting on March 15th and at a special meeting on April 8th. Progress is being made.

In closing, your staff found that none of the four service accessibility criterion were met in this application. Collaboration makes better sense.

Thank you.

MS. KASPARIE: My name is Betty Kasparie, K-a-s-p-a-r-i-e. I'm the compliance officer for the Blessing Health System.

Respectfully, six reasons Project 18-042 should be denied: Number one, a joint venture with Blessing Hospital is a less costly alternative. Review Board members have encouraged it, community leaders and employers support it, unnecessary duplication and adverse impacts are avoided by it, and a joint venture offer remains on the table in a sincere and a thoughtful way.

Two: Your staff have found the project to be an unnecessary duplication of service that will not improve service accessibility under the Review

Board criteria.

Three: Your staff found that the project will adversely impact existing facilities by reducing utilization and constitutes a misdistribution of services under the Review Board criteria.

Four: Your staff found that the project fails to meet multiple criteria for financial viability. The Applicant seeks exemption from the criteria because it is a physician group, but Review Board criteria contain no such exemption.

Five: The project will not provide cost savings, as the existing surgery center is already transitioning to the ASTC facility pricing and will be charging the same rates as the proposed ASTC. Our community gets no savings but suffers the adverse impact on existing providers.

Six: The proposed freestanding remote cardiac cath service is unprecedented in Illinois, risks patient safety, and should, ideally, be reviewed by IDPH for licensability prior to any further Review Board action.

If denied, Blessing will follow through on collaboration.

Thank you.

MR. LAWLER: My name is Dan Lawler. I represent Blessing Hospital.

Last month QMG questioned the timing of Blessing's correction to its surgical data. That led Mr. Sewell to ask Blessing for an assurance that the numbers were not changed to influence QMG's project. Blessing's CEO gave that assurance under oath.

We have since learned that it was QMG who had been asking Mr. Constantino to check Blessing's numbers. There is nothing wrong with that, but when the corrected numbers came out, QMG then said that the timing was suspicious. But the timing of the correction is on QMG, not Blessing.

Last month QMG told you they can't get the anesthesiologists to work late at the existing surgery center. The anesthesiologists said they've never been asked. Mr. McGlasson noted the contradiction and asked, "Who do we believe?"

QMG's response to this Board was, quote, "We heard today from a well-respected anesthesiologist that he's never been asked, but about 10 or 12 years ago, we stopped asking,"

end quote, so they hadn't asked in over a decade. But Blessing has since worked with QMG, and now they have their extended hours.

Finally, QMG sent Blessing a letter last fall on discussions for a joint venture at the existing surgery center. It's in the record. If that letter was sent in good faith, let's do it. Blessing has offered a 50/50 joint venture at the existing facility and welcomes it.

Thank you.

MS. GUILD: Moving on to Quincy Medical Group, the first person is Beverly Helkey. Katie Schelp, Kristen Rogers, Michelle Frazier, Shauna Harrison, and Richard Schlepphorst.

MS. HELKEY: I'm Beverly Helkey, H-e-l-k-e-y, executive director of the Tri-State Health Care Purchasing Coalition. I support Quincy Medical Group's project.

Our coalition represents over 50 employers, and that's equal to 31,000 covered lives. We're dedicated to improving health care costs, outcomes, and choice. We have supported the project from the beginning.

QMG and Blessing have a history of working

together when it is advantageous and beneficial to the community; however, our coalition adamantly opposes a collaborative surgery center, as this will defeat any opportunity for competition, which we desperately need as a community.

Quincy is not like Chicago or Springfield, where there are many providers. In Quincy we have one hospital, and that hospital owns the only surgery center within a hundred miles. We do not have competition for surgery services. As a result, health care prices in Adams County are significantly higher than prices in other markets. We do support and encourage local providers to work together on strategies to improve health care quality and patient outcomes.

In other respects we encourage Blessing and Quincy Medical Group to be fierce competitors in order to ensure that the community gets quality access to care at the best price it has to offer. It was only after Quincy Medical Group submitted its certificate of need that Blessing announced a reduction in its ambulatory surgery center rates. This clearly illustrates that competition does work and should be allowed.

The majority of employers and the community as a whole approve of Quincy Medical Group's project. Please note we have no direct affiliation to Quincy Medical Group and we receive no financial gain by supporting this project. This support is in the best interest of our community to reduce health care cost and to improve quality.

This is our only choice for health care competition in our community. Please grant us this opportunity for competition and patient choice. Please approve Project 18-042.

MR. ROATE: Two minutes.

MS. HELKEY: Thank you.

MS. SCHELP: Hi. My name is Katie Schelp, S-c-h-e-l-p. I'm the chief development officer for QMG.

Six weeks ago Chairman Sewell asked us to determine what is the best interest of the people of Quincy. We're proud that on social media alone our support has grown from 65 percent supporting the QMG Surgery Center to 73 percent supporting it today, and even more organizations, businesses, and individuals have come forward with support.

The support is not indicative of being anti-Blessing and pro-QMG but indicates a genuine need for health care options in Quincy. Those who publicly support QMG's project represent community-based organizations like The Great River Economic Development Foundation, the Quincy Area Chamber of Commerce, the Mayor of Quincy, Quincy Next strategic planning committee, an Adams County board member, District 17 Congressman Darin LaHood, and the Tri-State Health Care Coalition.

The support is from Top 5 employers like Knapheide Manufacturing, Titan International's owner, Mr. Maury Taylor, the teachers coalition on health, who represent Quincy public schools, and other great businesses like Prince Manufacturing, Phibro, McNay Truck Lines, O'Brien Insurance, Kirlin's Hallmark, We Care TLC, a direct primary care competitor to us, and many, many others.

We have also spoken with many who support the project quietly, business owners and community-based organizations that are rooting for us from behind closed doors but fear retribution if they provide public support.

All of the organizations that submitted

any form of opposition to the project or who indicated a desire for collaboration are financially obligated to Blessing, employed by Blessing, or are seated on Blessing's boards.

In fact, as I sat here today, I received an email from a high-ranking official at one of the organizations that signed Blessing's collaboration letter. She said, "I am behind -- I am 100 percent behind QMG, and I believe we need this. I am praying for you."

Ultimately, we've done our level best to earnestly determine and represent what is in the best interest of the people of Quincy. On behalf of all of them and us, we ask that you approve this project.

MS. ROGERS: My name is Kristin Rogers, R-o-g-e-r-s, and I'm the strategy director for Quincy Medical Group.

Our physicians own QMG. Before coming to work for the organization, I thought that meant they wanted to own a business. I was wrong. These doctors want to own the care experience for their patients and to have a voice in how care is provided, financed, and implemented. They are

steadfast in their commitment to the surgery center because there is very little they can control for their patients in their current environment for practicing surgery.

This led QMG to the proposed surgery center, a project developed alongside the City of Quincy and our community in a location where QMG will be an anchor tenant in a fully renovated space, centrally located in a retail district that is fundamental to substantial economic development in Quincy, with convenient, accessible services for patients. Patients can easily access the proposed location through public transportation.

A QMG-owned surgery center brings additional tax revenue to Quincy as a for-profit business that pays taxes on revenue. Additionally, as those awaiting a loved one in surgery shop neighboring stores, producing additional tax revenue, and as property taxes are paid on the surgery center's building.

QMG vetted many locations for the proposed surgery center in both Illinois and Missouri. The Missouri option is an alternative presented in our CON application.

The people of Quincy have told us that a new surgery center is in their best interest, so it is clear that we need to move forward with the proposed surgery center, and the reality is we've found the best location. The proposed surgery center was twice offered as a collaborative partnership to Blessing and was twice declined.

The project meets the key criteria of the application, the needs of the patients, the desires of the community, and it allows our doctors, after 80 years of a proven track record of care to their patients, the right to own the care experience where they choose, preferably in Illinois.

Please approve this project today.

MS. FRAZIER: Good afternoon. My name is Michelle Frazier, F-r-a-z-i-e-r. I work in the QMG business office.

By using Blessing Hospital's own financial data, we may conclude that our project will not negatively impact the hospital's financial ability to subsidize safety net services.

In order to comment on the impact to safety net services, we would like to reference

two sets of public documents. The first is Blessing Hospital's IRS 990 for the fiscal year 2016, ending September 30th, 2017, and Blessing's CON application project to this Board, 18-010. It was approved June 5th of 2018.

On their 2016 990 Blessing Hospital reported total revenues of over $398 million, while they reported total expenses of just under 324 million. That leaves a net income of approximately $74 million.

In lay terms, Blessing brought in $398 million, paid all of their expenses and bills, including the bills for all their social safety net services and all the charity care delivered. They were left with $74 million at the end of the year. In the private sector we call that profit.

As Mr. Moore mentioned earlier, the hospital transferred $41 million of that profit as a corporate allocation in 2017 at the end of the year.

We disagree that our proposal will cause the worst-case scenario presented by Blessing to this Board; Mr. Gerveler cited a $40 million net

income loss. Although we don't believe the impact will be that great, let's use that number to calculate the worst possible scenario.

The hospital would still show a profit of $34 million -- that's 74 minus 40 -- with no changes to the current level of subsidizing safety net services.

Further, Blessing's CON application for Project 18-010 demonstrated a $242 million unrestricted reserve in 2017 in the Standard & Poor report. Blessing's own statement of operations, which is Exhibit B in that report, validated the data on their 990 by showing an excess of revenue over expenses of $74 million in 2017 and $50 million in 2016.

MR. ROATE: Two minutes.

MS. FRAZIER: Thank you.

MS. HARRISON: Good afternoon.

I am Shauna Harrison, H-a-r-r-i-s-o-n, the chief clinical officer for QMG. Much focus has been on where QMG and our local hospital disagree. Today I'd like to share common ground between our organizations and address capacity in a slightly different way.

We both understand the future of medicine demands that services be rendered in the most cost-effective setting. Nobody in Quincy debates that fact; however, our GSA lacks the appropriate ASC capacity to deliver health care in the cost-effective setting. For example, knee scopes are done in the hospital with facility fees over $80,000 rather than in the ASC at less than $25,000.

By performing outpatient surgeries in the most appropriate setting, the ASTC, three important things will happen: One, our patients will save money on facility fees; two, capacity increases in the inpatient setting so that Blessing and QMG may focus on collaboration for programs like trauma surgery, neurosurgery, orthopedics, and other areas that leverage the inpatient setting to provide innovative, sophisticated care delivery; and, three, Quincy remains a medical destination in our region.

We agree that this CON project has already made a positive impact towards lowering the cost of health care in our community. As of today the only ASTC in Quincy, owned by Blessing Hospital,

is billing patients as a hospital outpatient department, 30 to 50 percent higher than a freestanding ASTC.

The BSGA firm studied Blessing Hospital's patient charges and determined that its outpatient fees are 16 to 43 percent higher than services at similar hospitals in the area. One of the tenets of the CON process is cost containment, and the introduction of another surgery center will undoubtedly lower costs. Competition works.

Finally, sometimes collaboration is good. But in the case of providing health care services, competition has been shown to improve care and lower costs for our patients.

Thank you.

DR. SCHLEPPHORST: I'm Dr. Richard Schlepphorst, S-c-h-l-e-p-p-h-o-r-s-t. I'm the chief medical officer for Quincy Medical Group, a lifelong resident of Quincy and serving Blessing Quincy Medical Group since 1986.

Before filing the application we had many discussions with Blessing and our community about the underlying issues necessitating this project and we carefully tailored the project to meet the

needs of our community and its physicians.

We hear from patients that leave our service area because of pricing and access issues. We provided the Board with real-life examples of patients' financial realities that have been barriers to them accessing care in the current environment.

I speak with prospective physician recruits every week, especially among the surgeons. They have concern that lack of block time and operating room access which is currently available to run an efficient operating room environment are barriers to them signing employment contracts in Quincy.

While we applaud Blessing's recent efforts to address the operational limitations of the existing center, these efforts do not eliminate the need for the proposed surgery center as presented in our application.

It's difficult to listen to the 47 testimonies so far today -- friends, coworkers -- and to not respond to that. It seems very adversarial. The idea that there's not collaboration in our current market is just not

the facts. We do it every day, in the emergency department, in the wards, in the ICU, on the floors. Our physicians work with the hospital constantly. Blessing is our hospital.

But the fact remains that the current surgery center is at capacity and lacks sufficient surgical blocks to accommodate current and newly recruited physician needs and lacks the equipment and physical space to accommodate the existing number of outpatient surgical procedures for which a surgery center is the appropriate site of service.

These limitations have resulted in outpatient procedures being performed in the hospital, inappropriate site of service, with significantly higher cost to patients with the scheduling and access limitations of having outpatient procedures compete with inpatient operating room needs and priorities.

The proposed surgery center is needed in our community, as that will improve patient access to existing and new surgical procedures that are not currently offered in our region, and that will provide significant cost savings for patients.

We respectfully ask you to approve our project. Thank you.

THE COURT REPORTER: Please leave your remarks.

MS. GUILD: The last group is Patty Williamson, Ralph Weber, Meredith Duncan, Meredith Eng, and Tracey Klein.

MS. WILLIAMSON: I am Patty Williamson, W-i-l-l-i-a-m-s-o-n, CFO for Quincy Medical Group.

We have heard repeatedly today that the existing surgery center is not at capacity. We disagree. Prior to Blessing's most recent provision of their surgical volume information made at the March 5th, 2019, Board meeting, the existing surgery center was at 85 percent capacity, which meets the State standard.

At that meeting Blessing officials testified that they reduced their hours in the ASTC procedure rooms for 2017. All 319 hours were a reduction in the category of prep and cleanup time for GI procedures. This was a reduction of nearly 50 percent from the previous 624 hours reported for prep and cleanup in 2017.

A quick analysis shows that the new number

of 305 hours for 5,231 cases means that Blessing now claims that it can do prep and cleanup in 3 1/2 minutes per case. For each of the past four years, prep and cleanup were reported at 7 minutes per case. 3 1/2 minutes is simply not enough time.

It takes approximately a minute and a half to apply the disinfectant, which needs a minimum of 2 minutes to dwell while wet and then an equal amount of time to dry. That process totals 5 1/2 minutes. Removal of the used, soiled scope takes approximately 30 seconds and bringing in the new scope, 1 minute. We estimate the minimum amount of time prep and cleanup would require is 7 minutes, the exact number that Blessing has been reporting for the last four years.

For comparison purposes, the average prep and cleanup for the 41 ASTCs in Illinois that reported prep and cleanup time for GI procedure rooms is 15.7 minutes. As you recall, Blessing has contracted with QMG to manage the ASTC, so we are familiar with the length of the process.

This is significant because this reduction of 319 hours is just enough to reduce total hours

to 125 hours below the State standard. In our opinion, this is a blatant effort to block our CON application from proceeding.

I urge the Board to be cautious of Blessing's numbers and of the motive behind their recent change in GI procedure room cleanup time.

Thank you.

MR. WEBER: I am Ralph Weber, W-e-b-e-r, certificate of need consultant for QMG.

I also address the frequent and opportunistic adjustments Blessing has made to its ASTC volume data. Blessing's data has been revised twice since the filing of QMG's CON application. QMG believes these revisions were intended to be a roadblock to its CON application.

As Patty has just discussed, Blessing reduced prep/cleanup hours in the existing ASTC from 7.0 to 3 1/2 minutes per case in year 2017. Of the 41 ASTCs in Illinois reporting GI prep and cleanup time, none reported a prep/cleanup time this low.

Why is Blessing's change so important to this permit application? The questionable reduction in prep/cleanup time results in

Blessing's ORs appearing to be underutilized. If this revised prep time is accurate, the annual utilization falls 125 hours short of the State standard for the six rooms. This shortfall of just 125 hours on a base of about 7400 hours allows the attorney for Blessing to claim that the ASTC, quote, "is underutilized and not at the State's utilization target." State staff reflected that in the supplemental State Board report.

No explanation was given to this Board last month when Blessing's president and others appeared under oath before the State and reported new numbers. We believe this is not just an oversight or carelessness. At a minimum, it should be a cause for grave suspicion by the State Board.

These are not just inconsequential numbers. We believe these small but questionable and unrealistic changes were made to impact QMG's project negatively.

I recommend approval. Thank you.

MS. DUNCAN: My name is Meredith Duncan, D-u-n-c-a-n. I'm one of the attorneys

representing QMG in relation to its proposed surgery center, and I speak in support of Project 18-042.

I would like to very briefly address the statements by Blessing regarding the licensure of the proposed ASTC and to clear up any confusion those statements may have caused.

First, as you know, the licensure process will follow from your CON approval. QMG will necessarily take all required steps to comply with IDPH's licensure requirements and to ensure patient safety in relation to all procedures, including cardiac catheterization performed at the surgery center.

We have spoken directly to Karen Singer at IDPH, and we have confirmed there are no rules or regulations that prohibit licensure of the freestanding ASTC. We have confirmed there are no regulatory prohibitions preventing licensure of the ASC performing cardiac catheterization services. We have confirmed there are no regulatory prohibitions preventing licensure even if those services, including cardiac cath, are not performed on or adjacent to a hospital campus.

So any suggestion to the contrary is not consistent with the information we have received directly from IDPH.

So determining how or whether a facility will be licensed is not before you today, and I hope that this clarification has provided the assistance to allow you to continue to focus on your task of approving projects such as this one that satisfy the Illinois Health Facilities Planning Act and substantially conform with your applicable review criteria.

Thank you.

MS. ENG: My name is Meredith Eng, E-n-g. I'm one of the attorneys representing Quincy Medical Group and will address Blessing Hospital's safety net impact statement.

Something not apparent from Blessing's public statements is that in fiscal year ending September 30th, 2018, the State of Illinois determined that Blessing does not qualify as a safety net hospital. The term "safety net hospital" is a special designation that results in enhanced Medicaid reimbursement.

In order to qualify, the facility -- the

Medicaid utilization rate of the facility must be at least 40 percent and the charity care percentage must be at least 4 percent. Blessing Hospital simply does not meet this criteria.

Within the context of Illinois CON law, "safety net services" largely refers to unreimbursed care. It does not include subsidies for health professional education or money spent on health professional recruitment or $40 million invested in a physician office building or providing free meeting space to community organizations or shortfalls experienced because of lack of expense management.

We've reviewed Blessing Hospital's safety net impact statement in detail. It shows that the amount of charity care provided in the last complete fiscal year comprised only 1.5 percent of Blessing's annual operating revenue, which is also less than amounts offered by similarly situated not-for-profit hospitals.

Yes, the hospital provides some safety net services in Quincy, as does QMG. But I am sure that the CON staff saw what we saw, an unremarkable amount of charity care provided by a

hospital with a flush balance sheet, including approximately a quarter of a billion dollars in cash reserves.

You're here to ensure great health care in Illinois. If you carefully consider the merits of the project, you'll see that it's about improving health care in Quincy and it meets the requirements set out by this Board. Throughout the process there have been games, distractions, and politics that have been played to avoid the disruption of the current monopoly in Quincy.

We ask you to see beyond the games and approve this project. Thank you.

MS. KLEIN: Good afternoon. My name is Tracey Klein, K-l-e-i-n, and I represent, proudly, Quincy Medical Group.

I am going to give a quick recap of what I think was important from the last Board meeting for those that are not in attendance.

One of the things that was presented by -- and I think found important by Board members in attendance -- was that Quincy -- or I'm sorry -- that Blessing has a market share of 80 percent. Accordingly, for similarly situated hospitals,

Blessing's costs were 14 to 70 percent higher.

Blessing's outpatient surgical margin was found to be 6 to 8 percent higher, and Blessing's outpatient fees, importantly, were 16 to 43 percent higher than similarly situated area hospitals.

We've heard today that that was -- that's not true. I would just note that our consultant's report is on the website and it did involve an analysis of Quantros CareTracks, also data filed with CMS, also claims analysis provided by QMG's employee health plan on a deidentified basis, and this is something we verified with employers. It's something we've heard from employers. It's something we've heard from patients.

We hear about employers -- for those of you that weren't here the last time, we heard employers talking about sending people out of the marketplace. We heard from patients who actually spoke about deferring needed care because of high prices, including things like screening colonoscopies.

So it just doesn't ring true. It's not what we've heard from employers; it's not what our

data showed. And one has to wonder, if their prices are in line with other area providers, why they're doing a pricing study in order to lower them.

I think that the Board members that were here heard from the people of Quincy. Though only five members were present, we had three positive votes. Two didn't vote no; they abstained and they asked QMG to try to collaborate, to try to build trust. They didn't ask us to necessarily join a collaborative joint venture surgery center.

We did a couple of things in response --

MR. ROATE: Two minutes.

MS. KLEIN: Thank you. We all urge your support.

MS. GUILD: Okay. This brings the public participation to a close.

THE COURT REPORTER: Please leave your remarks.

(Applause.)

CHAIRMAN MURPHY: All right. Thank you, everybody, for your brevity.

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CHAIRMAN MURPHY: There are no items approved by the Chairwoman on No. 9, so we're going to move to Agenda Item No. 10, items for State Board action.

First up, under letter A, is permit renewal requests.

We have A-02, Project 16-043, Rush Oak Park Hospital, Oak Park.

May I have a motion to approve a seven-month permit renewal for Project 16-043, Rush Oak Park Hospital.

MEMBER DEMUZIO: Motion.

CHAIRMAN MURPHY: Second?

MEMBER MC NEIL: Second.

CHAIRMAN MURPHY: Is there any -- yes, there is.

Will you please identify yourselves and be sworn in if you haven't been already.

MR. SPADONI: My name's Robert Spadoni, S-p-a-d-o-n-i. I'm the vice president for hospital operations of Rush Oak Park Hospital.

MR. AXEL: Jack Axel, Axel & Associates.

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

(Two witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN MURPHY: Mike, will you please give the State Board report.

MR. CONSTANTINO: Thank you.

The permit holders are requesting a seven-month permit renewal until November 30th, 2019, to complete the project.

The permit holders have met all the requirements of the State Board.

Thank you, ma'am.

CHAIRMAN MURPHY: Thank you.

Do you have a statement for the Board?

MR. AXEL: We'd be happy to answer your questions.

CHAIRMAN MURPHY: Thank you.

Are there any questions?

(No response.)

CHAIRMAN MURPHY: Okay.

George, can I have a roll call?

MR. ROATE: Thank you Madam Chair.

Motion made by Demuzio; seconded by McNeil.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon -- no testimony, I guess, but -- but, yes, I vote yes --
MR. ROATE: Thank you.
MEMBER DEMUZIO: -- on the State report.
MR. ROATE: Sorry.
Mr. Gelder.
MEMBER GELDER: I vote yes based --
THE COURT REPORTER: Use your microphone, please, sir.
MEMBER GELDER: I vote yes based upon the staff information and analyses.
MR. ROATE: Ms. Hamos.
MEMBER HAMOS: Yes, based upon the staff memo and the reason why the project has not been completed but the evidence of commitment. I vote yes.
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 the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Okay.

Next is A-03 --

MR. AXEL: Thank you.

MR. SPADONI: Thank you.

CHAIRMAN MURPHY: Oh, I'm sorry.

The motion's approved.

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CHAIRMAN MURPHY: A-03, Project 16-033, DaVita Brighton Park Dialysis. This is the second request.

May I have a motion to approve a six-month permit renewal for Project 16-033, DaVita Brighton Park Dialysis.

MEMBER HEMME: So moved.

CHAIRMAN MURPHY: Second?

MEMBER MC NEIL: Second.

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: Okay.

Will you please state your name and be sworn in.

MS. COOPER: Anne Cooper, attorney for DaVita.

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

(One witness sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN MURPHY: Mike, can you give the State Board staff report?

MR. CONSTANTINO: Thank you, Ms. Murphy.

The permit holders are requesting a six-month permit renewal until October 31st, 2019,

to complete the project.

The permit holders have met all the requirements of the State Board.

CHAIRMAN MURPHY: Thank you.

Do you have any comments or statements for the Board?

MS. COOPER: Construction is complete. We're just waiting for Medicare certification.

CHAIRMAN MURPHY: Thank you.

Are there any questions from Board members?

(No response.)

CHAIRMAN MURPHY: George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Hemme; seconded by McNeil.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the State report and testimony.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes, based on the State staff report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on the staff report and testimony.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the testimony and the staff report.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Your permit renewal is approved. Thank you.

MS. COOPER: Thank you.

- - -

CHAIRMAN MURPHY: Next on the agenda, A-04, Project 17-047, Vascular Access Center of Illinois. This is the third request.

May I have a motion to approve a four-month permit renewal for Project 17-047, Vascular Access Center of Illinois.

MEMBER HEMME: So moved.

CHAIRMAN MURPHY: Second?

MEMBER MC NEIL: Second.

CHAIRMAN MURPHY: Thank you.

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

(Two witnesses sworn.)

THE COURT REPORTER: Thank you. Please state your names for the record.

MR. SILBERMAN: Mark Silberman.

MR. MORADO: Juan Morado.

CHAIRMAN MURPHY: Thank you.

Mike, will you please give the State Board staff report.

MR. CONSTANTINO: Thank you, Ms. Murphy.

The permit holders are requesting a four-month permit renewal until September 30th, 2019, to complete the project.

The permit holders have met all the requirements of the State Board.

CHAIRMAN MURPHY: Thank you.

Do you have a statement for the Board?

MR. SILBERMAN: Just briefly.

The prior renewals were due to a delay in the implementation of the survey process. The survey identified a correction that needed to be made. That has been done and the construction is being completed this week.

This should leave us enough time to be done, licensed, and begin seeing patients.

CHAIRMAN MURPHY: Thank you.

Are there any questions or comments from Board members?

(No response.)

CHAIRMAN MURPHY: Okay. George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Hemme; seconded by McNeil.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report and, also, testimony.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes, based on the testimony and staff report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on the hopeful testimony that IDPH inspections will be done by September 30th.

Good luck.

MR. SILBERMAN: We are confident.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on staff reports and testimony here today.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report and the testimony of why the delay.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Your permit renewal's approved.

MR. SILBERMAN: Thank you.

MR. MORADO: Thank you.

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CHAIRMAN MURPHY: Next on the agenda is A-05, Project 17-030, SwedishAmerican Hospital.

May I have a motion to approve a four-month permit renewal for Project 17-030, SwedishAmerican Hospital.

MEMBER MC NEIL: So moved.

MEMBER DEMUZIO: Motion.

CHAIRMAN MURPHY: Second?

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: Thank you.

Can you please identify yourself and be sworn in.

MS. CANTRELL: Hi. My name is Jedediah Cantrell. I'm a vice president of operations for SwedishAmerican Health System, a division of UW Health.

THE COURT REPORTER: Would you spell your name for me, please.

MS. CANTRELL: J-e-d-e-d-i-a-h. Last name, Cantrell, C-a-n-t-r-e-l-l.

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

(One witness sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN MURPHY: Thank you.

Mike, will you please give the State Board staff report.

MR. CONSTANTINO: Thank you, Ms. Murphy.

The permit holders are requesting a four-month permit renewal until September 30th, 2019, to complete the project.

The permit holders have met all the requirements of the State Board.

Thank you, ma'am.

CHAIRMAN MURPHY: Thank you.

MEMBER HAMOS: I have a question.

CHAIRMAN MURPHY: Well, first we're going to have -- do you have any comments for the Board?

MS. CANTRELL: The only comment is that this is our first request for this project, and it's significant -- particularly due to extreme weather.

CHAIRMAN MURPHY: Thank you.

Are there any questions from Board members?

Yes.

MEMBER HAMOS: So just a quick question: The project is 68 percent complete with vertical construction needing to be complete, remaining

components, interior build-out, parking lot, landscaping, finish construction, and then licensure and inspection? And all that in four months?

MS. CANTRELL: That is correct. We'll -- the project is expected to be completed by the end of September.

MEMBER HAMOS: Is four months your decision, to just seek four months?

MS. CANTRELL: Yes, yes.

And that -- the 68 percent was as of the time we submitted this request, which was at the end of February. So since then we have gained even more ground and more progress in the project.

MEMBER HAMOS: Okay.

CHAIRMAN MURPHY: Dr. McNeil, did you have a question?

MEMBER MC NEIL: Yeah.

I probably drove by there Saturday for soccer games with a 12-year-old, so I see the construction in going to Minnesota constantly. So good luck on completing it because the winter has been horrible.

MS. CANTRELL: It's been tough.

MEMBER MC NEIL: I saw 10 spinouts on 39 Saturday evening -- and one was not me.

(Laughter.)

MS. CANTRELL: Thank you. Thank goodness for that.

CHAIRMAN MURPHY: Are there any other questions or comments?

MR. CONSTANTINO: Ms. Hamos, that facility won't need to be licensed by IDPH. That's a medical office building --

MEMBER HAMOS: Okay.

CHAIRMAN MURPHY: Thank you.

MR. CONSTANTINO: -- so there won't be that requirement.

MEMBER HAMOS: Thank you.

MS. AVERY: Sorry. I should have mentioned that.

CHAIRMAN MURPHY: Okay. Any other comments or questions from the Board?

(No response.)

CHAIRMAN MURPHY: George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by McNeil; seconded by

Demuzio.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the testimony and staff report.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes, based on the staff report and the testimony.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on the testimony and staff report. Yes.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on testimony and staff report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report, the inclement weather, as testified.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Your permit renewal's approved. Thank you.

MS. CANTRELL: Thank you very much.

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CHAIRMAN MURPHY: Okay. We do not have any extension requests, so we will move on to Item C on our agenda, which is exemption requests.

First up on the agenda under that heading is C-01, Project E-004-19, Pipeline Westlake Hospital, doing business as VHS Westlake Hospital.

May I have a motion to approve Exemption E-004-19, Pipeline Westlake Hospital, to discontinue a 230-bed acute care hospital in Melrose Park.

MEMBER MC GLASSON: So moved.

CHAIRMAN MURPHY: Is there a second?

MEMBER HAMOS: Second.

CHAIRMAN MURPHY: Is there anyone to represent the Applicant?

MS. MITCHELL: Before they begin, I'd just like to make a brief statement.

MS. AVERY: Use your mic.

MS. MITCHELL: Before they begin, I would just like to make a brief statement.

This is an exemption. And according to the statute, an exemption cannot be voted down, so please keep that in mind when issuing your vote. An exemption cannot be voted down if all the

requirements are met, and according to the staff report, all requirements are met.

MEMBER GELDER: I'm sorry. I couldn't hear the last --

MS. MITCHELL: Sorry.

An exemption cannot be voted down if all requirements are met. And according to the staff report, all requirements are met.

MEMBER GELDER: Thank you.

CHAIRMAN MURPHY: Will you please identify yourselves and be sworn in.

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

(Four witnesses sworn.)

THE COURT REPORTER: Thank you. And please state your names.

MS. MURPHY: In light of the --

CHAIRMAN MURPHY: Excuse me.

Did you get everybody's names?

THE COURT REPORTER: No, I didn't.

Please state your names.

MS. MURPHY: Anne Murphy, A-n-n-e M-u-r-p-h-y.

Do you want the names of the other --

THE COURT REPORTER: Yes.

DR. WHITAKER: Eric Whitaker, W-h-i-t-a-k-e-r.

MR. ORZANO: Nicholas Orzano, O-r-z-a-n-o.

MS. LENNON: Roslyn Lennon, R-o-s-l-y-n L-e-n-n-o-n.

THE COURT REPORTER: Thank you.

CHAIRMAN MURPHY: Mike, will you please give the State Board staff report.

MR. CONSTANTINO: Thank you, Ms. Murphy.

The Applicants propose a discontinuation of a 230-bed acute care hospital in Melrose Park, Illinois.

There is no cost to discontinuation. A public hearing was conducted by the State Board staff on March 11th, 2019, in Melrose Park, Illinois. Approximately 600 individuals were in attendance. The Board staff has received a number of letters and petitions in opposition to the proposed closure and as well as information provided here today.

All the information required by the State Board has been provided by the Applicants for this discontinuation.

Thank you, Madam Chair -- or thank you, Ms. Murphy.

CHAIRMAN MURPHY: Thank you.

Do you have a statement for the Board?

MS. MURPHY: Yes.

I think in light of the comments from the general counsel, I do not need to make any statements for this second hearing.

We also think, at this stage of the day, less is more, so we are going to limit the comments to Dr. Whitaker's.

CHAIRMAN MURPHY: Thank you.

DR. WHITAKER: Good afternoon, members of the Board and fellow citizens.

Thank you for the opportunity to testify before you today on what we believe is a better way to provide quality, cost-effective care to the Chicagoland region, a place where I was born, raised, and have called home nearly all of my life.

I'm Eric Whitaker. I lead TWG Partners as its CEO and chairman, and I serve as a principal of Pipeline Health, a company that currently owns and operates Westlake Hospital, whose future we

are here to discuss today, and I hope my testimony and the past testimony of my colleagues and the facts will lead you to support our application.

In my 26-years career as an internal medicine physician, public health practitioner, and health policy expert, my work has been focused solely on vulnerable populations and ways to improve their health. It's why I trained at San Francisco General Hospital in the mid-1990s and concentrated my early research on how HIV impacts the African-American community, especially black men.

After my residency I came back to Chicago to work at Cook County Hospital as a senior attending physician for nearly eight years. I created the first African-American men's clinic in the United States in the year 2000, Project Brotherhood, a weekly walk-in clinic in Woodlawn on the South Side of Chicago that provided medical care and social services with a barber shop embedded in the clinic.

I had the privilege of becoming the director of the Illinois Department of Public Health in 2003, where one of my three areas of

focus was reducing the health disparities we see between racial and ethnic groups.

I tell you this today not to put myself on a pedestal but to make clear my life's work and my passion has been to help the most vulnerable in Chicago and Illinois. It would be hard to know that, though, if you read some of the statements elected officials have falsely made in the press over the last several months.

Throughout the experience that I just mentioned, it was clear that new models of health care delivery was necessary, especially in impoverished and urban communities. On the South Side of Chicago I saw that, long term, many of the community hospitals were not sustainable without significant government support.

The payment landscape was changing, the IT infrastructure needed to be overhauled, and the management and clinical expertise available was outstripped by the mounting challenges. Simply put, surviving as a one-off hospital without the benefit of scale from a network is a losing proposition for community hospitals.

It led me to search for groups that were

innovating and building a 21st century health care system that provided high-quality, cost-effective health care, a challenge that has eluded the United States for far too long. The US spends more on health care and has worse outcomes than every other industrialized country.

Along the way I saw a health system in Los Angeles, Pipeline Health, successfully working towards this goal, serving minorities in Compton and East Compton, and believed that, if Pipeline could do that there, surely, together, we could begin building a better health care system here in Chicagoland in communities with the most need.

The plan would be to use these hospitals as a way to begin building this 21st century health care system, and it's clear here in Chicago and in Illinois we currently have a system from the past.

And it's not just me saying that. The people in community -- the communities that surround Westlake Hospital are voting with their feet to get medical care --

UNIDENTIFIED AUDIENCE MEMBERS: Liar, liar.

DR. WHITAKER: -- from hospitals, clinics, and locations.

The numbers and facts bear this out. At Westlake Hospital there are fewer overall inpatient visits, dropping to around 4,100 last year, down from around 4,800 two years before.

The service area where Westlake Hospital sits has an oversupply of 473 extra medical/surgical and pediatric beds, according to the Inventory of Health Care Facilities and Services and Needs Determination, which serves as the definitive statement of health care needs in the state of Illinois, which this body uses itself.

On average, as you've heard multiple times today, Westlake is 70 percent empty daily and is the last chosen among 10 hospitals in our service area. To think that we're going to be able to reverse this trend that has been set in motion by the Federal government with the passage of the Affordable Care Act, changes by the State of Illinois with its Medicaid managed care plan, and private insurance is foolhardy. Worse, it leaves citizens with an inefficient system that doesn't invest in them.

Even with the Westlake Hospital closure, the region will not be without hospitals or major medical centers. In fact, there will be three nearby, including West Suburban, which is about 4 miles away; Gottlieb Memorial Hospital, a Level II trauma center in Melrose Park, 1.5 miles away; and Loyola Medical Center, a Level I trauma center as well as a stroke center, at 3 miles away. Municipalities the size of Melrose Park often are lucky to have one hospital nearby, let alone three.

To maintain Westlake Hospital in its current form is to maintain the past. Westlake Hospital can't safely provide for the latest technology and services needed for quality care because it needs $30 million in upgrades to facilities, equipment, and information technology.

We would rather invest in patients, not buildings. That's why Pipeline put forth a commitment of $2.5 million to invest in ambulatory care with 500 -- at least 500 of that going to a Federally qualified health center, PCC Wellness, that would be on the Westlake campus.

Let's be clear. We do not relish closing

the hospital. Pipeline Health, rooted in a commitment to turn around community health care delivery, has never shut down a hospital despite working in other challenging environments in both Los Angeles and Dallas.

And the irony of all the discussions that have been held today is that if Westlake Hospital did not exist and Pipeline came here and proposed to build it in its current form, capacity, and location, this Board would not approve it because of the severe overbedding in the area. Instead, outpatient centers that are designed to improve population health would be what should be built.

There are a few other -- there are few things as personal as health care, and I realize that hospitals are more than just buildings. For many people it's where they were born, where they had their kids or have seen loved ones pass away. I understand that.

For me, I was born in Michael Reese Hospital on the South Side of Chicago. My mother trained as a nurse there when black women could only get their education at Michael Reese or Cook County Hospital. She worked there for

30 years. My two brothers and I were born there. I had my first summer job there and worked 20 hours a week there through my junior and senior years of high school.

I dreamed of practicing medicine there one day but never got that opportunity because the hospital was closed in 2008 after first opening in 1881.

As unfortunate as that was for my personal dreams, I know that, in the end, delivering the best quality health care cannot be based on a building. It must be based on what's best to serve this region's needs in a proven way that results in high-quality, cost-effective care, independent of the building or how we have always done things.

I hope the Board will approve our application to do just that. Thank you for the opportunity to testify today.

CHAIRMAN MURPHY: Thank you.

Are there any questions or comments from Board members?

(No response.)

CHAIRMAN MURPHY: You don't have further

comments, do you?

MS. MURPHY: No. I was just going to offer that any of the four of us could answer any questions that Board members have.

CHAIRMAN MURPHY: Thank you.

Are there any questions or comments from Board members?

(No response.)

CHAIRMAN MURPHY: Okay. George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by McGlasson; seconded by Hamos.

Senator Demuzio.

MEMBER DEMUZIO: I'm going to go -- I'm going to go ahead and vote -- I've heard so much today, and I totally appreciate your comments about not wanting to close down a hospital.

I come from a small area so I know the impact; however, as we move forward, I guess we do have to look at what innovation, what's new, and where we go from there.

So I hope that, as you move forward, that you keep the residents of that location and of

Melrose to -- to really keep them in your heart and mind as you move forward.

So I'm going to go ahead and vote yes with the understanding and hope that you will always keep those residents in your heart.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: I vote yes based on my understanding of the law as explained by the general counsel and would also add my voice to many, many others about your -- the importance of your contributions to not just facilities but to the health of the people who rely on those facilities and the access to primary care as we've already described.

So we're trusting you to move ahead in that responsible fashion and I vote yes.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes. I vote yes because the law, to me, seems very clear, "An exemption shall be approved when information required by the Board by rule is submitted."

And so, as earlier -- I stated I think the

law is important here and that's what the legislature intended.

Dr. Whitaker, you weren't here earlier when we talked about hospital transformation being the future of the changes in the health care delivery system, and we hope very much -- not just hope but really encourage you not just to hold them in your heart, as my colleague said, but also to really actively use your power and stature in this state to really move ahead and look at the community needs and the employer needs but also to accomplish hospital transformation along with this change.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: The law requires me to vote in favor of this, but my heart is breaking for all the thousands of people who won't have access to care. They won't get to West Suburban, they won't get to Gottlieb, and you've abandoned them.

But, again, I vote yes.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: I vote yes based on

the State report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: This is a dilemma on a vote because you have the emotional vote and you have the realization vote.

I think there has been a public relations issue of dealing with the community, and what I encourage is dealing with the community more effectively because you can't continue losing $2 million a month -- or a little more than 2 million a month. Changes need to be made no matter what.

So I would vote yes because of the law but encourage you to work with the community during the transition for the property.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Based on the successfully completed State Board staff report and requirements, I am forced to vote yes.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Your exemption is

approved.

Thank you.

MS. MURPHY: Thank you.

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CHAIRMAN MURPHY: Next on the agenda is C-02, Project E-005-19, US Renal Care Villa Park Dialysis.

This is going to be a series of change of ownership so there's -- one, two, three -- there's seven of them. We are going to have to take each one of them individually.

So may I have a motion to approve Exemption E-005-19, US Renal Care Villa Park Dialysis, to approve a change of ownership transaction.

MEMBER MC NEIL: So moved.

CHAIRMAN MURPHY: Second?

(No response.)

CHAIRMAN MURPHY: Second?

MS. MITCHELL: Second?

CHAIRMAN MURPHY: Somebody?

MEMBER GELDER: I'll second.

CHAIRMAN MURPHY: Thank you.

Will you please state your name and then be sworn in.

MR. DOMSTEN: My name is Ethan Domsten, counsel for the Applicant.

CHAIRMAN MURPHY: Can you please state

your name louder.

MR. DOMSTEN: Ethan Domsten, counsel for the Applicant, D-o-m-s-t-e-n.

MS. MONTAGUE: Valerie Montague, counsel for the Applicant, V-a-l-e-r-i-e M-o-n-t-a-g-u-e.

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

(Two witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN MURPHY: Mike, will you please give the State Board staff report.

MR. CONSTANTINO: Thank you, Ms. Murphy.

US Renal Care, Inc., a provider of dialysis service in the United States, is being acquired by a private equity investor group at a cost of approximately 2.3 to $2.8 million. This is a nationwide transaction. US Renal Care operates in 32 states and the territory of Guam.

US Renal Care owns seven ESRD inpatient dialysis facilities in Illinois. They're certified entities and the owners of the sites are not changing because of this change of ownership.

No public hearing was requested, and no letters of support or opposition were received.

All the information for all seven exemption applications we received has been provided by the Applicants.

Thank you, Ms. Murphy.

CHAIRMAN MURPHY: Thank you.

Do you have a statement or comment for the Board?

MR. DOMSTEN: No.

MS. MONTAGUE: We do not.

CHAIRMAN MURPHY: Are there any questions from Board members?

(No response.)

CHAIRMAN MURPHY: Okay. George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by McNeil; seconded by Gelder.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on staff report.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report and the knowledge that this is a national issue, not just Illinois.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: 7 votes in the affirmative.

CHAIRMAN MURPHY: Your exemption is approved.

We will move to the next one.

MEMBER HAMOS: Madam Chair --

CHAIRMAN MURPHY: Yes.

MEMBER HAMOS: -- isn't it possible to combine these into --

MS. AVERY: No. We have to take them in a separate motion.

CHAIRMAN MURPHY: No, we can't.

MS. MITCHELL: We have to -- we have to have a separate record for them, so that's why --

MS. AVERY: They can't hear you.

MS. MITCHELL: We have to have a record for each one of them.

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CHAIRMAN MURPHY: Next up is C-03, Project E-006-19, US Renal Care Bolingbrook Dialysis.

May I have a motion to approve Exemption E-009-19 [sic], US Renal Care Bolingbrook Dialysis, for a change of ownership transaction.

MEMBER MC NEIL: So moved.

CHAIRMAN MURPHY: Second?

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: You've already been sworn in and identified yourselves.

Do you need -- you don't need to do one for each thing.

Do you have any --

MS. MONTAGUE: We do not.

CHAIRMAN MURPHY: Are there any questions from Board members?

MEMBER MC NEIL: Call the question.

(Laughter.)

CHAIRMAN MURPHY: George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by McNeil; seconded by Senator

Demuzio.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report and testimony.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes, based on the report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on the fact that they didn't have testimony.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on staff report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Ditto. Yes, based on the staff report.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Yeah, based on the State Board staff report.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Your exemption is approved.

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CHAIRMAN MURPHY: Next is C-04, Project E-007-19, US Renal Care Hickory Hills Dialysis.

May I have a motion to approve Exemption E-007-19, US Renal Care Hickory Hills Dialysis, for a change of ownership transaction.

MEMBER MC NEIL: So moved.

CHAIRMAN MURPHY: Second?

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: Thank you.

You've been sworn in; we have the staff report. No comments; no questions.

George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Dr. McNeil; seconded by Senator Demuzio.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Okay.

- - -

CHAIRMAN MURPHY: Next up is C-05, Project E-008-19, US Renal Care Streamwood Dialysis.

May I have a motion to approve Exemption E-008-19, US Renal Care Streamwood Dialysis, for a change of ownership transaction.

MEMBER DEMUZIO: Motion.

CHAIRMAN MURPHY: Second?

MEMBER MC GLASSON: Second.

MEMBER MC NEIL: Second.

CHAIRMAN MURPHY: Thank you.

Stated. In. Statement. Questions? No.

George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Senator Demuzio; seconded by Dr. McNeil.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes, staff report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on staff report.
MR. ROATE: Thank you.
Ms. Hemme.
MEMBER HEMME: Yes, based on staff report.
MR. ROATE: Thank you.
Mr. McGlasson.
MEMBER MC GLASSON: Yes, based on the staff report.
MR. ROATE: Thank you.
Dr. McNeil.
MEMBER MC NEIL: Yes, based on the staff report.
MR. ROATE: Thank you.
Madam Chair.
CHAIRMAN MURPHY: Yes, based on the State Board staff report.
MR. ROATE: Thank you.
That's 7 votes in the affirmative.
CHAIRMAN MURPHY: Exemption's approved.

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CHAIRMAN MURPHY: Next up is C-06, Project E-009-19, US Renal Care Oak Brook Dialysis.

May I have a motion to approve Exemption E-009-19, US Renal Care Oak Brook Dialysis, for a change of ownership transaction.

MEMBER DEMUZIO: Motion.

CHAIRMAN MURPHY: Second?

MEMBER MC NEIL: Second.

CHAIRMAN MURPHY: Thank you.

George, will you please call the roll.

(Laughter.)

MR. ROATE: Thank you, Madam Chair.

Motion made by Senator Demuzio; seconded by Dr. McNeil.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes. I'm convinced by the staff report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based upon the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report.

MR. ROATE: Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Exemption approved.

- - -

CHAIRMAN MURPHY: Next on the agenda is C-07, Project E-010-19, US Renal Care Dan Ryan Dialysis.

May I have a motion to approve Exemption E-010-19, US Renal Care Dan Ryan Dialysis, for a change of ownership transaction.

MEMBER DEMUZIO: Motion.

CHAIRMAN MURPHY: Second?

MEMBER MC NEIL: Second.

CHAIRMAN MURPHY: Thank you.

George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Demuzio; seconded by McNeil.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes, staff report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Exemption is approved.

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CHAIRMAN MURPHY: And, finally, C-08, Project E-011-19, US Renal Care Scottsdale Dialysis.

May I have a motion to approve Exemption E-011-19, US Renal Care Scottsdale Dialysis, for a change of ownership transaction.

MEMBER DEMUZIO: Motion.

CHAIRMAN MURPHY: Second?

MEMBER MC NEIL: Second.

CHAIRMAN MURPHY: Thank you.

George, will you please call the roll.

MEMBER GELDER: Can I ask a question?

CHAIRMAN MURPHY: Sure.

MEMBER GELDER: Where does Scottsdale come into this?

MR. DOMSTEN: This Scottsdale facility is located in Chicago.

CHAIRMAN MURPHY: That's just the name of the facility. It's not Arizona.

MEMBER GELDER: They were all locations. Okay.

MR. ROATE: All right. Motion made by Demuzio; seconded by McNeil.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes, staff report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on staff report.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on staff report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on staff report.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Congratulations.

MS. MONTAGUE: Thank you very much.

CHAIRMAN MURPHY: All your exemptions are approved.

MR. DOMSTEN: Thank you.

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CHAIRMAN MURPHY: Okay. Next up we have C-09, Project E-013-19, Naperville Fertility Center.

May I have a motion to approve Exemption E-013-19, Naperville Fertility Center, for a change of ownership transaction.

MEMBER DEMUZIO: Motion.

CHAIRMAN MURPHY: Second?

MEMBER MC NEIL: Second.

CHAIRMAN MURPHY: Thank you.

You've already identified yourselves; you've already been sworn in.

MS. AVERY: Identify yourselves for the record.

CHAIRMAN MURPHY: Oh. Can you identify yourselves for the record.

MR. SILBERMAN: Mark Silberman.

MR. MORADO: And Juan Morado.

CHAIRMAN MURPHY: Thank you.

Mike, can we have the State Board staff report?

MR. CONSTANTINO: Thank you, Ms. Murphy.

In September of 2017 the Chair of the State Board approved the sale of Naperville

Fertility Center, a single-specialty ASTC, to DMG Practice Management Solutions, LLC, at a cost of approximately $5.8 million from the Jody L. Morris Trust.

Today, Jody L. Morris Trust and Randy S. Morris, MD, are requesting that the Board approve the sale of Naperville Fertility Center from DMG Practice Management Solutions, LLC, for approximately $5.8 million.

The facility will continue to provide the same services; there will be no change in the owner of the site or the operating entity licensee. The expected completion date is July 10th, 2019.

No letters of support or opposition were received, and there was no request for a public hearing.

All the information required by the State Board has been provided.

CHAIRMAN MURPHY: Thank you.

Do you have any comments for the Board?

MR. SILBERMAN: Very briefly.

Simply put, this project is why pencils have erasers.

MEMBER HAMOS: What?

MR. SILBERMAN: 18 months ago --

MS. AVERY: "Pencils have erasers."

MEMBER HAMOS: You said what?

MR. SILBERMAN: "Pencils have erasers."

18 months ago Dr. Morris sold his practice and surgery center to DuPage Medical Group. 18 months later, everyone is in agreement that was not an ideal decision, and this transaction is to unwind.

Dr. Morris will take back over the surgery center and the practice. Care will continue unabated, as it has, to the community.

CHAIRMAN MURPHY: Thank you.

Are there any questions or comments from Board members?

(No response.)

CHAIRMAN MURPHY: George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Demuzio; seconded by McNeil.

Senator Demuzio.

MEMBER DEMUZIO: Yes. I vote yes on the

testimony.

And can I ask a question?

CHAIRMAN MURPHY: Yes.

MEMBER DEMUZIO: Okay. Can you tell me why he left or why he went back?

MR. SILBERMAN: No, he's been practicing there the entire time.

MEMBER DEMUZIO: Oh, he has been?

MR. SILBERMAN: I think administratively he and everyone felt it operated better when it was under his control.

MEMBER DEMUZIO: Perfect. Perfect.

Yes. Based upon the State --

MS. MITCHELL: I don't mean to interrupt -- I'm sorry -- but we're taking a roll call. So it's kind of not time for discussion right now.

MS. AVERY: Sorry.

MS. MITCHELL: I apologize.

MEMBER DEMUZIO: Okay.

I vote yes.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes, based on the staff

report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on testimony and staff report.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report and some unintended testimony.

(Laughter.)

MR. ROATE: Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Your exemption is

approved. Thank you.

MR. SILBERMAN: Thank you.

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CHAIRMAN MURPHY: Next on the agenda, C-10, Project E-014-19, Peoria Ambulatory Surgery Center.

May I have a motion to approve Exemption E-014-19, Peoria Ambulatory Surgery Center, for a change of ownership transaction.

MEMBER MC NEIL: So moved.

CHAIRMAN MURPHY: Thank you.

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: Thank you.

You are still here. Will you please identify yourselves for the record.

MR. SILBERMAN: Mark Silberman.

MR. MORADO: And Juan Morado.

CHAIRMAN MURPHY: Thank you.

Mike, will you please give the State Board staff report.

MR. CONSTANTINO: Thank you, Ms. Murphy.

In January of this year, the State Board approved a sale of the Peoria Ambulatory Surgery Center to two physicians for $2 million. Peoria Ambulatory Surgery Center is a single-specialty ASTC providing plastic surgery.

In March of 2019 the State Board approved

the relinquishment of that exemption, E-062-18, because the sale could not be finalized.

Today they're back before you again asking you to approve a change of control resulting in -- a change in the control of the ASTC licensed entity. There is no change in the licensee or owner of the site. The expected completion date is July 10, 2019.

No letters of support or opposition were received, and there was no request for a public hearing.

All the information required by the Board has been provided.

CHAIRMAN MURPHY: Thank you.

Do you have a statement for the Board?

MR. MORADO: Yes. I'll be quick, as well.

This one might hold the record for the most consecutive appearances at the Board meeting for one Applicant.

But the reason is, as Mr. Constantino described, we had an original change of ownership that was approved in January, and then, as required by your rules, because that transaction couldn't close, we relinquished the permit, filed

a relinquishment and appeared before you, and that was approved, as well.

We're here today, now, for a new transaction that's going to change operational control of the facility. You'll notice that the price point is exactly the same as the previous application. We're still dealing with Dr. Soderstrom, who's been practicing for 40 years in the community, was looking to relieve some of the administrative burden associated with practicing medicine, and he's found that new partner now.

The facility continues to operate. There has been no change in the categories of service or the hours that the facility's been operating, and that will not change subsequent to this transaction.

Thank you.

CHAIRMAN MURPHY: Thank you.

Are there any questions or comments from Board members?

MEMBER MC GLASSON: Yeah.

Have you guys discovered a new niche in your market?

MR. MORADO: Yes. Back and forth, back and forth. Please let everyone know.

(Laughter.)

CHAIRMAN MURPHY: Okay. George, can you please call the roll?

MR. ROATE: Thank you, Madam Chair.

Motion made by McNeil; seconded by Demuzio.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon staff report and testimony.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes, based on the testimony and staff report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on testimony and the staff report.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on testimony and staff report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report, the ongoing explanations of what has happened to relieve the administrative burden.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Your exemption is approved.

MR. MORADO: Thank you.

MR. SILBERMAN: Thank you.

CHAIRMAN MURPHY: Oh, you're getting up.

MR. MORADO: Yes, finally. We'll be back.

MR. SILBERMAN: Billie told me I have to leave now.

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CHAIRMAN MURPHY: Next on the agenda is C-11, Project E-015-19, Methodist Hospital of Chicago.

May I have a motion to approve Exemption E-015-19, US Methodist Hospital of Chicago, for a change of ownership transaction.

MEMBER MC NEIL: So moved.

CHAIRMAN MURPHY: Second?

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: Thank you.

Will you please state your names and then be sworn in.

MS. PAIGE: Billie Paige, consultant to Thorek Medical Center.

MR. KAMBEROS: Pete Kamberos, COO.

THE COURT REPORTER: I'm sorry. I didn't understand a word you said.

MR. KAMBEROS: Pete Kamberos, K-a-m-b-e-r-o-s, COO.

THE COURT REPORTER: Thank you.

MR. HEINRICH: Tim Heinrich, H-e-i-n-r-i-c-h, chief financial officer.

MR. BUDD: Edward Budd, B-u-d-d, president and CEO of Thorek Hospital.

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

(Four witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN MURPHY: Thank you.

Mike, can you please give the State Board staff report?

MR. CONSTANTINO: Thank you Ms. Murphy.

Thorek Memorial Hospital is requesting approval to purchase Methodist Hospital of Chicago, a 145-bed acute care hospital, at a cost of approximately $22 1/2 million.

Part of that purchase price includes the sale of a 245-bed sheltered care facility, Bethany Retirement Home -- I'm sorry -- a 254-bed sheltered care home. The State Board does not have jurisdiction over the sale of sheltered care facilities.

The licensee and the owner of the site of the hospital will be Thorek Memorial Hospital. The expected completion date is June 30th, 2019. No letters of support or opposition were received, and there was no request for a public hearing.

All the information required by the

State Board has been provided.

CHAIRMAN MURPHY: Thank you.

MR. CONSTANTINO: Thank you.

CHAIRMAN MURPHY: Do you have any statements or comments for the Board?

MS. PAIGE: Good afternoon.

We are here to, hopefully, get your approval for Thorek Memorial Hospital to purchase the assets of Methodist Hospital of Chicago.

We thank the staff for all their hard work. And because we have a positive staff report, we will wait for any questions the Board may have.

CHAIRMAN MURPHY: Thank you.

I have a question/comment.

Based on what's been going on here today with other situations, could you please expand on your statement that you are going to do a comprehensive review of all your services and affirm that you will not have a more restrictive charity care policy that's been in effect from the last year for the following two years?

So, basically, what do you plan to do?

MS. PAIGE: Well, once the hospital has

been -- once the deal has closed --

CHAIRMAN MURPHY: Yes.

MS. PAIGE: -- we plan to take a look at everything, both at Thorek and at Methodist, to determine how best to serve the community.

And once that is done, we will determine those services or whether there needs to be remodeling, rehabbing, whatever to make better health care for the community. And for anything that we do that requires a permit from this Board, we will certainly return to this Board and request one.

CHAIRMAN MURPHY: I would just like to note that facilities are very close in proximity and very similar in their profiles.

MS. PAIGE: 2 miles apart.

MEMBER HAMOS: Yes.

CHAIRMAN MURPHY: Are there other questions or comments from Board members?

MEMBER GELDER: Yes.

CHAIRMAN MURPHY: Yes, Mr. Gelder.

MEMBER GELDER: So could you describe the differences and similarities as you see it now between -- you've done a fair amount of due

diligence on the acquisition of -- what -- yeah.

MS. PAIGE: I'm sorry, Mr. Gelder. Could you say the end of that again, please?

MEMBER GELDER: I was just looking for your perspective and a statement about what you see as the similarities and differences of the two facilities as you pursue your due diligence on the acquisition.

MS. PAIGE: Mr. Budd can explain.

MR. BUDD: Sure.

We're both acute care hospitals, obviously, very close to each over. We both provide inpatient and outpatient services, serve a high governmental population in our area.

We're very similar in medical and behavioral health services, as well, inpatient and outpatient. And Thorek has the more comprehensive services than Methodist.

Overall, we're very similar in the service that we provide in the community.

MEMBER GELDER: Given that -- given your statement of reviewing -- I forgot how it was that the staff framed it -- perhaps more artfully --

MEMBER HAMOS: We can't hear you.

MEMBER GELDER: Yeah. Sorry.

-- of how closely Thorek made a comprehensive review of all services provided by each hospital, so that review could -- you know -- could lead to a recommendation to close one or both of those? At least one of them?

MS. PAIGE: It's wide open. Absolutely. It can -- it runs the whole gamut.

One of the things is, you know, what services should remain where, which hospitals -- which hospital should do what. And, in fact, ultimately should both hospitals exist?

We have not made a determination on any of that. That's what we're going to do once we get your approval here and once we have done our review.

CHAIRMAN MURPHY: Do we have any other comments?

Yes, Ms. Hamos.

MEMBER HAMOS: I appreciate your candor because I'm looking at your data, and it shows that Thorek's occupancy rate in 2017 is 35.8 percent and Methodist is 38.5.

So are you not experiencing the same

financial pressures that we've heard about, that we heard about this morning?

MR. BUDD: I think it's safe to say it's difficult everywhere for all hospitals.

MEMBER HAMOS: Is this sustainable long term at this occupancy rate?

MR. BUDD: As individual hospitals, no. Working together and collaborating, yes.

CHAIRMAN MURPHY: That's been fun.

MEMBER GELDER: Can I ask one more question?

I was just curious about the Thorek -- the difference in the Thorek Medicare -- or specifically Medicaid -- ratios where Methodist is at about 50 percent and Thorek is at about half of that, I guess -- or was it -- 22 percent -- 22 percent.

What accounts for the difference, given your proximity and serving pretty much the same neighborhoods?

MR. HEINRICH: Well, at Thorek our Medicaid inpatient utilization rate is 83.3 percent, which is the highest acute care hospital. So the data that you're looking at may

be on paid claims because typically it's what it's based on.

But we know based on -- we're both State-mandated hospitals. Methodist has a very high Medicaid inpatient utilization rate. Ours is actually 83 percent so ours is -- in the data that's submitted based on paid claims -- actually higher, so we, I guess, win the award of having a higher Medicaid inpatient utilization rate than Methodist.

MEMBER GELDER: What -- can somebody -- maybe from the staff -- explain why the data that I'm looking at -- maybe I'm looking at the wrong page -- in Roman numeral II, Table 1, those numbers are very different.

MR. CONSTANTINO: Yes. That was the information we were provided with their annual hospital questionnaire.

To make it clear, we do -- those are management of the hospital's responsibility, not the staff. We do not do any review of these numbers other than an analytical review.

MEMBER GELDER: Okay. So maybe going from 80-some percent to 20 -- 22.3 percent seems like

a -- a -- not just a rounding error.

MEMBER HAMOS: No.

MS. PAIGE: I think what Mr. Heinrich was trying to explain is what you see there were paid claims. What he is talking about is utilization.

MR. HEINRICH: Right.

MS. PAIGE: They are two different things --

MR. HEINRICH: Right.

MS. PAIGE: -- you know, that -- I think.

MR. HEINRICH: Correct.

MS. PAIGE: And, therefore, that's the reason for the discrepancy. We reported what we were asked to report --

CHAIRMAN MURPHY: Thank you.

MS. PAIGE: -- on the annual -- on the questionnaire.

CHAIRMAN MURPHY: Any other questions or comments?

(No response.)

CHAIRMAN MURPHY: Okay. George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by McNeil; seconded by

Demuzio.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the testimony and the staff report.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes, based on the testimony and the staff report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on the testimony and staff report.

Good luck.

MR. ROATE: Thank you.

MS. PAIGE: Thank you.

MR. ROATE: Ms. Hemme.

MEMBER HEMME: Yes, based on testimony and staff report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report and the testimony.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: 7 votes in the affirmative.

CHAIRMAN MURPHY: Your exemption is approved. Thank you.

MS. PAIGE: Thank you, Madam Chairman and members of the Board.

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CHAIRMAN MURPHY: Next up we come to Item D, which is alteration requests.

On the agenda is D-01, Project 17-044, Smith Crossing, Orland Park.

May I have a motion to approve an alteration for 17-044, Smith Crossing, Orland Park, to increase debt financing for the project.

MEMBER DEMUZIO: Motion.

CHAIRMAN MURPHY: Is there a second?

Is there a second?

MEMBER HEMME: Second.

MEMBER MC NEIL: Yes.

CHAIRMAN MURPHY: Thank you.

Will you please state your names for the record and then be sworn in.

MR. KNIERY: Yes. Good afternoon.

My name is John Kniery with Foley & Associates, CON consultant.

With us today is Kevin McGee, CEO of Smith Senior Living. To his left -- to your right, I guess -- is Juan Morado, Jr., CON counsel with Benesch, as well as Mark Silberman of Benesch.

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

(Two witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN MURPHY: Thank you.

I just want to let you know we are going to take these next two alteration requests and then the Board is going to take a 10-minute break.

So, Mike, will you please give the State Board staff report.

MR. CONSTANTINO: Thank you, Ms. Murphy.

The permit holders are requesting approval of an alteration of Permit No. 17-044 that authorized the addition of 46 long-term care beds to an existing 46-bed facility for a total of 92 long-term care beds at a cost of approximately $22.2 million. This is the second alteration to this project.

In April of 2018 the permit holders were approved to increase the size of the project by approximately 1,600 gross square feet of space or 2.1 percent.

Today, the permit holders are asking to increase the amount of the debt financing by approximately $2.2 million, which, if approved, would make the funding for this project total debt

financing. There is no increase in the number of beds or scope of the project. No opposition or support letters were received by the Board.

The permit holders' alteration request meets the requirements of Part 1110 and of Part 1120.

Thank you.

CHAIRMAN MURPHY: Thank you.

Do you have a statement for the Board?

MR. KNIERY: If I may, thank you for considering this project as well as your staff for their work on this project, review of this alteration request.

I'd like to correct -- you know, point out one thing. The one original finding that was not in conformance this corrects from the original project, and that is the availability of funds is now -- would now be positive in that original review.

Due to the late hour -- I have to apologize, also -- we lost our CFO, so the rest of us are filling in for him, but we are prepared to answer any questions.

Just shortly or to summarize, this project

does what we said. We were able to shop this -- the loan for this project -- and get much favorable terms.

And with that, I'd answer any questions that you may have.

CHAIRMAN MURPHY: Great. Thank you.

Do we have any questions or comments from the Board?

MEMBER MC GLASSON: Question.

CHAIRMAN MURPHY: Yes, Mr. McGlasson.

MEMBER MC GLASSON: Does this extend the time for the project?

MR. MORADO: No. At this point it -- I apologize.

MR. KNIERY: Please.

MR. MORADO: We also can confirm for you that this project is otherwise on schedule and on budget. The alteration is going to provide the organization with the lowest form of financing and access to liquid cash.

So we're going to continue to meet the State's utilization rates, and once the project's complete, we'll be able to meet our obligation to you and the community.

And if you have any other questions, we'll be happy to answer those, as well.

CHAIRMAN MURPHY: Thank you.

Any other questions or comments from the Board?

(No response.)

CHAIRMAN MURPHY: Okay. George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Demuzio; seconded by Hemme.

Motion made -- Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon testimony and staff report.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Yes, based on the testimony and the staff report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on testimony and the staff report.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on testimony and

staff report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report and testimony.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Your alteration is approved. Thank you.

MR. MORADO: Thank you.

MR. KNIERY: Thank you.

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CHAIRMAN MURPHY: Okay. Next on the agenda is D-02, Project 17-019, SwedishAmerican Hospital in Rockford.

May I have a motion to approve an alteration for 17-019, SwedishAmerican Hospital, to decrease the size of the project.

MEMBER MC NEIL: So moved.

CHAIRMAN MURPHY: Second?

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: Thank you.

Will you please identify yourselves and be sworn in.

DR. BORN: Dr. Michael Born, the president and CEO of SwedishAmerican, and Jedediah Cantrell, vice president of operations.

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

(One witness sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN MURPHY: Mike, will you please give the State Board staff report.

DR. BORN: Thank you.

MS. CANTRELL: Not that Mike. That Mike. He's Mike, too.

MR. CONSTANTINO: Thank you, Ms. Murphy.

The permit holders are requesting approval of an alteration of Permit No. 17-019 that authorized a major modernization of SwedishAmerican Hospital at a cost of approximately $126 million. This is the first alteration to this project.

Today, the permit holders are asking approval to reduce the gross square footage from 342,236 gross square feet to 328,656 gross square feet or 13,580 gross square feet or approximately 4 percent. In addition, the alteration asks to reduce the number of approved ER stations by 9 stations, from 50 stations to 41 stations.

No opposition or support letters were received by the Board. The permit holders' alteration request meets the requirements of Part 1110 and Part 1120.

Thank you.

CHAIRMAN MURPHY: Thank you.

Do you have a statement for the Board?

DR. BORN: Yes, I do.

I'm Dr. Michael Born, the president and CEO of SwedishAmerican. I last met you in

February of 2018, at which time this Board approved this $126 million modernization project, which had been filed initially in September of 2017, and I appreciate this opportunity to provide some very brief remarks regarding our request for an alteration to the permit.

There are two components of project costs which are slightly out of conformance with the provisions of Part 1120.

First, the construction costs exceeded the State standard of $452 per square foot by $12. The primary drivers for that were the delay in starting the project, unanticipated steel tariffs, and an unanticipated construction cost index spike in Northern Illinois.

The second area was in architectural/ engineering fees, which are 10.3 percent or less than 1 percent above the high end of the range for State standards. The primary driver for this was the additional value engineering work necessary to prepare the alteration request. This alteration request does not increase the approved project cost of $126 million.

Thank you for consideration, and we'd be

happy to answer any questions.

CHAIRMAN MURPHY: Thank you.

I do have one question. It was just -- I was curious.

If your allotment is being reduced by approximately 3.96 percent, your space, why are the project costs remaining at the previously approved level? Why aren't those also going down?

MS. CANTRELL: Hi. Again, my name's Jedediah Cantrell.

That's a very good question, and it's the reason we're here today.

Because, ultimately, the cost of the project was higher than we anticipated, so we needed to make adjustments in the project. With those adjustments we were able to continue with the new construction portion of the project, but in the modernization area, that's where we were able to make some -- take a step back, make some adjustments, and spend less money there.

It cost us more on the front end, so we were trying to figure out how to make it cost us less on the back end. At the end of the day, that meant the price stayed the same. So, for

example's sake, what was going to cost $12 now costs $18, but we still had a $12 budget, so we were working within that.

CHAIRMAN MURPHY: Okay.

MS. CANTRELL: Okay.

CHAIRMAN MURPHY: That's perfect. Thank you very much.

Are there any other questions or comments from Board members?

(No response.)

CHAIRMAN MURPHY: Okay. George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by McNeil; seconded by Demuzio.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the testimony and the staff report.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: I abstain.

MR. ROATE: Ms. Hamos.

MEMBER HAMOS: Yes, based on staff report and testimony.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on the staff report and testimony here today.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report and the testimony showing how you balanced the budget one way or the other.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: Yes, based on the State Board staff report.

MR. ROATE: 7 votes in the -- 6 votes in the affirmative, 1 recused.

CHAIRMAN MURPHY: Your alteration is approved. Thank you.

MS. CANTRELL: Thank you very much.

DR. BORN: Thank you.

CHAIRMAN MURPHY: Thank you.

We are now going to take a 10-minute break.

(A recess was taken from 4:48 p.m. to 5:02 p.m.)

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CHAIRMAN MURPHY: We're going to get started. Okay.

All right. We have no declaratory rulings or other business.

We have no health care worker self-referral.

There are no status reports on conditional or contingent permits.

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CHAIRMAN MURPHY: So now we come to letter H on our agenda, which is applications subsequent to initial review.

First up, H-05, Project 19-005, Memorial Hospital of Carbondale.

May I have a motion to approve Project 19-005, Memorial Hospital of Carbondale, to build out existing shell space on the campus of its hospital in Carbondale.

MEMBER MC NEIL: So moved.

CHAIRMAN MURPHY: Second?

MEMBER HEMME: Second.

CHAIRMAN MURPHY: Will you please state your names for the record and then be sworn in.

THE WITNESS: Sure.

My name is Philip Schaefer. I'm a senior vice president for Southern Illinois Health Care in Carbondale.

MS. BLYTHE: Hi. I'm Cathy Blythe, Cathy with a "C"; B-l-y-t-h-e. I am the system planning manager for Southern Illinois Health Care.

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

(Two witnesses sworn.)

THE COURT REPORTER: Thank you. And please print your names.

CHAIRMAN MURPHY: Thank you.

Mike, will you please read the State Board staff report.

MR. CONSTANTINO: Thank you, Ms. Murphy.

In March of 2014 the State Board approved a large modernization project at Memorial Hospital of Carbondale at a cost of approximately $52.4 million.

At that meeting the Board approved shell space and, today, the Applicants are here seeking approval to build out that shell space at a cost of approximately $4.9 million. This project will also add 8 medical/surgical beds for a total of 99 medical/surgical beds as part of this build-out.

There was no request for a public hearing, and no support or opposition letters were received by the Board.

On page 3 of your report, the Board staff found the Applicants did not meet the Board's standard for modernization and contingency costs. An excellent, excellent explanation of that

difference is at the end of your report.

Thank you.

CHAIRMAN MURPHY: Thank you.

Do you have any statements for the Board?

MR. SCHAEFER: We have a very eloquent and long presentation that we would love to share with you --

MEMBER HAMOS: Please do.

MR. SCHAEFER: -- but, truthfully, the project is in excess of the State standards because we have to meet the seismic requirements. We're in the New Madrid earthquake zone.

And this is empty space. It is really concrete floors, girders. There are no doors. There's no electricity, no plumbing. It all needs to be finished out to make it into patient rooms. Those two factors together caused this to go over the State standard.

And we'd be happy to entertain any questions that you might have.

CHAIRMAN MURPHY: Thank you. That was very eloquent. I appreciate your brevity.

Do we have any comments or questions from the Board members?

(No response.)

CHAIRMAN MURPHY: Seeing none, George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by McNeil; seconded by Hemme.

Senator Demuzio.

MEMBER DEMUZIO: Excuse me. I vote yes.

MR. SCHAEFER: Thank you.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: I vote yes based on the testimony.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Yes, based on testimony and staff report.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on the staff report and the overage that was provided -- the overage explanation provided at the end of the report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff report, including the explanation.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the staff report and the building costs exacerbated by the Madrid potential earthquakes.

MR. SCHAEFER: Thank you.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: I vote yes based on the State Board staff report and today's explanation for the reasons for noncompliance.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Your application for permit is approved.

Thank you for traveling all the way up here from Carbondale for your few minutes of fame.

MS. BLYTHE: Thank you very much.

MR. SCHAEFER: No, thank you to the Board and thank you to the staff.

CHAIRMAN MURPHY: Thank you.

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CHAIRMAN MURPHY: Next on the agenda is H-01, Project 18-047, Ophthalmology Surgery Center of Illinois.

May I have a motion to approve Project 18-047, Ophthalmology Surgery Center of Illinois, to add surgical services to an existing multispecialty ASTC.

MEMBER MC NEIL: So moved.

CHAIRMAN MURPHY: Second?

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: Thank you.

Will you please state your names for the record and then be sworn in.

MS. FRIEDMAN: Kara Friedman.

MR. BECTON: Wes Becton.

MS. LINDSAY: Christine Lindsay.

MS. COOPER: Anne Cooper.

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

(Four witnesses sworn.)

THE COURT REPORTER: Thank you. Please print your names on one of those sheets.

CHAIRMAN MURPHY: Mike, will you please give the State Board staff report.

MR. CONSTANTINO: Thank you, Ms. Murphy.

The Applicants are asking the Board to approve a single-specialty ASTC for two operating rooms and eight recovery stations in approximately 5900 gross square feet of leased space in Itasca, Illinois, at a cost of approximately $4 million.

A public hearing was held on this project on February 13th, 2019. Opposition and support letters have been received by the State Board staff.

An impact letter was received from Advocate Aurora Health and Midwest Center for Day Surgery indicating that, should this project be approved, that approximately 35 percent of Midwest Center for Day Surgery will lose a portion of their caseload.

As provided on page 3 of your report, the Applicants have not met all the requirements of the State Board.

Thank you, madam -- thank you, Ms. Murphy.

CHAIRMAN MURPHY: Thank you.

Do you have a statement for the Board?

MR. BECTON: We do.

First of all, thank you for your service.

I was appointed to a state university board. I was the chair and my first meeting lasted 12 hours. So, hopefully, we won't meet that record but thank you all for your service.

In Illinois and in the greater metropolitan Chicago area, there's a need for access to high-quality and affordable surgical care for patients that need eye surgery, most critically for low-income patients participating in the Medicaid programs. We have demonstrated that a need currently exists and this need currently is going unmet.

We believe this Board has a unique opportunity to improve access to high-quality care for underserved populations and to conserve valuable resources for taxpayers in the state of Illinois by approving this project.

SCA, another provider, which is the only opponent to this proposal, is more concerned with making money and less concerned with being a part of the health care safety net to provide access for patients to high-quality ophthalmologic care.

At the Ophthalmology Surgery Center of Illinois, we will perform eye surgery in a safer,

more efficient, more inclusive, and more economically viable environment as a fully accredited single-specialty surgery center.

I'm the president of Kovach Eye Institute. This is the group currently affiliated with the planned center, and I'll be the chief executive officer for the Ophthalmology Surgery Center of Illinois.

Next to me is Christine Lindsay, who will be the director of operations for the surgery center.

I have over 20 years of experience in health care, almost 9 years as an administrator at the UIC in the college of medicine, and also previously been the administrator of two fully licensed ambulatory surgery centers in Illinois.

I also serve as a part-time surveyor for the Accreditation Association for Ambulatory Health Care, where I accredit ambulatory surgery centers throughout the country.

Christine has over 20 years of experience in the ophthalmology space and has seen the advancement of this specialty with the assistance of lasers and making those procedures affecting

the eye extremely accurate and safe when performed in the right environment.

I'd like to start with just a couple of things about eyes. First of all, optometrists are the primary care providers for eyes. They see the patients, they diagnose the disease, and then they refer them to an ophthalmologist for surgical care. And in many cases, we refer those same patients back to those optometrists for postoperative care.

We at Kovach Eye work with over 500 optometrists throughout the region who refer patients to us for surgical care. You were able to hear from Dr. Vince Brandys earlier. Dr. Hasan, unfortunately, had to leave. But we also received support letters from over 16 optometrists, other optometrists, who are thought leaders and provide primary eye care for patients throughout the Northern Illinois region.

In addition to those letters of support that we received from individual optometrists, we also received letters of support for our project from area stakeholders like the Illinois College of Optometry and the Illinois Optometry

Association. These are two organizations that represent the vast number of optometrists in the state.

It's because of our vast network of collaborating optometrists that our service area is so broad. That was one of the findings, that our services area is too broad. We don't see that as a negative, as you did in our assessment of our project, but we actually see that as a positive.

I'd like to refer you to a map, which I can leave -- it's also in our packet. It's a heat map that shows the 10-mile radius around our proposed surgery, with the darker green areas indicating where the majority of our patients come from. We have a broad reach because we have a vast network of referring optometrists.

The reason for this overwhelming support is, when optometrists refer patients, a lot of times they don't want to have to think about where they should refer them based on the insurance that the patient has, specifically the public aid and managed Medicaid patients. They refer them to our practice, and we provide surgical care for them.

We provide care to over 20 percent of our

patients who have Medicaid, and we have a proven track record of being a safety net provider. But oftentimes we have to tell our Medicaid patients that we do not have a surgical facility available that will accept these Medicaid patients because those surgery centers, specifically the ones opened by SCA, discriminate, and they don't allow Medicaid patients in their facilities. They just don't accept them.

We accept those cases, and then we have to take them to the hospitals, and those hospitals only allow limited access for those Medicaid patients. And I think everyone would agree that, for an outpatient procedure like cataract surgery, the hospital is a waste of a resource, not the right environment to do those cases.

We also run into issues with scheduling those cases and patient satisfaction as well as making sure is that we have qualified staff that are used to working on eyes to work with us on those patients.

We submitted a deidentified patient list that had approximately 200 names of patients who were waiting for a slot where we can take them for

cataract surgery. We obviously offered those patients the opportunity to go elsewhere, but, unfortunately, there just aren't a lot of locations where they can go, other ophthalmologists that will treat those Medicaid patients.

The surgery centers also discriminate against patients by asking us to take less-profitable cases to the hospital, whether those are stents for glaucoma surgery or, even as I was preparing this testimony, we were asked to not send as many patients that didn't speak English to the surgery center, and we've got an electronic copy of that communication.

Surgery centers that are opposing our project would also not purchase the technology and the lasers that we needed to provide the high-quality -- highest quality care for our patients.

So what happened, contrary to what was delivered in the testimony in opposition to our project, is we actually went out and purchased those lasers ourselves. They're our lasers but we have to pay those surgery centers to house our equipment in their facility. When this project is

approved, if this Board approves our project, those lasers and that technology will move with us to the Ophthalmology Surgery Center of Illinois.

As I mentioned earlier, hospital outpatient surgery departments are not the appropriate setting for cataract surgery, lots of data out there from both MedPac and the Healthcare Bluebook saying that hospital outpatient surgery departments are more expensive and the risk of infection is higher than it is in ambulatory surgery centers.

The optometrists who refer patients to our practice really don't have a lot of viable choices, as I mentioned, because other ophthalmology practices are not as open as we are to seeing their patients. As a single-specialty, eyes-only, ophthalmology-only ambulatory surgery center, we'll be able to create significant efficiencies that just don't exist in multispecialty ambulatory surgery centers because all we will do is surgery on the eyes.

We don't have to make a decision about whether to use a microscope for a spine procedure or an otolaryngology procedure or whether the

orthopedic team is now going to have to work on eyes. We'll only do one thing, eye surgery, and we will do it very efficiently.

The surgery center will allow for continuous process improvements and seamless coordination between the practice and the surgery center. We'll be able to provide the highest quality patient care at a price point that will provide savings to both patients and to the health care system in general.

We have received letters of support for our project from the Mayor of Itasca, the Itasca Chamber of Commerce, and Choose DuPage, which is a chamber-related group that promotes business in DuPage County, as well as from the Senate majority leader from the State of Illinois.

We will create jobs and we will hire well-trained and experienced health care professionals that will provide the highest quality care for our patients. We will improve the quality of all of our patients' lives by helping them to see better, which is our mission statement. We will meet the current needs and the future needs of the patients of the state of Illinois.

We'd also like to thank our banker, Sohila Parsinejad -- who is also here still if you have additional questions for us -- for attending this hearing today and to confirm the financial support from CIBC. They stand behind their commitment letter of providing financing for the project.

As a small, final item on the Board report, our architect included a small budget for interior design fees in the fee quote, which was probably better categorized as a consulting fee or interior designing fee, which caused a minor deviation in our architectural and design fees. Otherwise, our costs are in line with your standards.

I really want to thank you for your time, for giving us the opportunity to present our case. We feel very comfortable that, with the purpose, the scope, and the location of our project and our aim to improve access to services for the state's Medicaid population and to extend our safety net, that we have brought before you today a project that deserves your approval.

We ask for each of you to vote in favor of

it, and we're happy to take any questions.

Just one last point, though. The opposition, SCA, referenced a surgery center that we included in our response letter, which is Golf Surgery Center, which is located just at the edge of the 10-mile radius.

Golf Surgery Center did 6,312 cases in 2017, and they only allowed 51 Medicaid patients. That surgery center, first of all, doesn't have the block time available and, second of all, would not allow for all the Medicaid/public aid cases that we have to be done.

Thank you very much for your attention.

CHAIRMAN MURPHY: Thank you.

Does that conclude your comments for the Board?

MS. FRIEDMAN: Yes, it does.

CHAIRMAN MURPHY: Okay. Thank you.

Are there any questions or comments from Board members?

Yes, Ms. Hemme.

MEMBER HEMME: In your testimony --

THE COURT REPORTER: Use your mic, please.

MEMBER HEMME: Oh, sorry.

In your testimony -- is this on?

MS. AVERY: It's on. You've just got to get real close.

MEMBER HEMME: In your testimony today you mentioned both public aid and the need for Medicaid services; however, the area -- the geographic service area that you're locating this in is a rather high-rent district, where you probably wouldn't find a good chunk of the population that would be on public aid.

There is no -- there is no public bus service to get to that particular area -- I happen to know it because there's a business right across the street that I'm involved in, so I know exactly where you're located. And I don't understand why you're including information for public aid individuals -- how are they going to get to your facility?

MR. BECTON: That's a great question, and there are several ways that we'd like to look at this.

I refer back to the heat map -- thank you, Kara -- that we prepared.

The way that we receive our patients and

that way that they get to our offices is through the referral network that we have with those optometrists that are embedded in the communities that have high percentages of public aid patients.

They refer those patients, they're seen in our office, and then they're operated on at the surgery center. We chose this area because of its proximity to major interstates, and we also chose this location because we felt like it was an area that was central to where we were -- where our patient base was.

The patients don't have -- have not expressed issues getting to our offices, and they haven't expressed interest in -- excuse me -- have not expressed concerns getting to the surgery centers where we're currently working, either. We don't anticipate any concerns with them getting rides or getting to the location where we have the surgery center planned.

MEMBER HEMME: Okay. Thank you.

CHAIRMAN MURPHY: Yes, Mr. Gelder.

MEMBER GELDER: Okay. Well, thank you very much for that very helpful opening statement a few minutes ago. I appreciate that. You did

address -- there were several issues that I had some questions about, but there are still a couple of others.

Well, maybe we -- the staff report says that there -- for two criteria -- that there was not enough documentation that the loan would be available, and you're saying it is. You weren't able to convince our staff of that, so what's the status now?

MR. BECTON: So our banker was here and provided public testimony during the public hearing where she stated that our financing would be approved contingent on this group awarding us -- or approving the certificate of need.

Our banker is still here -- she's raising her hand right back there -- and, yes, that point, we believe, has been addressed sufficiently.

MEMBER GELDER: So can I ask Mr. Constantino or anyone else from the staff to --

MR. CONSTANTINO: Yeah. What we've been requiring is a letter from a bank -- if they're going to get bank financing -- that the letter state if the Board approves this CON, this loan

will be made. That language has to be in the letter.

Most of the letters we receive is regarding association, letter of intent to loan, well -- they come to the Board and say, "Well, I've got this great relationship with a bank," yet they can't get us this letter.

That's why the findings are there. I didn't see a letter that said that -- what we needed -- that if you approve the CON, this loan will be made.

MR. BECTON: Our banker is here and we'd be happy to have her sworn in and have her restate her position that, if the CON is granted, they provide financing if that would be helpful.

MEMBER GELDER: Well, that's -- let's get to that maybe in a little bit.

The other criteria that -- where it was being challenged by being in the staff report was the -- not improving access to services. Now, as I understand it, you're kind of refuting that. You're saying you will improve access to services.

So can someone help me understand why they

may not be improving access to services?

MR. CONSTANTINO: There's existing capacity in that area, 10-mile area. That's one thing.

And over the past five years, for ASTCs in Illinois, the average Medicaid percentage of review is 2 percent, not 10 percent, not 20 percent. 2 percent. And no charity care.

Now, I don't know where these numbers -- all this Medicaid population is coming from because we didn't see any indication of that in our information we received.

MR. BECTON: If I could just respond to that, in our letter to the certificate of need Board, we stated very clearly that, of our patient base, 20 percent of our patient base is Medicaid. In addition to that, 27.6 percent of our patient base is Medicare.

But 20 percent -- not 2 percent but 20 percent -- of our patient base is on Medicaid, and we would treat them as we would treat any other patient.

MEMBER GELDER: All right. So the way to get Medicaid business these days, under Medicaid

managed care, is to have contracts with the State's contracted managed care organizations.

With which MCOs do you have contracts?

MR. BECTON: So we have contracts with all of the major managed Medicaid payers as a practice, and we would anticipate getting those same contracts when we have a -- when the Ophthalmology Surgery Center of Illinois is approved.

So I could list them all, but I would not want to leave anyone out of that list --

MEMBER GELDER: There are --

MR. BECTON: -- but we listed it in our packet.

MEMBER GELDER: There are only six so why don't you give it a shot.

MR. BECTON: So we can start with Blue Cross Community, who is our largest. IlliniCare, Aetna Better Health, and -- I know -- Meridian. And if I'm leaving somebody out, it's a mistake.

But we accept all of the managed Medicaid payers as a practice, and that is cited as a practice in our application.

MEMBER GELDER: Okay. That -- thank you.

Then the last one about the architectural and engineering fees you addressed --

MR. BECTON: Yes, sir.

MEMBER GELDER: -- by saying that they had added something --

MR. BECTON: About $15,000.

MEMBER GELDER: -- into the A and E which should have been somewhere else?

MR. BECTON: Yes, sir.

MEMBER GELDER: Does that sound right?

MR. CONSTANTINO: It's the first I'm hearing that. I didn't know that.

MR. BECTON: So that was in our response letter back to the State. It was actually posted on the certificate of need Board's website.

CHAIRMAN MURPHY: We do have a copy of that.

MR. BECTON: Yes, ma'am.

MEMBER GELDER: Thank you very much.

MR. BECTON: Yes, sir.

CHAIRMAN MURPHY: Are there any other questions?

(No response.)

CHAIRMAN MURPHY: I know the financial

information was provided during public comment.

Did you want to have that sworn in and provided now as part of the record?

MS. FRIEDMAN: If that would be of use to anyone who feels that that would --

MR. BECTON: If that's the sense of the Board, we would be happy to do that.

CHAIRMAN MURPHY: Better safe than sorry.

MR. BECTON: Okay.

Sohila. I'll give her my seat.

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

(One witness sworn.)

THE COURT REPORTER: Thank you. And if you'd state your name again, please.

MS. PARSINEJAD: Sohila Parsinejad, P-a-r-s-i-n-e-j-a-d.

So I have known Dr. Kovach for the last 12 years, and I've helped him with his banking and financial --

CHAIRMAN MURPHY: Can you speak a little bit louder?

MS. PARSINEJAD: I'm sorry.

I've known Dr. Kovach for the last

10 years and he -- I'm a managing director at CIBC bank. They have full commitment and final approval to proceed as soon as they get approval from the Board.

CHAIRMAN MURPHY: Thank you.

MS. FRIEDMAN: Thank you.

CHAIRMAN MURPHY: Does that address -- Mr. Gelder, does that address your question?

MEMBER GELDER: Maybe just -- yes. Do you know why that wasn't in writing a month ago when you were filing this?

MS. PARSINEJAD: I provided a commitment letter --

MS. FRIEDMAN: It didn't have those buzzwords in it.

MS. PARSINEJAD: I see.

MEMBER GELDER: Are these --

MS. FRIEDMAN: I said it did not have those buzz- -- she provided a commitment letter. It did not have those buzzwords in it.

MS. PARSINEJAD: Right.

MEMBER GELDER: By commitment --

MS. PARSINEJAD: Commitment letter that the bank is committed to providing the funding for

the project.

MR. CONSTANTINO: I didn't see that. I needed that specific language, that if the CON was approved, the loan would be made.

That's the way I'm looking at all these that get bank financing.

MEMBER GELDER: No, I appreciate that and I'm obviously --

THE COURT REPORTER: I'm sorry. I can't hear you.

MEMBER GELDER: I appreciate that and I -- I'm learning, and I may be taking up too much time in my learning curve here today. So I apologize if anybody feels that way.

But a commitment letter usually has the word "commitment" in it, and that's the word you're looking for.

And yours didn't have it so I --

MS. PARSINEJAD: No, ours did have the words "commitment letter."

MS. FRIEDMAN: Right. I think that's a lesson for me, as well, that we need to make sure that it has the buzzword that, upon approval by this Board, that the loan would be

issued.

CHAIRMAN MURPHY: Mike, can you clarify? Because I know when you and I discussed this, you said it's not unusual for the Board to get commitment letters from the bank that don't necessarily say "upon approval from the Board."

MR. CONSTANTINO: That's the --

CHAIRMAN MURPHY: So we get a lot of commitment letters, but they're not always exactly worded the way we need them to be. So it's not unusual that we got this letter and it wasn't perfect, but that doesn't mean the commitment doesn't exist.

MS. PARSINEJAD: And I can provide that if needed.

CHAIRMAN MURPHY: Is that accurate, Mike?

MR. CONSTANTINO: Yes. We get a number of bank letters, but we need that specific language to have a positive finding on this report.

I -- you know, we've been doing this for quite some time, and this is not the first ASTC that's come before you, and the same finding has been there.

CHAIRMAN MURPHY: Right.

So that's a lesson to everyone in the audience, that your commitment letters need that language or you're going to get a finding.

Are there any --

MR. CONSTANTINO: I'd just like to make one other comment.

We're very limited on what we can review as far as financial information. Okay?

We don't ask for personal information; we don't ask for their personal income tax or their 1120s. So we have to accept their word that this money's going to come and they're good clients of these banks.

CHAIRMAN MURPHY: Thank you.

Are there any other questions or comments from Board members?

(No response.)

CHAIRMAN MURPHY: Okay. George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by McNeil; seconded by Demuzio.

Senator Demuzio.

MEMBER DEMUZIO: Yes. I vote yes based

upon the testimony and the clarification of the staff report. And, hopefully, that will get clarified. And I'll vote yes.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: Just to clarify, this is a motion to approve the application?

MR. ROATE: Yes, sir.

MEMBER GELDER: Okay. I vote yes, as well, based on the testimony provided here and clarification of some of the information that was in the staff report.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: I vote yes based on the fact that you're willing to and want to accept Medicaid clients. And we know how difficult it is for them to find specialists, especially in the suburbs and elsewhere.

So based on that and the staff report, I vote yes.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: I vote no based on the

fact that they are not in conformance with Criterion 1110.235, all three points.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the testimony.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the testimony and the report and specifically the banker under oath saying the money will be funded if this is approved.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: I vote yes based on the State Board staff report and today's testimony addressing the negative findings.

MR. ROATE: Thank you.

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

CHAIRMAN MURPHY: Congratulations. The motion passes. Your application for permit is approved.

Thank you.

MR. BECTON: Thank you very much.

MS. LINDSAY: Thank you.

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CHAIRMAN MURPHY: Next on the agenda is H-02, Project 18-050, Associated Surgical Center.

May I have a motion to approve Project 18-050, Associated Surgical Center, to add a surgical specialty to an existing multispecialty ASTC in Arlington Heights.

MEMBER DEMUZIO: Motion.

CHAIRMAN MURPHY: Second?

MEMBER MC NEIL: Second.

CHAIRMAN MURPHY: Thank you.

Is there anyone here to represent the Applicant?

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

MS. FRIEDMAN: I cannot defer. I'm not involved with that. I thought you told me they deferred.

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

CHAIRMAN MURPHY: So there's nobody here.

MS. AVERY: Who are we on?

CHAIRMAN MURPHY: The Associated Surgical.

MS. MITCHELL: They extended, didn't they?

MS. AVERY: I think we extended it.

MR. CONSTANTINO: I'm sorry.

MR. ROATE: It was deferred.

MR. CONSTANTINO: I'm sorry. I'm sorry, Kara.

MS. FRIEDMAN: I'm off my game.

MEMBER HAMOS: It was deferred voluntarily?

MR. ROATE: This is on the June agenda.

CHAIRMAN MURPHY: Okay. So that application has been deferred to the June agenda at the request of the Applicants; correct?

MR. ROATE: Yes, ma'am.

CHAIRMAN MURPHY: Okay.

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CHAIRMAN MURPHY: Then we will move to H-03, Project 19-003, River North Center for Reproductive Health.

May I have a motion to approve Project 19-003, River North Center for Reproductive Health, to establish a limited-specialty ASTC in Chicago.

MEMBER MC NEIL: So moved.

CHAIRMAN MURPHY: Second?

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: Thank you.

Will you please state your names for the record and then be sworn in if you haven't been already.

DR. UHLER: Dr. Meike Uhler, U-h-l-e-r.

MS. JASULAITIS: Sue Jasulaitis, director of medical affairs, J-a-s-u-l-a-i-t-i-s.

MR. WILLIAMSON: Marcus Williamson, W-i-l-l-i-a-m-s-o-n.

DR. SIPE: Dr. Chris Sipe, S-i-p-e.

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

(Five witnesses sworn.)

THE COURT REPORTER: Thank you.

Actually, you don't have to spell any more if you just print it on the sheet.

CHAIRMAN MURPHY: Thank you.

Mike, will you please give the State Board staff report.

MR. CONSTANTINO: Thank you, Ms. Murphy.

The Applicants propose to establish a limited-specialty ASTC with a total of three procedure rooms and a room to perform HSG. The cost of the project is approximately $15.6 million and an expected completion date of June 30th, 2021.

There was no request for a public hearing, and no letters of opposition were received. Letters of support were received by the Board staff.

The Board staff did have findings related to this project, and, once again, we did not accept the bank letter as evidence that the loan would be made.

Thank you, Ms. Murphy.

CHAIRMAN MURPHY: Thank you.

Do you have a statement or comments for the Board?

DR. UHLER: My name is Dr. Meike Uhler,

and I am a board-certified reproductive endocrinologist. I am also one of the principals of the River North Center for Reproductive Health.

I would like to thank you for your patience. There were many projects presented today for your consideration. For us, it is with much anticipation that we present our request today to establish a family-building ambulatory surgery center in Chicago, otherwise referred to as the IVF center.

Coincidentally, the timing of our proposal today is very appropriate, as last week was National Infertility Awareness Week. Every year the last week in April is designated as National Infertility Awareness Week to bring infertility awareness to the forefront, break barriers, and remove stigmas for anyone desiring to have a family. Infertility affects every one in eight couples with an estimated 7.3 million people affected.

With me today are my partner, Dr. Christopher Sipe, the planned medical director of the center; Sue Jasulaitis, director of medical affairs; Marcus Williamson, our planned

administrator; and Kara Friedman, legal counsel.

At our affiliated practice, Fertility Centers of Illinois, there are 11 physicians, initially all trained and board certified in obstetrics and gynecology with subsequent training through a fellowship in reproductive endocrinology and infertility.

We are known in lay terms as fertility specialists. We identify and treat fertility -- infertility issues to help people conceive a child. The sole focus of our practice is family building to help people become parents when infertility and, perhaps, other life circumstances have presented obstacles to this path.

This planned IVF center is associated with our long-established medical practice. Fertility Centers of Illinois is the largest group of fertility specialists in the Midwest and the third largest in the country.

We have achieved our outstanding reputation due to our high pregnancy rates and the ability to treat the most complex infertility issues. We have had more babies born than the next 10 IVF centers combined in the Chicagoland

area. Annually we perform over 7,000 cases, including 3,000 retrievals, egg retrievals, 4,000 embryo transfers, and 500 gynecological surgeries.

This wealth of experience has allowed us to offer patients all the available and most effective up-to-date treatment options for family building to manage complicated fertility situations.

As a result, we are very proud of our high rate of single-embryo transfers. By transferring only one embryo at a time, we decrease multiple births, which, in turn, decreases preterm delivery, infant mortality, and the corresponding economic burden to society.

There are five key reasons why we need to move our surgical operations and obtain an IDPH license. The first reason is there are physical constraints at our primary IVF location with no ability to expand our space and inadequate parking available for the patients and staff.

The second reason is due to the specialized nature of our work. As Dr. Sipe will explain, we must schedule our patients seven days

a week all year long. Timing of the egg extraction and embryo transfer is critical to our patients' outcome.

The third reason, we anticipate an increase in volume due to the Illinois law passed last year which mandates insurance coverage for cancer patients who need fertility preservation.

Additionally, every year we are increasingly seeing more and more patients for elective egg freezing since this fertility preservation strategy became an option for women six years ago.

The fourth reason is, with a fertility center, we will be able to manage more complex cases for patients with comorbidities whom we cannot treat in an office setting due to the life safety support needed to provide a safe environment for patients who may, for example, have cancer, be overweight, or have hypertension. We have seen this group expand as the population of patients who seek fertility treatment increases in age.

The final reason is the surgery center will allow our urology colleagues to provide

services to treat male infertility patients and gynecological surgeons to offer surgical procedures related to fertility services.

Physicians who are not part of our current practice cannot operate in our office facility, so the IDPH license will permit doctors outside of our practice to provide services essential to our patients.

Our plan is to enhance and centralize our surgical fertility services program at a freestanding location on the Near North Side of Chicago.

You have heard earlier this morning from our urology colleague Dr. Ohlander and former patients Monica Varri and Richard Greenberg, all individuals with fertility challenges who are able to have children thanks to assisted reproductive technology.

We would like to express our appreciation to them for coming forward with their support and sharing their experience of becoming a family. We are privileged to be able to help people have children, and this is the main focus of our practice. Our project has no opposition.

My colleagues, Dr. Sipe and Sue Jasulaitis, will describe our services in some technical detail to help you better understand the unique nature of our model due to the services we provide and the importance of providing these services in a dedicated environment adjacent to our advanced reproductive technology lab.

Thank you for your time, and I urge the Board to approve this project.

DR. SIPE: Good evening. My name is Dr. Chris Sipe. I'm a board-certified reproductive endocrinologist and the medical director of Fertility Centers of Illinois.

And our main job in creating families is to help create these: That is a human embryo. It is made from an egg and a sperm. It's a very sensitive environment.

Most couples can do this in the privacy of their own home, but, unfortunately, 15 percent of all couples are unable to achieve that goal, and that's when they start seeking infertility services. No one couple is -- every couple is unique. None are the same.

We have to do a workup on the woman in

every phase of her menstrual cycle, looking at her fallopian tubes, her ovaries, whether she has eggs, looking at her uterus. We need to check the man to make sure he makes sperm.

Once we've identified the root cause of infertility, we tailor our treatments to that individual couple. Most of the treatments can be done in a clinical setting, but IVF requires anesthesia and surgery, so we have to go to a different location to do that.

To create this embryo before you requires the woman taking one to three injections anywhere from 8 days to 20 days as her ovaries respond in different ways. Once the eggs are grown, we have to surgically remove them from the woman's body. We used to do this laparoscopically; now we're able to do it by placing a needle that's 18 inches long into the woman's vagina, puncturing the ovaries, puncturing each follicle that we have, and draining the fluid that is around the egg.

Immediately behind us and attached to the OR is our IVF lab, where we hand off the tube and the embryologist takes it to a sterile hood environment to then look and see if they can find

the precious eggs that are there. As one said this weekend, it was sort of like an Easter egg hunt.

Unlike most surgery which is planned well in advance, this can't be. The eggs have a short window in which they can become fertilized, and we typically have around 36 hours once we identify the eggs are ready, which means we have to do this procedure seven days a week, holidays, weekends, whatever time we need to do it for the patient, so we have to be on-call all the time. If you go too early, you get a bunch of eggs that are not useful; they're immature. If you go late, the eggs will degrade.

The IVF lab must be adjacent to the operating room, which is why a standard ASC can't accommodate us. The environment within the IVF lab has to have positive pressure that blows the gases of specific concentrations out from the IVF lab into the ambient area so -- adjacent -- so we don't have any infections or contamination going back into the lab.

Once we fertilize the egg, then we have to mimic the human uterus and the fallopian tubes and

incubators at very specific temperatures, pHs, and electrolyte concentrations and proteins to keep those eggs and embryos alive. Any contamination will result in wrong gasses missed or a temperature change and kill all of the embryos and will kill the eggs.

Once the sperm and the egg fertilize, we now have to put the embryo back in. It takes three to seven days for that embryo to grow into what you're seeing here before you.

Once we put it in, nine months later, I hope you end up with this, and that's really our goal. Our goal is to make families. One of our speakers earlier today said that her goal was to have a child from the minute she was a young woman and then she had difficulty later on in life, and that's what we help people with.

Over the years the average age of women seeking our services has increased significantly. That is reducing their fertility. We've seen a lot more patients over the last 10 years, and our IVF lab is now 13 years old, and we've run out of capacity. It's time that we have to expand.

At the same time, obesity is an epidemic

in the United States. And patients are becoming more and more ill, and the ability to do some of these cases in a safe setting in a clinic has been compromised or we've had to set limits on BMI and certain health conditions where we have to turn patients away.

Another issue driving the increase in demand and usage is what Dr. Uhler mentioned earlier, which is the egg freezing.

So a few years ago, women were empowered by the ability to freeze their eggs so that they could do their career, they could delay having families, or they could do whatever they wanted and it wasn't forced, but there is a biological clock. It's usually not talked about, but it's talked about readily online; it's talked about in National Infertility Awareness Week, and this is a really great way to empower women to not have to be forced into making a choice now but to preserve that option for the future. Last year alone we did over 200 cases of egg freezing for couples, and we expect that number, again, to go up.

As Dr. Uhler also mentioned, the Illinois legislature just passed a law requiring egg

freezing for women with cancer, and so we know that's going to increase the demand for our services.

Egg freezing is a very, very technical thing, and our embryologist is one of the people who helped write the textbook on egg and embryo freezing.

Chemotherapy and radiation used to kill cancer also kill a woman's eggs, so you've got to get the eggs out before. What that means is that you've got a matter of a few days to get them started on stimulation, and then you have to get them to the OR. Any existing ASC right now does not have the ability to do our 3,000 egg retrievals.

Some people have talked about transporting embryos and eggs from one IVF -- from one OR to the IVF lab. I'm not sure I want my precious cargo going on the streets of Chicago.

Another huge impediment to using any existing ASC is that we cannot plan these dates ahead of time. As I stated earlier, the eggs have to be harvested at a very specific time and the embryos have to be put back at a very specific

time. So with the seven days a week, holidays included, we do this all the time, and most ASCs are not designed to work on holidays and weekends.

I hope our -- my testimony has helped you understand the complexity of what we do and why we need a dedicated surgery center with an IVF lab attached to it.

Sue Jasulaitis will explain a bit more about the lab requirements before Marcus Williamson will assess the financial issues of the project.

Thank you.

MS. JASULAITIS: Thank you, Dr. Sipe.

I want to focus on two key points that are critical for a better understanding of our project.

The first is the essential nature of our assisted reproductive technology laboratory, which is combined with our surgical service, and secondly, again, the complex nature of the fertility patients in which we treat.

You could see from Dr. Sipe's pictures what we do is amazing. In vitro fertilization is a highly complex procedure designed to conceive a

baby outside of the womb.

To achieve this we need to replicate the precise environment inside the womb and re-create in a laboratory. This is no small undertaking. This process requires a highly specialized laboratory which is located alongside our surgical suite. Other surgery centers do not have anything like this specialized lab. Because of this, we cannot perform our IVF in any other surgical center.

To provide an analogy, it would be unthinkable to deliver your baby, then have the hospital put your newborn in a car and drive them to an off-site ICU. Our reproductive laboratory is an ICU for embryos. Like an ICU, it's critical for the success of our patients that the lab be housed together with the surgical arena.

As a highly specialized and complex laboratory, our assisted reproductive technology laboratory is credentialed by the College of American Pathologists. In addition to this lab credentialing, all of our experienced embryologists are credentialed by the American Board of Bioanalysis. This credentialing is

indicative of the high level of technical ability our embryologists possess, and we strongly feel this expertise lends to our high cumulative pregnancy rates.

To preserve the high standards in the reproductive laboratory, our lab director, Dr. Juergen Liebermann, maintains a continuous accreditation as a laboratory director of high complexity testifying. To qualify for this certification, a laboratory director must have a PhD in chemical, physical, biological, or clinical laboratory science and be certified by a government agency, such as the American Board of Bioanalysis.

Our reproductive laboratory director is world renowned in the field of reproductive embryology. Again, this expertise contributes to our high pregnancy rates and our ability to treat the most complex cases provided by our highly specialized scientists.

Due to his heightened experience, our lab director is also an auditor for the College of American Pathologists, which means he inspects other IVF laboratories to confirm that they are

current with accreditation.

Because of our elevated expertise in the area of reproductive medicine, not only do we have the highest utilization for single embryo transfers in the Chicagoland area, as Dr. Uhler mentioned earlier, but we are known in our success rate for treating even the most complex cases. These patients are often referred from other IVF centers, both locally and around the world, after their failure to become pregnant and these other centers.

Please understand these complex cases are difficult. Approximately 40 percent of our patients are of advanced maternal age, which we define as 40 years and older, many of whom have age-related associated medical conditions. These conditions require advanced care.

And as Dr. Sipe mentioned, we treat other patients, such as morbidly obese patients. These types of patients pose additional medical challenges while attempting pregnancy. Overall, our pregnancy rates, including these highly successful -- highly complex patients, is 50 percent, which is impressive considering both

the high complexity of our patients and our overall high patient volumes. This rate is higher than that of the national average for IVF pregnancies.

As I mentioned, we have a national reputation for our ability to treat the most complex reproductive cases. As a result, we see more patients for treatment but, unfortunately, we do have to turn patients away. The most difficult patients are turned away.

Complex patients who require surgery in conjunction with their reproductive treatment require substantive monitoring that cannot be done in our current office setting. Because we currently lack full-scale surgical resources combined with a specialized laboratory, we're currently unable to treat these patients effectively. We simply cannot accommodate most complex patients in our existing center.

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

MS. FRIEDMAN: I know Sue has some other comments, but given the time of the day, we're going to move on and just discuss the imperative we have around our real estate right now and,

hopefully, she will explain the complexity of the lab.

MR. WILLIAMSON: Thank you, Sue.

My name is Marcus Williamson. I'm the executive director of the Fertility Centers of Illinois and planned administrator for the ambulatory surgery center.

I'd like to describe the planning predicament we were placed in when our architects and zoning consultants brought to us the news that we couldn't expand our IVF services in our current location.

Relatedly, despite some suggestions that we should bring this project to you at a later date because the agenda was so challenging, it was essential for us to move ahead with the project. We didn't want to jeopardize a hefty interim deposit arrangement we had made with the owner of the property. As you know, we cannot commit to lease any property without securing your approval today.

In the city of Chicago, finding commercial real estate suitable for development and close to your practice location is a real challenge. We've

been working on that for over a year now. In a lessor market in the area of Chicago, the landlord holds all the cards.

We need your votes today to avoid having him walk away in this case, which would create a long delay for us moving forward. The due diligence, the physical plant, our working and specialized requirements for the surgery center -- we would have to present that to you in another application, which is not a good thing for us.

By the way of background, we've been working on a plan to consolidate our surgical services downtown for several years, predating my hiring, which was nearly four years ago. For most of that time we worked on a design and associated negotiations with our medical practice landlord to expand those services within the current location, which is just a few blocks from our site.

The current building we're in now at River North is an 11-story building with 300 residential units. It has some commercial spaces on lower floors, and it's right on the river across from Goose Island. It would have been our preference to expand there, but we could

not acquire additional and adjacent space with associated parking for the City of Chicago requirements as needed to consolidate our two IVF centers, embryology and andrology labs, and still have adequate space for other functions, so in the winter of 2018 we started searching for a site for IVF functions.

Not only is the real estate market really challenging in the Near North Side of Chicago, but the site parameters for the planned clinic eliminated many locations that might be acceptable for other types of businesses. Any multitenant site is a nonstarter due to the City of Chicago and IDPH life safety code requirements.

The site we've temporarily secured by paying a hefty -- again -- monthly deposit is a single-tenant site. To secure it, we worked with two real estate brokers specializing in Chicago real estate.

In general, we need a parcel about an acre that would accommodate a single floor, 18,000-square-feet building with covered patient pickup and drop-off and adjacent parking. Beyond that, it must be appropriately zoned for a health

care purpose. This is one of the two sites that we found in nine months of searching. The other site was snatched up just a week after being on the market by a tenant with no CON contingency.

As your staff report notes, the services we plan to provide outside of government -- are outside of government payer programs. Neither Medicare or Medicaid pay for any element of these services, as they have no impact on governmental finances if this project is approved.

Likewise, as we pointed out in submissions, the medical practice is already receiving technical and professional fees for these services, so we don't expect reimbursement for commercial payers to increase or escalate either.

Finally, I would like to thank you -- I'm sorry -- thank our banker, Wintrust, Jim Draths, for testifying today to confirm that Wintrust is willing to fund our project on competitive terms and at the market rates after this Board's approval of our request.

Once we lined up our site to get everything in place on a shortened time line, we

really appreciated Jim and his colleagues to step up and help us out. The financial analysis that was done for this attractive opportunity came at a good time for us, a really good time for us.

We believe our testimony today fully explained the unique nature of our family-building business, and we've also explained, with such a geographically broad practice base, why we can't send our patients to an ordinary surgery center.

We thank you for your time. Please, if you have any hesitation of voting yes, let us know what your concerns are so we can provide further background, clarification, and analysis you may need.

Thank you.

CHAIRMAN MURPHY: Okay. Are those your --

MS. FRIEDMAN: Yes. Thank you.

CHAIRMAN MURPHY: Thank you.

Do Board members have any questions or comments?

Mr. Gelder.

MEMBER GELDER: So where are your patients going now?

MS. FRIEDMAN: There are two clinics. One

is --

THE COURT REPORTER: Microphone, please.

MS. FRIEDMAN: There are two clinics. One is just a few blocks away at the IVF clinic at FCI, and the other one is in Highland Park, Illinois.

MEMBER GELDER: So when -- I guess what I'm curious about is, as you say, when you say you can't send them to another site -- I'm -- I don't know where they're going now and how you've been able to expand, you know -- to succeed and expand your practice so large without your own site, which now seems so imperative.

DR. SIPE: We've had both labs open for over 14 years. And the volume started lower and has grown over time. It's an Illinois law that IVF is covered. It's one of eight states where it is covered in the country. And so as patients have gotten older, there's been more of a need.

We have 11 offices -- 10 offices in the Chicagoland area, and patients -- we get people from around the country and around the world because of how good we are at what we do. It's very hard -- right now in our clinic in the

River North area is where we're doing the procedures, but we're worried that our complication rate will go up because of the complexity of the cases that are going on and the comorbidities of the patients.

So it's -- for us, it's much -- we want to be as safe as we can. We've had to start bringing in anesthesia teams to start administering the anesthesia to make sure that everything is safe, and it's getting more and more complex to do this in the clinic.

MEMBER GELDER: Could you explain the organizational relationships between and among River North Surgery, Fertility Surgical Partners, and Fertility Centers of Illinois?

MS. FRIEDMAN: So Fertility Centers of Illinois is a medical practice that employs 11 reproductive endocrinologists. Several of those physicians will be owners of the surgery center, and that's Fertility Surgical Partners, which is one of the Coapplicants to the application. Fertility Centers of Illinois is also a Coapplicant because the cases are expected to transfer from that facility and also because

they will be guaranteeing the lease obligations at the inception of the lease.

MEMBER GELDER: River North -- you created River North of that --

MS. FRIEDMAN: That's a new entity.

MEMBER GELDER: That's the new entity?

MR. WILLIAMSON: Right.

MS. FRIEDMAN: And in order to move the surgical cases away from the rest of the medical practice, a license is required from the Illinois Department of Public Health because the licensure act says that surgery can be done in a location where physician services are provided as long as they're a minority of the activities at that site. But once the IVF services would be in a separate building, then a license would be required.

And, also, in order to allow the urologists to do cases at the surgery center, a license would be required because you can't have physicians from outside your practice do cases in your center.

MEMBER GELDER: Thank you. So I must admit I'm -- I -- you asked if we were hesitating or thinking we might vote no.

I would put myself in that category because, based on the staff report, I mean, there are so many things at which your application is -- is deficient. So I don't know whether it's our standards that are not consistent with the type of practice you're describing or whether our standards are right and you just aren't meeting them.

But that's what -- I'd like to listen to some more comments people make or --

MS. FRIEDMAN: Sure.

MEMBER GELDER: -- if there are other staff comments, it might help clarify the discrepancy between what is required and -- the criteria that are required and your analysis that -- the ways in which they -- the gap between what they're offering and what's required.

MS. FRIEDMAN: If I may -- and then if Mike wants to supplement me, he can.

There are some criteria that sort of relate to each other. So when you look at the service accessibility, unnecessary duplication of services criteria, for example, those are really -- the negative findings on that are tied

into the fact that there are a number of other surgical providers in the area.

And because your rules are not so specific that they would consider the laboratory requirements for embryology and andrology, it said, "Well, here are these other surgery centers; they have some capacity."

And staff doesn't have a way to be able to analyze whether or not we could refer cases there with respect to the embryology component of it. So that's part of the reason you've heard so much about what this service is and the unique nature of having to have the embryology lab adjacent to it, is because it can't be replicated, you know, by just getting on staff at another center and sending the cases there.

Another negative finding in the application -- which, again, I think it actually demonstrates the high quality and high reputation of this group -- is that it says that at least 50 percent of your patients should come from a 10-mile area of the surgery center.

They have a low percentage in the grand scheme of things coming from the immediate area

because they have a reputation throughout the Midwest and the country and even the globe to provide fertility services, so their patients come from all over the Midwest and the nation.

So that doesn't technically fit in very well with your rules, but, again, we think that it shows the unique and excellent services that they provide.

This issue that I just explained about needing the license, to the extent that you go from one setting to the other, the treatment need -- room assessment and service demand items both relate to the fact that we are going to be transferring these cases from a medical practice setting to a surgery center setting.

And the reason you had testimony earlier about the fact that there are no Medicaid or Medicare patients that will be receiving services from this clinic is because, if you're changing the site of service, you might expect that there would be a change in the reimbursement. Government payers would pay more for hospital services; they pay more for surgery center services than they do in medical practice.

But that's -- but we don't have a government payer issue here. And as we stated, they're already getting a technical fee, so we don't -- we think this is a site of service-neutral project.

And then the final item is the financing issue, the bank commitment that we discussed at the previous practice. And we did have our bankers here earlier today testifying that, subject to your issuance of a permit, that they would be willing to fund the project.

And I think that covers the negative findings.

CHAIRMAN MURPHY: Mike, did you have anything to add?

MR. CONSTANTINO: I just -- a couple of things.

We can't accept referrals to an office practice. We can only accept referrals to an ASTC or a hospital, both licensed by IDPH.

So you see a number of these -- I think it was over 7,000 procedures performed. We would only -- could only accept 300 of those.

That's one area where -- when we say

there's only one procedure room needed, that is the reason. We could only accept 300 procedures of the 7,000 that were submitted to us.

CHAIRMAN MURPHY: So is it the case of our standards and your needs not exactly fitting and aligning?

I mean, we're talking more general and you're talking more specific when it comes to what you're doing? You're just not any ASTC or any surgical center; you're very specific and specialized, which creates a specialized need, which is not addressed by our general requirements? Is that accurate?

DR. SIPE: Yes.

MR. CONSTANTINO: One other comment.

We don't concern ourselves with real estate. As far as we're concerned, that's not an issue if they have to pay a monthly -- whatever they were having to pay.

So if you don't approve it today, we'll bring them back, and they'll have to continue to pay the fee. It's not an issue for us.

CHAIRMAN MURPHY: But it's an issue for them.

MS. FRIEDMAN: We're more concerned about losing the site 100 percent because this landlord -- because of the market -- and it's very much a landlord's market -- that we will just lose the site.

MR. CONSTANTINO: But it's not a need criteria --

MS. FRIEDMAN: No.

MR. CONSTANTINO: -- that this Board looks at.

CHAIRMAN MURPHY: Thank you. Thank you.

Are there any other questions or comments from Board members?

MEMBER GELDER: Just one last one about -- I know you don't take government programs and Medicaid -- that's not a covered service under Medicaid or Medicare.

But what about charity care? What is your ability to -- or willingness -- to serve people who can't afford some of these very, very high frequency --

DR. SIPE: We do that, actually, quite a lot. Because of our size and excellence, many pharmaceutical companies are looking at new

medicines, new techniques, new technologies.

Currently we are able to offer 10 free IVF cycles per month for couples who have no coverage. Some of these are coming from the Medicare population. That's one of our ongoing studies.

I don't know the exact number over the last eight years that we've had studies. My guess is in the thousands of free IVF cycles that have been given out to patients. I don't know the specific number but it's been a lot.

MS. JASULAITIS: We also serve on the medical advisory board for The Life Foundation, so that is a nonprofit organization. Many of the practices donate, as we do, a free IVF cycle to patients. They apply and -- between April and May -- and then we accept their applications.

And we either provide them with an IVF cycle or a fund of money if they're going to do egg donation or adoption or some other service that we don't -- that we can assist them with.

So we have a number of ways that we can help patients who do not have insurance coverage.

CHAIRMAN MURPHY: Thank you.

Are there any other questions or comments

from the Board?

(No response.)

CHAIRMAN MURPHY: Okay. George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by McNeil; seconded by Demuzio.

Senator Demuzio.

MEMBER DEMUZIO: I'm going to go ahead and vote yes due to the fact that there's been the explanation of your specialized services and -- which has been addressed by the findings here -- and that explains what -- why there were so many findings.

So, yes, I'm -- and keep up the good work.

MR. WILLIAMSON: Thank you.

DR. SIPE: Thank you.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: I vote no, based on the staff report and just needing to give some further consideration to what is evolving in our health care system with the further atomization of all of these particular services and needing -- each

needing, possibly, their own building and -- it -- I don't know what our -- I don't know how that helps our society.

So I vote no.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: I am going to vote yes.

After really reading this long and hard, the staff report and, you know, mystified by it and really paying attention to it -- because that's what we should do with staff reports, and I think it was a thoughtful staff report.

But I think I am convinced, based on your testimony, that this is a very unique and specialized service, and I do believe it's a really important one. And I don't know -- we didn't get any opposition letters from other, you know, potential ASTCs who do some of this work, maybe, so I guess I -- I think I see the need, and that's why I'm voting yes.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: I have to abstain.

MR. ROATE: Mr. McGlasson.

MEMBER MC GLASSON: Realizing the uniqueness of the situation, I think that the testimony covered my question and I vote yes.

MR. ROATE: Thank you.

Mr. McNeil.

MEMBER MC NEIL: Based on the report, the clarifications, the fact that this is leading edge, the fact that our rules don't include a lot of the patients, and it's pushing the envelope forward in terms of medicine -- medical science -- I vote yes.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: I'm going to vote yes based on the report, based on all of your testimony today.

Thank you for educating us. It was fascinating. I learned a few new terms.

So I vote yes.

MR. ROATE: That's 5 votes in the affirmative, 1 vote in the negative, and 1 recusal.

CHAIRMAN MURPHY: So your application is approved. Thank you and good luck.

MS. JASULAITIS: Thank you.

DR. UHLER: Thank you very much.

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CHAIRMAN MURPHY: All right. Next up is H-04, Project 19-004, Smith Village.

May I have a motion to approve Project 19-004, Smith Village, for a major modernization project on the campus of its long-term care facility in Chicago.

MEMBER MC NEIL: So moved.

CHAIRMAN MURPHY: Second?

Please.

Somebody?

MS. AVERY: Second?

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: Thank you.

Will you please state your name for the record and be sworn in if you haven't been already.

MR. KNIERY: Good afternoon again. My name is John Kniery, CON consultant with Foley & Associates.

MR. MC GEE: Kevin McGee, M-c-G-e-e.

MR. MORADO: Juan Morado.

CHAIRMAN MURPHY: Mike, will you please give the State Board staff report.

MR. CONSTANTINO: Thank you, Ms. Murphy.

The Applicants propose to modernize their existing 110-bed long-term care facility and reduce the number of beds by 22 beds for a total of 78 long-term care beds at a cost of approximately $23.9 million, with an expected completion date of January 31st, 2022.

There was no public hearing and no opposition letters. There were support letters received by the State Board. Historical utilization justifies the 78 beds being requested.

The Board staff found the Applicants did not meet the current ratio of -- debt to capitalization ratio and the modernization and contingency costs.

Thank you.

CHAIRMAN MURPHY: Thank you.

Do you have any statements for the Board?

MR. KNIERY: Yes. I will try to be as brief as I can.

CHAIRMAN MURPHY: Thank you.

MR. KNIERY: I'd like to acknowledge Charles Foley of Foley & Associates who's also behind us who helped prepare the project.

Smith Village is a sister facility to the

Smith Crossing project you heard, the business item you heard for the permit alteration request earlier today.

Everyone likes to say that their project is unique, but this project really is one that has areas that are not -- do not neatly fit in with the long-term care certificate of need application.

The project addresses the tenets of the Planning Act with the reduction of nursing beds in the planning area and was found to be in conformance of the need criteria, all the need criteria.

Therefore, I will briefly address the State findings under the financial criteria, and then we will have the Applicant briefly tell you about them themselves and Mr. Morado concluding the presentation.

We're very excited at the overwhelmingly positive staff report, and I'd like to thank your staff for their hard work in their review of this project.

I'd first like to address the reasonableness of project costs. The design

presented for the Smith Village supports the continuum-of-care model. As an existing entity, there are physical limitations that are placed upon any significant renovation Smith Village seeks to do which increases typical renovation costs.

For example, Smith Village campus is one city block. It's landlocked by the major streets that surround it. As a mature campus, there is not an area for staging the new construction or the major mechanical and electrical installations. These major mechanical and electrical systems are also not typically found in modernization projects, another reason for the increased costs.

Again, this is not a typical wallpaper, paint, carpet renovation project. We're not just changing out the PTAC wall units in the units. We're talking about plumbing and electrical being rerouted through the entire three-floor structure. All the windows, the entire roofing system all need to be replaced.

These are many of the very labor-intensive and invasive installations that are, again, more typically found in new construction and rarely

seen all done at once in major modernization projects.

Finally, the modernization will have to be staged to minimize disruption of services to the residents. Each phase of the project only converts a double-occupancy room into private rooms.

Currently there are only 18 private rooms and 41 doubles for a total of 81 beds within the double rooms. This will change to 66 private rooms and only 6 double-occupancy rooms with a new and more modern and effective therapy station.

The only other finding were the ratios. And simply put, the ratio findings are due to the nursing unit not being a freestanding nursing unit, as typical projects are presented, but, rather, this is a large CCRC life plan community with all the components under a single entity instead of broken up.

For instance, the current ratio and the percent debt-to-total capitalization ratio are noncompliant due to GAAP principles in which entrance fees, which is money in hand for this entity, must be considered as a negative asset

with $25 million identified as debt. This creates a steep hole to overcome when calculating these particular ratios.

The net margin percentage ratio only had a finding in the projected year. Like the previous two ratios, this nursing unit is being considered, as we said, as a much larger organization, unlike typical freestanding nursing home projects; however, this is the only ratio where, for us, it was possible to separate out the nursing unit from the entire campus.

In doing so, the projected ratio for the net margin percentage is actually 14.9 percent compared to the State standard of needing to be over 2 1/2 percent. This information was provided in the application on page 279. Therefore, it really appears to be in conformance.

I'd like Kevin to briefly present the project.

MR. MC GEE: I will be brief.

Just a little background about our organization: Our not-for-profit, senior living community was established in 1924 by local citizens, both business and civic leaders, because

they saw a need to honor the lives of older adults by providing a more inclusive way to serve them and keep them in the community at large.

Today our board of trustees continues our mission of the 95-year-old legacy by volunteering their time and professional expertise to provide a variety of services, programming, and living arrangements to enhance the quality of life for Smith residents.

Smith and surrounding communities are built with the DNA of Smith Senior Living. Today, for instance, Smith Crossing in Orland Park and Smith Village on Chicago's southwest side continue to serve our neighbors a number of ways, including regularly scheduled support group meetings for people who care for relatives with dementia or Alzheimer's disease, internships and clinical programs for nursing students as well as others planning careers in senior living fields, dozens of relationships with schools, scouting, and other groups to promote intergenerational experiences.

I can speak on behalf of the board of trustees I report to that we are also responding to market demand, and time and time again people

are asking for private rooms. I'm proud to say that we are a five-star rated community within CMS.

And we're asking for your support of the application today.

MR. MORADO: Okay. I told you we were going to be moving this along quickly, so I'll try to do the same, as well.

You can tell from the State Board staff report and our presentation that what we're really trying to do today is take into account the planning process. And what this project does is it right-sizes the facility, so we're not asking to add beds to the planning area. In fact, we're reducing beds 22, going from 100 to 78.

If you look at the number of beds in the health planning area, there's an excess that exists currently, so we're going to be helping to lower that amount.

In addition, the findings of nonconformance with this project really have nothing to do with the goal of the underlying project, which is to modernize a facility that really hasn't seen a significant capital

improvement since 1991.

As we previously discussed the modernization portion of contingencies, they're slightly higher than the State standard. The standard is 200 bucks; we came in at 217. So it's not like it's grossly over.

And this is due to the current state of the building; right? So if the building -- it's a little bit older, and what we're talking about is an extensive overhaul. It's going to include higher efficiency mechanical and electrical systems that ultimately are being installed to save money for the facility over the lifetime of their use.

The one finding that's found in the "Financial Viability" section, it's a result of Board rules that aren't necessarily designed to accommodate for CCRCs. And for those of the members who may or may not be familiar with CCRCs, it's the idea that you move from an independent living unit on to assisted living. If necessary, you would then go on to skilled nursing.

Now, what's unique about this facility and the reason it doesn't necessarily conform with

your rules is only skilled nursing falls under your jurisdiction. But we can't just go in and replace the medical and electrical for the skilled nursing; we have to do the whole project -- or the whole campus -- because that's what makes the most sense. But that's also what's led to this finding on the modernization contingencies.

Just to circle back again to the financial viability, it's the same reason that we're also not hitting in that standard. But as you heard earlier today with regard to the Smith Crossing project, this organization is very well financed and financially viable, so much so that we actually put out bids for people who wanted to finance our project. There is no finding otherwise with regard to the financing of the project.

The project itself meets 14 of the 16 criteria, so it is in substantial compliance. This is a five-star facility and it is only one of nine Illinois communities that is accredited by the Commission on Accreditation of Rehabilitation Facilities. That's an industry association that conducts rigorous peer reviews to ensure the

highest performance of standards, and it's ranked among the top 19 skilled nursing care facilities in Chicago, according to US News & World Report.

Quite frankly, there's a strong basis to approve this project. Your rules are designed to allow for discretion in these types of situations.

And on behalf of Smith Senior Living and Smith Village, we thank you for your consideration, and we'll be happy to answer any questions you might have.

CHAIRMAN MURPHY: Thank you.

Are there any comments or questions from Board members?

(No response.)

CHAIRMAN MURPHY: All right.

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

CHAIRMAN MURPHY: Okay. George, would you like to call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by McNeil; seconded by Demuzio.

Senator Demuzio.

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

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: I vote yes based on the preponderance of the compliance and the testimony we've seen here.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: I'll repeat that. I vote yes based on the preponderance of evidence or factors that have been met and the testimony.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: I vote yes based on the staff reports and testimony here today.

MR. ROATE: Shall I mark Mr. McGlasson absent?

MS. AVERY: No. He'll be back.

MR. ROATE: Dr. McNeil.

MEMBER MC NEIL: I vote yes based on the staff report, your explanation. And you could have teased out the air-conditioning by square foot to get the number in compliance, quite frankly.

Yes.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: I vote yes based on the State Board staff report and today's testimony addressing the negative findings.

MR. ROATE: Thank you.

That's 6 votes in the affirmative, 1 absent.

CHAIRMAN MURPHY: The motion is approved.

Congratulations. Your application for permit is approved.

MR. KNIERY: Thank you.

MR. MORADO: Thank you so much.

MR. MC GEE: Thank you.

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CHAIRMAN MURPHY: Okay. Next up is H-06, Project 19-008, Rehabilitation Institute of Chicago.

May I have a motion to approve Project 19-008, Rehabilitation Institute of Chicago, to build out existing shell space on the campus of its rehabilitation hospital in Chicago.

MEMBER MC NEIL: So moved.

CHAIRMAN MURPHY: Second?

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: Thank you.

Will you please state your name for the record and, if you haven't been sworn in yet, please do so.

MS. PARIDY: My name is Nancy Paridy, P-a-r-i-d-y, and I'm chief administrative officer at the Shirley Ryan AbilityLab.

MR. AXEL: Jack Axel, Axel & Associates.

MR. CASE: Ed Case, C-a-s-e.

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

(Two witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN MURPHY: Thank you.

Mike, will you please give the State Board staff report.

MR. CONSTANTINO: Thank you, Ms. Murphy.

The Applicants are proposing to add 20 comprehensive physical rehab beds for a total of 262 beds in shell space at a cost of approximately $11.9 million.

Generally, a hospital can add a lesser of 20 beds or 10 percent of total authorized beds, whichever is less, every two years; however, to add beds in shell space the Applicants needed to come before the State Board for approval.

There was no request for a public hearing, and the Board has not received any support or opposition letters on this project.

At page 3 of your report, the Board staff found the Applicant exceeded the Board standard for the size of the room by 90 gross square foot per bed, and then the two-year average utilization will justify 204 comprehensive physical rehab beds in the target occupancy of 85 percent and not the 262 beds being proposed.

Thank you.

CHAIRMAN MURPHY: Thank you.

Do you have a statement for the Board?

MS. PARIDY: Yes.

CHAIRMAN MURPHY: Thank you.

MS. PARIDY: I will summarize our project, and then Jack Axel will address the findings in the staff report, and then we'd be happy to answer any questions. We'll try to make it as quick as possible.

The Shirley Ryan AbilityLab, formerly known as the Rehabilitation Institute of Chicago, has been rated the number one rehabilitation facility in the United States for 28 consecutive years by US News & World Report. While the majority of our patients come from Illinois and the Chicagoland area, we actually do attract patients from all 50 states as well as over 57 countries around the world because of the high quality of care which is interwoven with our cutting-edge research that results in our successful outcomes.

If I may take a moment just to describe our approach, which is very different from other providers.

We've been in existence since 1953 with a

sole focus on physical medicine and rehabilitation. Since that time we've been a pioneer and leader in treating the most difficult and complex conditions.

Because we are the world's destination for the most challenging cases, we are able to advance and share knowledge and expertise continuously. Our flagship facility is located at 355 East Erie in Chicago, where this project is proposed for. This research hospital opened in March of 2017 and has 242 beds.

The Shirley Ryan AbilityLab is organized around five innovation centers. It's a state-of-an-art hospital facility with equipment for exceptional patient care provided by the best medical and nursing support.

Each area within the Shirley Ryan AbilityLab, the patient areas known as the innovation centers, focuses on an area of biomedical science with extraordinary promise: Brain, spinal cord, nerve, muscle and bone, pediatric, and cancer, all related to the rehabilitation field.

We integrate the best medical and research

experts together in realtime. We innovate ways to speed the recovery from medical conditions that affect that particular ability. In our five ability labs, physicians and PhDs share space so medicine and science cross-pollinate constantly. Breakthroughs occur faster.

Each of our five ability labs focus on a specific functional outcome, are dynamic space where interdisciplinary teams provide a full range of therapeutic services and develop new research based upon insights to help patients gain function, achieve better outcomes, and enjoy greater independence.

Shirley Ryan AbilityLab's research enterprise is the largest of its kind and renowned for its breakthroughs. We have more than 350 studies and trials underway, human subject, applied research, and proof-of-concept testing. Shirley Ryan AbilityLab runs the largest active research enterprise incorporated into its clinical care in the rehabilitation field of medicine.

The project we are presenting to you today is narrow in scope, only proposing the expansion of two of our patient care units by combining

20 beds, and is in direct response to the increasing demand that we have experienced over the past two years as well as some recent initiatives that we believe will drive future demand.

For instance, we have a team of admission liaisons placed at acute care hospitals throughout the Chicagoland area. These admission liaisons are charged with identifying the very challenging patients that need the type of admission at the Shirley Ryan AbilityLab. We are working with discharge planners, social workers, and patient families to accomplish that so that they get the best outcomes for the care they need. We continue to expand that admission liaison program to other hospitals, including many who don't have rehabilitation units and need a place for those patients to be referred to.

In addition to the Chicagoland area, we've expanded our market presence to include admission liaisons in St. Louis and southwestern Michigan markets. These admission liaisons call on the major trauma centers in those regional markets, and they bring patients to the Shirley Ryan

AbilityLab. We've just had one person in St. Louis in the last six months, and we've already received nine admissions for that.

We are currently recruiting additional staff to support these national admissions. We have significantly expanded our presence at national and international physical medicine and rehabilitation and stroke conferences as well as other rehabilitation conferences with that differentiated capacity.

As a result of all of these initiatives, as well as additional ones we have, we've seen another 14 percent increase in our patients since January with our occupancies as high as in the 220s.

Now, I, one, thank you for your attention, particularly this late in the day, and I'll let Jack address the findings from the staff report.

MR. AXEL: Thank you.

The project, as proposed, failed to meet 2 of the 12 criteria, which -- for which findings were made, those being 1110.120(a) addressing square footage and 1110.205(b)(4) addressing the demand for beds.

Relating to the square footage, the proposed expansions of the 20th and 25th floor patient care units exceeds the standards by 90 square feet, as noted by Mr. Constantino. The proposed 749 square feet per bed is actually less than the current unit's square footage per bed.

Ms. Paridy described the manner in which inpatient services are delivered at the Shirley Ryan AbilityLab, and suffice it to say that it is significantly different than your typical hospital-based rehab unit, and, therefore, the space requirements are different.

Among the functional areas that are provided on this hospital's patient care unit that you would not find on hospital-based rehab units include areas for biomedical engineers and researchers, 10- rather than 8-foot corridors, and physician offices on the units.

Moreover, many of the patients have assistive devices, such as wheelchairs and gait-training devices, in their rooms where they can be easily accessed by the patients 24 hours a day.

As a result and while we understand that

staff is compelled to compare this project to the State norm -- which, for the most part, is based on converted med/surg units -- I think that you would agree with me that the standard is really not applicable to the Shirley Ryan AbilityLab.

The second criterion relates to service demand or the hospital's bed need. The hospital moved into its larger facilities on March 25th, 2017. During 2017, 66,999 patient days of care were provided, resulting in an average daily census of 184 patients, justifying 216 beds based on the State's 85 percent occupancy target.

During 2018, the first full year in which the -- with the new hospital, the average daily census increased from 184 to 198 patients, as identified on page 35 of the application. That's a 7.6 increase over the prior year. Based on 2018 utilization, annual increases of only 4 percent per year -- half of that experienced during the past year -- were used to support the proposed bed complement.

In addition, since Ms. Paridy has already talked to you about the initiatives that will attract additional patients, I will not duplicate

those comments.

With that, I thank you for your time, and we'd be happy to answer any questions that you might have.

CHAIRMAN MURPHY: Thank you.

Are there any questions from Board members?

(No response.)

CHAIRMAN MURPHY: Okay. George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by McNeil; seconded by Demuzio.

Senator Demuzio.

MEMBER DEMUZIO: I vote yes based upon the testimony I just heard and, also, the staff report.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: I vote yes based on the substantial compliance and the additional testimony.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: I vote yes based on substantial compliance with the findings and the testimony.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: Yes, based on the staff reports and testimony here today.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: I vote yes based on the testimony.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Yes, based on the testimony and the staff report and the clarifications therewith.

MR. ROATE: Thank you.

Madam Chair.

CHAIRMAN MURPHY: I vote yes based on the State Board staff report and today's testimony.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRMAN MURPHY: Motion carries.

Your application for permit is approved.

MR. AXEL: Thank you.

MS. PARIDY: Thank you very much.

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CHAIRMAN MURPHY: Next on the agenda is H-07, Project 19-016, Village at Mercy Creek.

May I have a motion to approve Project 19-016, Village at Mercy Creek, to establish a 40-bed long-term care facility in Normal.

MEMBER DEMUZIO: Motion.

CHAIRMAN MURPHY: Is there a second? Somebody?

MEMBER HEMME: Second.

CHAIRMAN MURPHY: Thank you.

Will you please identify yourselves for the record and be sworn in.

MR. SHEETS: Chuck Sheets, attorney with Polsinelli and consultant to the Applicant.

MS. AMIANO: Judy Amiano, CEO of Franciscan Ministries.

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

(Two witnesses sworn.)

THE COURT REPORTER: Thank you. If you'd print your names, please.

CHAIRMAN MURPHY: Thank you.

Mike, will you please give the State Board

staff report.

MR. CONSTANTINO: Thank you, Ms. Murphy.

This project was originally approved at the December 2018 --

MS. AVERY: Excuse me.

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

MR. CONSTANTINO: This project was originally approved in the December 2018 State Board meeting to establish a 40-bed skilled care facility in Normal, Illinois, and to discontinue 40 long-term care beds at a facility in Chenoa, Illinois, which was Meadows Mennonite Retirement Community.

Subsequently the Board staff learned that the owners of the facility in Chenoa would not live up to the terms of the contract that we reviewed and did not discontinue -- would not discontinue those 40 long-term care beds.

Today the Applicants are before you to ask you to approve the 40-bed facility in Normal without the discontinuation of the 40 beds at the Chenoa facility.

This project was brought back for your approval because the discontinuation of the

40 beds at the Chenoa facility was a material representation made by the Applicants before the Board.

That's why it's back here in 32 days, contrary to what some of the opposition has said. We did not take advantage or ignore our rules. We could not let this proceed if this was going to be -- if the representations made before this Board were not lived up to.

You have the opportunity to either approve this project without those beds or approve it with them.

MEMBER HAMOS: Without what beds?

MEMBER GELDER: Could you say that again?

MR. CONSTANTINO: You -- I'm sorry.

You have the opportunity to approve this project with 40 beds without those 40 beds being discontinued.

MEMBER HAMOS: Oh, okay.

MR. CONSTANTINO: Or -- or these Applicants need to decide whether they want to go forward with the original permit.

If this is approved here today, that original permit will be discontinued. That has

been our historical practice, contrary to what two attorneys told the Board originally this afternoon. That is not correct. That has been the historical practice of this Board since I've sat on it. Those two attorneys worked for this Board, and they know full well that is the case.

Thank you.

CHAIRMAN MURPHY: Thank you.

Do you have any statements for the Board?

MR. SHEETS: Just briefly.

CHAIRMAN MURPHY: Thank you.

MR. SHEETS: Thank you, Mr. Constantino.

Again, Chuck Sheets, representing the Applicant.

I would agree that we are going to forfeit the old permit, obviously, if we get the new one.

MS. AVERY: Pull the mic closer.

MEMBER GELDER: Speak up.

MR. SHEETS: We will forfeit the old permit if we get this new one.

And I would like Judy Amiano, the CEO of Franciscan Sisters and of this project, to just briefly tell you the differences between this

project and the last one.

MS. AMIANO: Thank you.

And thank you to the Board for enduring such a long day. And I promise I will be brief because this is an identical project that was approved on December the 4th.

There are two circumstances that happened subsequent to that approval, and one is there was a change in control of the facility that had originally promised those beds to us.

That change in control then -- when we noticed them that we had been approved and we were asking them to move forward with the decertification -- got reluctant and said -- they kind of said, "Well, we do not really want to do that."

At that time I had a conversation with Mr. Constantino and asked for advice. I also subsequently called Jeannie Mitchell and said, you know, "We have a quandary here."

At the same time there was also a facility in Le Roy, Illinois, which is in the same planning area, which was discontinuing 102 beds.

So while all of this was going on --

I think there was an act of God -- that while the former facility that had promised those beds to us reneged on that offer, was in the process of reneging on it, 102 beds were coming back into inventory in the same planning area.

And so in discussing with staff and counsel for the Board, you know, we had one of two options. We'd either pursue legal action against the prior or we'd use the 102 beds that were coming back into the inventory to further our project.

So that's why we're here today. Those 102 beds came back into the market since we were here in December, and so we would ask to move forward again -- it's the identical project that was approved at the December 4th meeting.

I won't address the negatives in this unless you have questions regarding that, as they were all addressed at the December meeting.

CHAIRMAN MURPHY: I have -- well, I have a couple of questions first. I just need a clarification.

So there is no relationship between your entity and the Meadows Mennonite Retirement?

MS. AMIANO: Great question.

We had worked with the MMRC board, and that was a consortium of 15 churches who made up that board and the governance structure. They had two facilities. One was the facility in Normal, and one was the facility in Chenoa.

We -- they came to us. You know, they were looking to sell both assets. We did not want to purchase the Chenoa facility. We did purchase, subsequently, the Bloomington -- or the Normal facility.

Part of the sponsor's requirements, their requirements, were that, if we were going to buy the Normal facility, we had to promise to them that we would build out that campus and fulfill their vision, their legacy, which is why the legacy board had pledged those 40 beds. We needed those 40 beds in order to fulfill their ministry.

What happened is that board, I think, got tired of managing the Chenoa facility and finding themselves in the circumstances that they just couldn't go forward with that. We closed on the property in August, early August of '18 on the Normal campus, at which time we had already made

application -- you know, we were in the process of making application to the Board for filling that.

What we found out in January, the end of January, is that those board members had assigned new board members and they essentially walked away from the Chenoa facility, leaving the control of the facility with people who were not honoring the prior commitment -- or don't want to honor the prior commitment. I'll say it that way.

CHAIRMAN MURPHY: So your assurances under the first permit which was granted really were out of your control?

You were assuring us of something that you -- that those 40 beds were going to disappear or be transferred to you, but at the same time, you didn't have ultimate control over that promise?

MS. AMIANO: We had multiple documents with the legacy sponsor that that all was going to happen, and we had legal advice that those were sort of ironclad.

Again, we have an avenue at this period of time of either legally pursuing who are the new control unit of the Chenoa property or, because

these Le Roy facility -- the beds came back into inventory -- using that avenue. Because of -- I mean, we're ready to start construction on this project, frankly.

Because of what would happen legally -- and no disrespect to any lawyer sitting here in this room but -- you know, the lawyers are the ones that win when you take legal action; right? It takes a couple of years; it's a very long and involved process. And, candidly, it's more attractive to us to say, you know, "There's these available beds that are now back in inventory" -- it's an easier process, more expeditious.

And we're ready to go. You know, we really need to build out that campus in Normal, number one. We made a promise to the legacy sponsor and those churches. That church land sits adjacent to the property that we're at in Normal, and so we feel a sense of, you know, honor and responsibility to a commitment that we made to the legacy sponsor, knowing that their prior governance just, you know, couldn't hang onto the Chenoa property anymore.

Again -- I don't know, Chuck, if you want

to add anything.

MEMBER GELDER: Could you just say who the "we" is that you're talking about? You keep saying "we" and "us."

Who is the "we"?

MS. AMIANO: "We" is Franciscan Ministries, who is the parent corporation for the -- Mercy Creek.

MEMBER GELDER: And that's not Franciscan Sisters of Chicago Service Corporation?

MR. SHEETS: It is.

MS. AMIANO: It is.

MEMBER GELDER: That is.

Keep going. I'm sorry. I just needed to know who the "we" was.

MR. SHEETS: No, I wouldn't add anything else other than there's actually a bigger need now than there was at the time Judy was here in December so -- you know, there's a 33-bed need after everything is cashed in, so we're looking for 40 beds with a 33-bed need. In the other instance, you know, there was no need at all. So it's actually a more favorable position right now than it was when the permit was granted earlier.

CHAIRMAN MURPHY: And I know you said you're not going to address the findings unless we ask you to, so I'm asking you.

Can you please address the findings on financial viability and reasonableness of project cost?

MS. AMIANO: Sure.

I think we met all the financial metrics except for the capital ratio, and I would just say to you that, you know, our debt is investment grade. We have $133 million in cash and investments that's available to us as of our March 31st financials. We certainly have the capacity and the ability to take on a project of this size.

You know, we have a strong balance sheet, 362 days' cash on hand, a 2.3 debt service coverage ratio. And our banks require a 1.05, so we're more than two times the coverage.

So I would say, you know, we have the capacity to handle this project. And we will self-finance it until such time as we take it out with other financing down the road.

CHAIRMAN MURPHY: And the reasonableness

of project cost here, you exceed the standard by $1.1 million dollars.

MS. AMIANO: I think it was about $975,000 variance from the State. I would say it's a couple of things on that.

You know, when it shakes all out, there are certain line items that are -- you know, shake out a little bit differently. We classify things maybe a little bit differently than the department does.

I think the biggest drivers of this are two things. Number one, we build in a lot of conservancy so, you know, we're not coming back to the Board to ask for more dollars for a project. So we're relatively conservative, actually, as we put our numbers together.

We are building a household kind of model for skilled nursing. In this particular market, it's a market that hasn't seen any new skilled nursing beds in over 30 years, almost 35 years. So all of the inventory that's in this market is really, you know, all double rooms -- or some facilities have taken some of the doubles and put them into privates.

But we are building a household type of concept so -- two 20-unit household kind of concept -- which is, you know, certainly desirable from the market, so that has additional cost in it.

Again, we have the capacity to fund that, and so I think that piece of it -- we have some additional costs as it relates to -- there are geothermal units that were installed on this particular parcel, which is wonderful except they put them right in the ground where we need to connect to the building to get to the kitchen, so we have to move all those geothermal fields, which is quite an expensive proposition. I think it adds about $250,000 of costs to this particular project.

And then I think, you know, our concept of households -- we have multiple small dining rooms -- again, everything's a household concept -- instead of carting all the residents to a central dining room. And so it's just the philosophy of design that we have and experience we want to create, both for our residents and for their family members, that drives those numbers.

CHAIRMAN MURPHY: Okay. Thank you.
MS. AMIANO: You're welcome.
CHAIRMAN MURPHY: Are there any other questions from Board members?
Yes, Ms. Hamos.
MEMBER HAMOS: Which one was the -- which one is the nursing home that was closing?
MS. AMIANO: It's the Le Roy facility.
I don't know, Mike --
MR. SHEETS: It's already closed.
MS. AMIANO: It's already closed.
MEMBER HAMOS: It's not on our list.
MR. CONSTANTINO: It wouldn't be on your report. It's 102 beds that were closed at the first part of the year.
MEMBER HAMOS: And that wasn't reflected anywhere in the report; right?
MR. CONSTANTINO: What's that?
MEMBER HAMOS: That was not reflected anywhere in the staff report?
MR. CONSTANTINO: Yeah, it was reflected on that front table as a footnote.
MR. SHEETS: Yeah.
MR. CONSTANTINO: They closed because of

financial reasons, the 102 beds.

I want to ask Judy a question.

On the original application they submitted to us, there was a contract, I believe, for the discontinuation of those 40 long-term care beds, and that was provided in the application. We relied on that contract that it was going to be withheld when we came to the Board.

I wanted to make that clear to the Board members that, hopefully, we didn't misrepresent what we provided to you at that time.

CHAIRMAN MURPHY: Thank you. Thank you, Mike.

Are there any other questions?

Mr. Gelder.

MEMBER HAMOS: Can I just -- again, I'm looking -- I'm trying to understand why we don't know -- I read this whole thing and was totally committed to voting no because I will never vote to expand bedded capacity of nursing homes. Anybody who wants to play that out, never. Because we are overbedded with nursing homes.

So I read this whole report from that lens, and now, at seven o'clock, we hear that, in

fact, there was this closure. And I'm just trying to understand why it wasn't reflected in the numbers.

MR. CONSTANTINO: Yes, it --

MS. MITCHELL: It is.

MEMBER HAMOS: Where? I mean, that's what I'm trying to understand, really.

The 33 versus 40 --

MR. SHEETS: Well, let --

MEMBER HAMOS: -- is what's stuck out for me --

MR. SHEETS: Right. Let me --

MEMBER HAMOS: -- so maybe I didn't read it as closely -- I accept that.

MR. SHEETS: Well, it's a difficult thing to -- you know, numbers.

Page 2, if you look at that table, what Mike has on the first column is, if approved, he has excess beds of 47 --

MEMBER HAMOS: Yeah.

MR. SHEETS: -- but that's with the permit that's open already that would be turned in. So, really, the excess beds would be seven; right?

CHAIRMAN MURPHY: Seven.

MR. SHEETS: And then underneath, if you look at Footnote No. 3 --

MEMBER HAMOS: Yeah, I see that now, the footnote.

MR. SHEETS: -- yeah -- it says "discontinued 102 beds," and those numbers are reflected in that table.

MEMBER HAMOS: I understand. And it does say "summary." There was a calculated need for 33 LTC beds --

MR. SHEETS: Right. Right.

MEMBER HAMOS: -- and that's not exactly true, I mean, based on what we're hearing.

I'm just trying to verify this from some other source. I mean, we do have the possibility of not being overbedded if we approve this project; correct?

MR. SHEETS: Right.

MEMBER HAMOS: Okay.

CHAIRMAN MURPHY: Mr. Gelder.

MEMBER GELDER: I'm still a little -- I'm still digesting that conversation.

But as that sinks in, what's -- let me ask about the nature of the skilled nursing beds.

What services are you providing there? Is this primarily rehab and recovery? Short term? Maybe your length of stay would be helpful for me to understand. Or is this mainly custodial care for --

MS. AMIANO: Good question.

There will be some of both. On the campus existing is assisted living, and there's just a very small -- four units of independent living. It is our intention, over time, to build out the independent living.

But we will do both transitional Part A Medicare services as well as long-term care in the expansion of what we're proposing.

MR. SHEETS: Right. And Franciscan Sisters, just for the record, last year, 7.3 million in charity care, 1.2 million in free care, 5 million in pastoral care. And then unreimbursed Medicaid -- you know, they did a lot more, too.

So I mean, it's really a good organization that, you know, does the right thing, and they're just trying to build out their model in this location in Bloomington-Normal here.

MEMBER GELDER: The "model" being their continuing care retirement community?

MR. SHEETS: Well, it's not a CCRC per se --

MEMBER GELDER: Right.

MR. SHEETS: -- but it does offer the different levels, yes.

So there's independent living; there's assisted living with memory care, I believe.

Right, Judy?

MS. AMIANO: Well, we'll build -- part of this project, the 40-bed expansion, will be an additional -- although it doesn't come under the purview of this Board -- it's in the dollars but it's not under the purview -- an additional household with 16 units of dementia services.

Again, state-of-the-art design with technology and support and services for those individuals who suffer from dementia, and that will be, again, part of this project.

MEMBER GELDER: Is physical therapy, occupational therapy, speech therapy on-site?

MS. AMIANO: Yes. State-of-the-art physical therapy will be built into this.

CHAIRMAN MURPHY: Mr. McGlasson.

MEMBER MC GLASSON: It's been a long day, as everybody knows.

Can you refresh my memory on what the public participation testimony was regarding this issue?

MR. CONSTANTINO: Yes. I'll be happy to.

MEMBER MC GLASSON: Thank you.

MR. CONSTANTINO: Okay. The two attorneys who used to work for this Board said that we brought this project back too fast, within 32 days.

What I told the Board was they may have -- the Applicants have made a material representation that you used to approve that project. That's why they were back here within 32 days.

Okay? We have a minimum of 30 days to review this project. That's the minimum. We usually don't do it. But you had provided -- you had accepted that testimony as part of your approval for that project.

That's why it was brought back to this Board for your consideration today.

MEMBER HAMOS: And also --

MR. SHEETS: Just for the record, if you note, there's been -- there was no request for a public hearing, and there was no opposition submitted. It was just, this morning, testimony.

MEMBER MC GLASSON: One more question.

Do you know who was --

MEMBER HAMOS: Wasn't there testimony -- excuse me. Clarification, please.

Wasn't there testimony in opposition from another one of the nursing home operators?

MR. SHEETS: Yeah. That's what we're talking about, the two lawyers.

MEMBER HAMOS: Oh.

MR. SHEETS: That's what Mike was talking about.

MEMBER MC GLASSON: That was --

MEMBER HAMOS: So based on that -- they were just the lawyers. But based on --

MR. CONSTANTINO: Yes. They're just lawyers, yes.

MS. MITCHELL: "They were just lawyers."

(Laughter.)

MR. SHEETS: The second lawyer joke.

MEMBER HAMOS: But I took their -- I took

their testimony as competitors, being opposed. So they were -- they're competition in the area, in the planning area?

CHAIRMAN MURPHY: Yes.

MEMBER HAMOS: Yeah.

MEMBER MC GLASSON: If I may, do you know the owners of the Le Roy facility?

MR. SHEETS: Yes. Actually, I represent them.

MEMBER MC GLASSON: Can you tell me who they are?

MR. SHEETS: Well, it's Manor Care. And -- you know, it's -- they have probably --

MEMBER MC GLASSON: Manor Care? Okay.

MR. SHEETS: It's not that Manor Care. It's Manor Court -- I'm sorry. Not the Manor Care that everyone knows. It's Manor Court.

And they have -- I'm guessing -- if John Kniery was here, he could tell me but -- I would say 15 facilities around the state. And this one had been, you know, not successful financially for a long time and ended up closing.

MS. MITCHELL: And I just want to say, if the Board does not recall considering that

project, it's because the Board does not have jurisdiction over the closure of long-term care facilities. All that's required is notice to the Board that that facility is closing.

CHAIRMAN MURPHY: Are there any other questions or comments?

(No response.)

CHAIRMAN MURPHY: Okay. George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Demuzio; seconded by Hemme.

Senator Demuzio.

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

MR. ROATE: Mr. Gelder.

MEMBER GELDER: I vote yes based on the testimony and the staff analysis.

MR. ROATE: Ms. Hamos.

MEMBER HAMOS: I vote yes based on testimony that clarified the staff report.

MR. ROATE: Ms. Hemme.

MEMBER HEMME: I vote yes based on the staff report and testimony here today.

MR. ROATE: Mr. McGlasson.

MEMBER MC GLASSON: I vote yes based on the testimony and the staff report today.

MR. ROATE: Dr. McNeil.

MEMBER MC NEIL: I vote yes based on the staff report and the clarifications to explain all the details that supported what the staff said and clarifications thereof.

MR. ROATE: Madam Chair.

CHAIRMAN MURPHY: I vote yes based on the State Board staff report and today's answers to our questions.

Thank you.

MR. ROATE: 7 votes in the affirmative.

CHAIRMAN MURPHY: The motion passes.

Congratulations. Your application for permit is approved.

MR. SHEETS: Thank you very much.

MS. AMIANO: Thank you, Madam Chairman and Board.

CHAIRMAN MURPHY: We are going to take a quick, five-minute break, and then we will come back to wrap up the agenda.

MS. MITCHELL: Real five minutes.

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(A recess was taken from 7:01 p.m. to 7:09 p.m.)

CHAIRMAN MURPHY: Would you please take your seats.

We are down to applications subsequent to intent to deny, and we will address next I-03, Project 18-042, Quincy Medical Group Surgery Center.

May I have a motion to approve Project 18-042, Quincy Medical Group Surgery Center, to establish a multispecialty ASTC in Quincy.

MEMBER MC NEIL: So moved.

CHAIRMAN MURPHY: Second?

MEMBER MC GLASSON: Second.

CHAIRMAN MURPHY: Thank you.

Will you please get to the table.

Once you're seated, if you'll please identify yourselves and then be sworn in.

THE COURT REPORTER: If you would print your name on those sheets and raise your right hands, please.

(Seven witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN MURPHY: Mike, will you please give the State Board staff report.

MR. CONSTANTINO: Thank you, Madam Chair.

The Applicant proposes to establish a multispecialty ASTC and cardiac cath service in the vacated space of Bergner's department store at the Quincy Mall in Quincy, Illinois.

The cost of the project is approximately $19.5 million. The anticipated completion date is March 1st, 2021.

The Applicant received an intent to deny at the March 5th, 2019, State Board meeting. There was a public hearing held on this project, and the Board has received numerous comments both for and against on this project which are included in the material we sent to you.

Finally, the Applicants have not met all the requirements of the State Board, as documented in your supplemental report.

Thank you.

CHAIRMAN MURPHY: Thank you.

I assume we have a presentation for the Board.

MS. BROCKMILLER: We do.

My name is Carol Brockmiller, B-r-o-c-k-m-i-l-l-e-r. I'm the CEO of Quincy Medical Group.

Thank you for the opportunity to reappear before you today. At the last meeting our project received 3 affirmative votes and 2 abstentions.

We tailored our brief presentation today to focus on the comments of those who abstained from voting and to address the few questions that were posed by the Board and its staff.

Those who abstained from voting commented on perceived tension between QMG and Blessing Health System. It was suggested that we return home and work to determine what is in the best interest of the people of Quincy.

We took the comments and suggestions of this Board to heart, and we took action to ensure that we understood what the people of Quincy want and need.

Our physicians identify needs and we solve problems. We follow rules and processes, including the CON journey. The QMG physicians provide the kind of foundational health care that Illinois and America needs, the kind of health

care that benefits economies and improves lives.

Quincy Medical Group for seven years has been a part of a Medicare ACO. We have taken risk and we have shared in savings, our low cost, high quality, and amazing patient experience in relationship with doctors, but that's only to the extent that we can control and influence our environment.

We believe that competition and choice is good. QMG responds to patients, employers, and consumers. We rise to the occasion. We step up our game when needed.

When Blessing started a competing physician group years ago, Physician Tower No. 1 was built, Physician Tower No. 2 and No. 3 and here recently when they applied for an 82,000-square-foot medical office building, we don't fuss. We go back to work; we try to up our game. We make sure that we're offering a service and a product that matters to people in the community. So we understand the importance of choice and competition.

QMG is a multispecialty physician group. We're owned and operated by 115 physicians. We

provide health care in Quincy, and we've done so since 1937, hardworking, nimble, willing to take appropriate risk and invest in the future of medicine.

We have lived with the hospital monopoly for some time now, but we want a chance to move ahead, to continue successfully recruiting and retaining the highest quality physicians. In fact, there are surgeons who are waiting to join Quincy Medical Group with your approval today. We have positioned ourselves in such a way to add a surgery center to the care experience that we provide.

The corporate tension that you sensed on May 5th [sic] is just that, two competing organizations, but that does not extend to the clinical realm. Physicians and health care workers will always do what's right for the patient. That was true before and after the last hearing, as well.

There are some outstanding issues and questions remaining, and today we believe that we have addressed the remaining 3 criteria, having met 28 of the 31. Today we will speak to service

accessibility, unnecessary duplication, and financial viability. We'll be brief, including a few closing remarks from me, and we want to be sure that we answer all of your questions.

Our relationship efforts with Blessing have existed and evolved for years, 80 years to be exact. That will always be our goal. We are better together in many ways.

But competition and choice is sorely needed and will benefit patients and the community. We can serve more patients, provide more services through the proposed surgery center. We can keep health care in our community, taking the lead and offering a service that further evolves health care of the future, outpatient, cost-effective, accessible to all, highly efficient, incredibly convenient. The future is outpatient procedures and more of them.

QMG physicians are vested in this project and in their communities. We've done our homework and we even have the wherewithal to plan ahead to perform the latest, greatest, and safest procedures in the ambulatory setting, including cardiac procedures.

I will not give much energy to what the past six months has been like. It has been difficult and there have been tactics used by the hospital in sort of unprecedented and aggressive opposition. It's been a little unseemly, unbecoming, unnecessary, and, in our opinion, unfair.

There is a difference between appearing collaborative and being collaborative, and we would like to think that our project is not being blocked for undue reasons.

It is our belief that the hospital will benefit from our project in many ways, including the reduction of outmigration, the use of inpatient ORs for the right surgeries in that setting, and I sincerely hope that they, like we will, take some time to look inward and decide what is right to do together and what the community needs, just a little corporate self-reflection.

Perhaps we will reach out to one another and do some sort of genuine collaborative spirit, as we do clinically now, and retool ourselves and truly think about the region's health care. Our

CON application has begun to change the landscape of health care in Quincy and the region. Your approval today ensures that that will continue.

Our efforts have awakened the hospital, patients, consumers, the community, even QMG physicians, and the team of so many who believe in what we're doing and why.

We believe that the remaining speakers here will answer any outstanding questions. We want to be sure that we exhaust everything that may be on your minds and, hopefully, earn your approval for our project.

Thank you.

DR. PETTY: Hi. I'm Dr. Todd Petty.

I'm a surgeon and do basically all of my operations at the hospital. I have worn a lot of hats there before. I've been the department of surgery chairman, the president of the medical staff; I've served on the hospital board. But tonight I speak to you as the board chairman for Quincy Medical Group.

When we were here last, there were really no concerns voiced regarding the technical merits of our project, but there were concerns voiced

regarding the cooperative nature or lack thereof that was being seen.

I think it's important, though, to separate competition from a corporate strategy level from collaboration and cooperation at a clinical patient level. I think that we've done very well with the cooperation from a patient level for years.

We've got a great trauma program. Many QMG physicians serve on various committees at the hospital, are involved in inpatient quality projects, cost efficiency projects. For example, I'm currently one of the leads of the surgical quality improvement team.

We've agreed to keep discussions with Blessing about all potential collaborative and employment opportunities, and we've met with them a couple times in the last month.

We also sent them a comprehensive alignment proposal again -- we sent the same thing last summer -- that detailed shared clinical responsibilities, cost savings, joint ventures, even shared governance by the physician groups. They're not interested in a broad collaborative

project such as that.

The competition is real in our community, and I think that competition's okay as long as we cooperate at the patient level.

They've recently expanded hours of the existing surgery center, but, despite that, the existing surgery center is still at capacity, still has no blocks for new physicians. The physical size of the rooms is just not adequate for some of the new procedures that need to be done. These limitations result in a lot of outpatient surgeries being pushed to the hospital, which is the inappropriate setting for it and much more expensive.

Even if we looked into a joint venture proposal at the current surgery center, that doesn't address any of those problems. A new facility site would.

Our surgery center will also provide the community access to services and procedures not currently available at the surgery center, including neurosurgery, urology, certain orthopedics, and EMT procedures. Regardless of what service lines are currently approved at the

surgery center, the simple truth is there are many operations that are not and cannot be done there currently.

Those will be offered at our new surgery center, which is why -- with all due respect to the Board staff -- we believe our project should have received a positive finding regarding service accessibility criteria.

Without expanded service accessibility, patients are forced to leave town or pay high prices locally or simply forgo care. An example, as I mentioned before, is a local farmer that had a hernia that bothered him. He had no insurance. He looked into a facility; they just quoted $30,000, but they'd drop it to 18,000 if he paid cash. He didn't have 18,000 cash; he never got his hernia fixed.

It's hardworking people like that that deserve a choice in town. They deserve a reasonable price, and they deserve good medical care and he did not.

There's also a question in my mind that it's not coincidental that the timing of the recent joint venture was given or that the

hospital has now taken some steps to address some of the limitations of the current surgery center, including expanding hours, planning to drop prices.

Those things are a direct result of our application and being here today. It's also because we have broad community support. It's because we believe our project is technically compliant.

Just the threat of competition has already led to these improvements in our local area, so we can just imagine the positive outcomes of seeing it actually getting approval. And although it may be somewhat counterintuitive, I think getting approval for our own surgery center may actually increase collaborative interest because we'll be on a more equal footing.

The project before you today is a proposed surgery center at 3347 Broadway. We've twice offered Blessing an opportunity to enter into a joint venture at that location and they've said no.

We believe we've done everything required from a technical reviewability standpoint and

everything asked of us at the last Board meeting to justify approval of our project today. I'd ask that you please do what is in the expressed interest of the majority of our community and approve this project.

Thanks.

MS. HELKEY: Thank you.

As I stated earlier, I'm Beverly Helkey, H-e-l-k-e-y. I'm the executive director of the Tri-State Health Care Purchasing Coalition located in Quincy, Illinois.

Our coalition represents 50 employers and more than 31,000 covered lives. We were founded in 1991. Our coalition has worked with Blessing and Quincy Medical Group for years, and we support both providers. They have a history of working together when it's beneficial to their patients and to the community, and we expect that to continue, for them to work together; however, a co-owned or collaborative surgery center isn't in the best interest of our community.

At the last Board meeting, it was suggested that QMG engage and consult with a third-party community leader who is not a health

care provider to help determine truly what's in the best interests of the people.

CHAIRMAN MURPHY: Excuse me. I'm sorry.

Are you an Applicant? Are you part the application? I mean, you -- the organization that you just stated you were with, the --

MS. AVERY: Do you work for QMG?

MS. HELKEY: No.

MS. KLEIN: Chairman Murphy, I would just address this real quickly.

We read Chairman Sewell's remarks to ask us to consult with a community leader, and Ms. Helkey is that.

MS. AVERY: Oh.

MS. KLEIN: She's not a community father, but she's a community mother. And we read that as a direct request of this Board.

CHAIRMAN MURPHY: Okay.

MEMBER HAMOS: But didn't you testify earlier?

MS. HELKEY: I did.

MS. AVERY: In public testimony.

MEMBER HAMOS: She testified.

MS. AVERY: Mr. Sewell had asked --

MEMBER HAMOS: We're hearing the same testimony twice at seven o'clock.

CHAIRMAN MURPHY: Sorry. We just wanted to clarify.

MS. HELKEY: No -- thank you.

CHAIRMAN MURPHY: Thank you. Go ahead.

MEMBER HAMOS: I don't know why.

MS. HELKEY: So at the last Board meeting you asked for an independent person that would bring an unbiased, objective perspective to you so that you could do that, and that's what we do as a health care coalition.

Since 1991 we've been working with the employers, and what we've heard from them on this project is that our community supports Quincy Medical Group but they adamantly oppose a co-owned collaborative surgery center.

And I'd like to field questions from you. Before I do, there's just a few things that I'd like to let you know about some of the work that we do so that you understand why our presence is important.

We have tons of surgical outmigration that leaves our community. And so the surgical

outmigration goes into Springfield, Illinois; Columbia, Missouri; and St. Louis, Missouri. If we can bring those people back to Quincy, we will have enough patients to fill probably even a third surgical center because the outmigration is so huge.

And what Quincy Medical Group is offering is a more affordable price, so it will increase the opportunity for people to come back because that's why most people really leave Quincy, is because the cost is just too high.

And that's what we do. We track cost and quality. Part of the thing that we do is we purchase MedPAR data -- you're probably familiar with that. And we purchase that through Quantros, and Quantros was mentioned earlier today.

But what we do with Quantros is we actually compare data to where our people go for care. So we look at cost in Springfield and Champaign, Peoria, into the St. Louis region. In all of those cases, Blessing ranges 20 to 60 percent higher, and this has been a long-term price increase for our community. It's spanned many, many years.

And the other thing that I want to mention about competition is that back in December I was asked to come to Blessing Hospital and meet with Maureen Kahn and Mr. Gerveler at a meeting.

And Ms. Kahn was absent that day, but I did meet with Mr. Gerveler. And he wanted me to know confidentially that they had made a decision to decrease their ambulatory surgery rates by 30 percent, thereby Quincy Medical Group wouldn't need to open a surgery center. So had they not put in their certificate of need, I'm confident those rates would have never gone down.

The other thing is about five years ago, as a health care coalition we opened two employer-sponsored health clinics. One of those is still operational, and one of them is closed.

And Mr. Gerveler told me in that meeting that the best thing that we ever did was to bring a third party into Quincy and create competition because it made them be a better provider.

Do you have any questions for me? Or do we just want to --

CHAIRMAN MURPHY: Let's finish the -- your presentation.

MS. HELKEY: Okay. Thank you.

CHAIRMAN MURPHY: Thank you.

MS. WILLIAMSON: Hello. My name is Patty Williamson. I am the CFO of Quincy Medical Group.

Our project meets six of the seven financial criteria. The one criterion that we did not meet was related to the State's financial viability ratios that are driven by the amount of cash on hand.

The State does not have a cash-on-hand standard for taxable physician medical groups despite the fact that their cash-retention practices are quite different than nontaxable hospitals.

Because QMG is a for-profit business entity, it uses its cash not only for capital expenditures but to make distributions to its shareholders. Those distributions are net with operating cash flow on QMG's financial statements but are discretionary. When they are reflected separately, they paint a very different picture of QMG's strong operating cash flow.

QMG provided two sets of financial viability ratios in its application in order to

demonstrate that it does, indeed, generate significant positive free cash flow from which earnings can easily be retained.

45 days' cash on hand, the State standard for ASTCs, when calculated on the ASTC operations, is $1.8 million. After the last meeting QMG voluntarily submitted a letter of commitment to earmark 1.8 million to be held on hand for the project. QMG also began retaining additional earnings in 2018 for funding of the project and will continue to do so through project completion.

QMG is a financially strong and viable group, as evidenced by our 80-year history of strong earnings and growth. Our annual revenue is over $200 million and has grown at a rate of 8 percent per year for the last decade, demonstrating our financial stability.

We have a very strong financial plan for the proposed surgery center, which has met our bank's rigorous standards for loan commitment. Our bank, Bank of Springfield, supports the project and the chairman of the bank provided a letter verifying our financial strength.

We also have a line of credit with the

bank that we have never drawn on, and that is available for the project should it be needed.

I believe we've demonstrated our financial viability and strength as a group and as an ASTC. If there are any questions or concerns regarding those topics, however, I'm happy to answer them.

MR. WEBER: Good evening. I'm Ralph Weber, W-e-b-e-r, CON consultant to QMG.

Patty has commented on the first of the negative findings. I will address the other two and, in doing so, I will update some of the information that I presented at the last Board meeting with Blessing's new numbers, and I will say, at the beginning, Blessing's numbers do not change any of the conclusions that I showed at the last meeting.

I promise I will not inundate you with numbers, either. This will go fairly quick.

MS. MITCHELL: I just want to make sure to ask -- staff has had an opportunity to review these?

MR. WEBER: They have. These were included in the March 25th packet that were sent to Mike --

MS. MITCHELL: Okay.

MR. WEBER: -- and -- updates of exactly the same types of charts, same content, with just the updated numbers.

The first chart shows that Blessing's 16 ORs and procedure rooms -- hospital and the ambulatory surgery treatment center combined -- will exceed the State standard of 1500 hours per room in 2021 when the proposed ASTC would open.

Based on Blessing's growth rate of 6.5 percent per year through 2017 for total surgery -- again, inpatient and outpatient -- there will be over 24,400 hours in year 2021 when the facility opens, and that exceeds -- the horizontal line is the 1500 hours per year per room for the 16 rooms that Blessing has.

Factoring in growth is appropriate here and consistent with the Board's practice. As a result, the two licensed surgery facilities in the 21-mile GSA are utilized at or above the State's utilization standard when QMG's project opens.

This supports the project meeting the service accessibility criterion, one of the three

negatives.

The second chart concentrates on just outpatient surgery hours at Blessing Hospital and the ASTC.

These grew by 12.2 percent per year through year 2017. Using a more conservative 10 1/2 percent projected growth, that shows that in the year 2023, two years after completion of the project, Blessing's outpatient surgical and procedure hours will be over 24,200.

Deducting QMG's projected hours at the new ASTC, that amount, leaves about 13,600 hours at the existing -- at Blessing, and that exceeds their 2017 hours.

So why is that important? The State's criterion for unnecessary duplication and impact on area providers states that within 24 months after completion -- in other words, by 2023 -- the project will not lower to a further extent utilization of other GSA facilities currently operating below the State's standard.

QMG's project in 2023, 24 months after project completion, will not lower Blessing below the total outpatient volume for the most

recent year of 2017. This supports the unnecessary duplication impact on providers criterion.

I was going to go over again the change -- that we covered really, I think, fairly well in the comment period -- about the 3 1/2 minutes for the room cleanup.

But I'd like to comment just briefly -- very briefly -- on the other changes that Blessing has made. Initial 2017 submittal showed their total outpatient surgical hours increasing from 11,700 in 2016 to over 18,400 in 2017.

That's an increase of well over 50 percent and raised questions on our part. We thought that maybe they were positioning a bit to get numbers that would support an ASTC in their new ambulatory surgery center that you approved last year. Also, it showed no volume -- their numbers in 2017 and 2016 showed no volume in their procedure rooms at the hospital.

And so, yes, I did call Mike, as was raised before, because Blessing's volumes of surgery in the hospital and the ASTC constitute a hundred percent of the surgical volumes in

Adams County.

I mean, this is one surgery center, the only surgery center in the entire health system's agency outside of Springfield, so we -- I needed to get the numbers right, and the place to turn was Mike.

So, fortunately, he made the request that they -- that led to them realizing that their numbers were wrong. And, frankly, when we're writing the permit application and we needed to show total existing use, we must have correct numbers.

So I do recommend that you be very careful about Blessing's numbers and that they -- I've not seen a hospital change numbers three times in a year -- or have three sets of numbers, the original and then two changes. That's very unusual.

So in closing, I will say we meet 21 out of -- 28 out of 31 criteria -- 28 out of 31 -- and the unnecessary duplication and service accessibility are very often not met by other permits for ASTCs that are approved. And if we don't meet them, I think we come very, very close.

The volumes support -- I want you to know that the volumes support the project, and that helped us get 3 positive votes last month.

The additional facility capacity is needed to meet the forecasted growth in surgical volumes. The current six-room ASTC is not enough. A QMG Surgery Center provides the community with a choice of provider that is otherwise not available.

Thank you for your time.

DR. RAFI: Good afternoon.

My name is Dr. Adam Rafi, R-a-f-i. I will serve as the group's interventional cardiologist, and I will work very, very closely with Dr. Derian, who has been working with QMG since 2008, and he's been doing cardiac cath there, as well.

I understand that the project's in full compliance in terms of the cardiac cath requirements, receiving positive findings on all the cardiac cath criteria. I would like to briefly address the safety concerns that were brought about today as well as at the previous Board meeting.

First, we intend to perform diagnostic

cardiac catheterization in the proposed surgery center. These procedures will not require general anesthesia or hospitalization.

At the last meeting Dr. Schlepphorst, our chief medical officer and our compliance officer, provided specific details as to the safety of performing these types of cardiac cath procedures in an ambulatory setting.

It was also mentioned in QMG's application and during the last Board meeting that CMS has recently approved 12 cardiac cath procedures to be performed in the ambulatory setting.

This approval was not done on a pilot basis or a limited basis. It was the result of CMS' very stringent process and exhaustive review of the safety and efficacy of performing cardiac cath and such procedures in an ambulatory surgery center.

Second, the successful performance of cardiac cath in a freestanding facility not located to, on, or adjacent to a hospital is not a new concept, including my current state of Florida. Caths are increasingly performed in facilities without in-house surgical backup,

including hospitals, freestanding cath centers, and ambulatory surgery centers.

In 2014 the Society of Cardiovascular Angiography and Interventions, the American College of Cardiology, and the American Heart Association put out a consensus document of -- to describe the efficacy of percutaneous interventions and offered in this range of sites without surgery backup, on-site surgery backup.

Outcomes have supported the growth of such facilities, and in 2007 there were 28 states that approved this. As of 2013 this number has grown to almost 45 states. Those facilities are well-established, including my current state of Florida, and continue to provide efficient and timely services in their communities with the goal of optimizing patient satisfaction, high-quality care, and continue to maintain patient safety in a cost-effective environment.

Ultimately, it is the physician's responsibility to do no harm and to provide care for their patients in the appropriate site of service, and this applies for any type of procedure or provision of health care service

provided, including cardiac cath services.

Both Dr. Derian and I strongly support and will provide appropriate patient selection. Just because an ambulatory setting is available does not necessarily mean that it is necessary for a particular patient. As a physician, I would only perform a cardiac cath procedure in an ambulatory setting if it is medically appropriate and the patient meets an appropriate selection and patient selection criteria for that particular patient.

If a procedure requires hospital backup on-site, which was also addressed in the consensus document with the three big interventional societies, it will continue to be performed at the local hospital.

Last week I discussed continued collaboration and backup support and planned development of protocols with Dr. John Arnold, who's Blessing's cardiovascular surgeon, and Dr. Tim Smith, who's a vascular surgeon with QMG. And we continue and will continue to concur and look forward to working collaboratively together when I will be joining QMG in late June.

In our session today I'm happy to answer

any questions this Board may have regarding the cardiac cath procedures portion of this. I really appreciate it and thank you for your attention.

MS. KLEIN: Good evening. My name is Tracey Klein, K-l-e-i-n. I represent Quincy Medical Group.

There's been a lot said today about collaboration, and I feel the need to just set the record straight.

Blessing Hospital today presented this Board with a false choice, block competition for Blessing or risk disharmony in the community. Had Blessing Hospital not mounted this level of opposition, there would be no disharmony in the community. We would have received approval in March and no -- and everyone would have been on their way.

Nonetheless, I would note for the record that QMG did hear the concerns raised by the Board regarding the tone in the community, and we followed Chairman Sewell's advice and involved the community in our deliberations.

I want to say emphatically that Dr. Petty picked up the phone and called the Blessing board

chair on March 13th, not vice versa. Dr. Petty called. And Dr. Petty, in his quiet, dignified way, suggested that Blessing and QMG board members sit together and discuss how the two organizations could work together. Specifically Dr. Petty suggested a collaborative alignment initiative could be a good way to begin, to walk before you run.

This was a sincere and gracious offer on his part, and he memorialized it in a letter that he sent to Mr. Tim Kunz, the board chair, on 3/20. I will say no response was received. None. I don't believe there was a return letter on that request.

Now, QMG had put some of these concepts on the table in June of 2018, and there was no uptake on that at that time, either. It was too big, too broad.

If you think about it -- and some of the new Board members have talked about their experience in health care transformation, which I thought was very helpful and inspirational.

Clinical alignments can do a lot of stuff in the industry right now. You have a contractual

arrangement. You work on high-cost structures or high-cost areas together. You can standardize care delivery; you can do care the right way the first time in the appropriate site of service. It's huge for health care.

And that's the kind of collaboration our doctors do day in and day out with Blessing, and we were seeking -- Dr. Petty was seeking to expand that initiative for the benefit of patients and patient safety and for the benefits of patients in terms of reduction of costs. There was no response.

Against my advice he went further. On the night of 4/17, when the -- they -- the two boards did meet, he placed -- or he said to them -- said to the Blessing board members and administration -- "Are you sure you're not interested in participating in our proposed venture?" the one that's before you today.

And, you know, I was reluctant because -- if you all know, you know, 50/50 partnerships are harder to get out of than marriages, so a 50/50 seemed hard to me -- and there are some legal limitations in the antikickback statute regarding

how doctors that have primary care employees can actually participate in a joint venture.

But anyway -- nonetheless, Dr. Petty made the executive decision he was going to put that on the table. And he said, "Do you, Blessing, have any interest in partnership on our proposed project?"

Blessing responded by saying, "We have no interest and we will continue to oppose your project."

I think that speaks volumes about the motives that were on display today. There was no mention of the letter to collaborate; there were really no alternatives put forward. It's kind of "You need to acquiesce on our proposed joint venture for the existing surgery center or there's no other collaboration that could be envisioned."

We, unfortunately, were put in an uncomfortable position of looking uncooperative unless we acquiesced in a joint venture for an antiquated facility that the CEO has said is slated for discontinuance in three years, that has limitations of space and equipment, that is already at capacity and cannot accommodate future

growth.

As Board Member Murphy noted, Blessing Hospital's opposition is an outgrowth of their resistance to competition. The truth is no organization welcomes competition. Implicit in the hospital's arguments today is that the status quo is just fine, and the corollary to that concept is that Blessing believes there's sufficient ambulatory surgical capacity in Quincy.

What I think they're really saying, in effect, is, "If there's additional surgical outpatient volume that would, in our world, be appropriately done in an ambulatory surgery center, we" -- they think it should be done in a hospital.

Now, what does that mean for patients? It means HOPD rates that we know are approximately 30 to 50 percent higher than ambulatory rates.

And we all also know -- and I don't know how this impacts exactly but -- their charges are 17 to 43 percent higher in the hospital than other similarly situated providers.

Why am I saying this? Because your duty, your charge -- and I know you know this -- is

about patients. It's about affordability of care. It's about accessibility of care. It's not about protecting a provider, especially one that's operating in a high-cost, high-price universe where there's been no competition. Your job is about the patients.

And in this case we believe we've designed something -- and our community partners have said -- we've designed something that will help the community, that would be good for patients, and we request to have the opportunity to move forward with this project in Illinois, in Quincy, where our physicians have served their neighbors and their friends and the hospital.

Thank you.

CHAIRMAN MURPHY: Does that conclude your remarks?

MS. BROCKMILLER: Just a brief closing. Sorry. I was listening intently.

In closing, we are passionate and extremely proud of our project. It was carefully designed to meet the needs of our patients in the community.

And while at the same time meeting the

Board's technical requirements, not adversely impacting nearby providers, it has the overwhelming support of our community, and we believe it's in the best interest of the people of Quincy. Quincy wants this project. Quincy needs this competition and choice. Quincy will benefit from this. Our patients need competition and choice.

You have our word that we will continue to be in a collaborative relationship with our local hospital to ensure the two organizations provide the very best level of care for the benefit of our patients.

I hope that we have successfully addressed and resolved questions from the last meeting. If there's hesitancy or concerns or follow-up questions today, I respectfully ask that you raise those and allow us to answer them so that we have an opportunity to do so before the project goes to vote.

And if no questions, then I thank you for your time, and we respectfully ask for your approval of our project.

CHAIRMAN MURPHY: Thank you.

Let's focus on the application for a minute. I know there's been a lot -- there seems to be more talk about things that aren't having anything to do with the application, like collaboration and buddy agreements and all that kind of stuff. And I appreciate that but let's talk about the application because that's why we're here.

Mike, I'd like a clarification from you.

In the State Board staff report on this new hearing, you said that there were originally four deficiencies and those four remain. Is that correct?

MR. CONSTANTINO: There were four deficiencies in the original staff report and then we -- on the one on the movable equipment cost, that was removed from the original report because it shouldn't have been movable equipment.

CHAIRMAN MURPHY: Okay.

MR. CONSTANTINO: It's permanent, stationary. Sorry.

CHAIRMAN MURPHY: So does that bring us to three?

MR. CONSTANTINO: Three. That's correct,

yes.

CHAIRMAN MURPHY: All right. Because I heard over here -- I heard three, I heard two, I heard one. I just want to make sure we're all in agreement.

So you addressed three finally.

MR. WEBER: I addressed two and Patty addressed one, yeah.

CHAIRMAN MURPHY: Okay. So three and three -- perfect. Thank you.

Are there any other questions, comments --

MR. CONSTANTINO: I would like to make a clarification.

CHAIRMAN MURPHY: Absolutely.

MR. CONSTANTINO: Blessing -- we did not approve Blessing hospital for another ASTC in Quincy.

We haven't done that. The Board has not done that. I think I -- I think there was a mention in the testimony here that there was another ASTC.

CHAIRMAN MURPHY: Right. But we haven't seen any application?

MR. CONSTANTINO: No. No.

CHAIRMAN MURPHY: Thank you.
MEMBER HAMOS: Can you explain that?
MS. BROCKMILLER: Sure.
MEMBER HAMOS: Can they explain that? I was confused about your reference to another ASTC, as well.
MS. KLEIN: I think what our consultant, Mr. Ralph Weber, was saying is he couldn't figure out why the numbers were changing.
And the only motive we can, you know, ascribe to it is that they were maybe trying to justify a bigger volume so that they could come in with an ASTC application.
When we brought our application forward, the numbers dropped repeatedly.
CHAIRMAN MURPHY: Are there any other -- Mr. Gelder.
MEMBER GELDER: So as you were presenting the demand --
MS. AVERY: Mr. Gelder, bring the mic closer.
MEMBER GELDER: As you were describing the demand for services and the increased demand that you anticipate shortly, that would bring -- that

would leave Blessing, I guess, with -- I'm trying to think of the lessons you were trying to teach us with that but -- partly it was that Blessing would still have an adequate business with its ASTC.

MR. WEBER: Yes.

MEMBER GELDER: Is that right? Is that what you were saying?

MR. WEBER: That's correct, that --

MEMBER GELDER: So -- I don't need to -- I just wanted to make sure I was on the same page.

MR. WEBER: Yes.

MEMBER GELDER: And my question is -- and you can address whatever you want in response to it -- is about pricing.

So the pricing now -- and that's a big concern to me. I know it's not an issue per se, I think, with the Health Facilities and Services Review Board, but health care costs so much in America because we have very high price -- we have very high prices.

You're addressing one of the challenges -- you're addressing one of the issues that contribute to the high prices, which is, in some

communities -- many -- the lack of competition. And so you're trying to create competition that would then help -- as you've already said -- already pushed Blessing's costs -- prices down that they were anticipating charging, which I guess is good.

But as the demand increases, what's the -- what's the decision-making process within the medical group to not increase prices to match what your competitor is able to charge?

MS. KLEIN: I think the real thing that we're saying here is that they did move their pricing down -- or they said they will. They've put in for -- to this date I don't know that it's been achieved -- to ambulatory surgery center rates in the existing ASTC.

If you don't have sufficient capacity, then where do the other cases go? And their own numbers projected a growth rate that's not dissimilar to what Ralph projected for you.

So they're recruiting doctors; we're recruiting doctors. Where do those -- and there's outmigration that's quite significant, in large part because of high costs.

So where did these patients go? They go to the hospital. In the hospital setting you're not reducing your cost -- you know, your prices -- to ambulatory rates. You're charging hospital outpatient department rates. Those rates are higher, 30 to 50 percent, than in the ambulatory surgery center.

And then we don't know -- what we don't know is how much their already high rates play into that. I'm not an expert on hospital, you know, rate structure. But that's the concern, is you put it in the world of extended care.

MEMBER GELDER: What about the Quincy -- how does Quincy make its pricing decisions?

MS. KLEIN: It would have to be on a freestanding ambulatory surgery center rate.

DR. PETTY: Part of that is the reputation. So we've got all these businesses and community leaders in town that are on board with us having a low-cost center. We'd obviously lose that if we became a high-cost center.

But just as importantly, we're part of a next-gen ACO, one of only about a dozen in the country. We're at risk. We need to have our

patients at low cost and right now we don't.

So that's our incentive, as well, is to help keep our patients' cost low because we're at risk if they're not.

MEMBER GELDER: How many providers -- how many doctors are in your group?

DR. PETTY: 115.

MEMBER GELDER: Okay. Thank you.

CHAIRMAN MURPHY: Do we have any other Board comments or questions?

MEMBER MC GLASSON: Yeah. I feel compelled to make a statement.

I feel compelled to make somewhat of a statement.

Dr. Petty -- have I got that correct?

DR. PETTY: Yes.

MEMBER MC GLASSON: He made mention of the fact that -- not to put words in your mouth -- you, frankly, doubted the sincerity of Blessing in some of their statements of making price improvements. And I, frankly, came away with that impression from the public participation.

I don't think there has been any reason that they couldn't have begun to charge

freestanding ASTC rates long before now. And I, frankly, am left with a doubt that, if this petition is denied, many of the statements and price improvements made today will actually happen.

CHAIRMAN MURPHY: Thank you.

All right. George, will you please call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by McNeil; seconded by McGlasson.

Senator Demuzio.

MEMBER DEMUZIO: Well, it's been a long day, and we have now come to our final vote, I believe.

It's been two sessions of hearing both QMC and Blessing Hospital, and it's very, very difficult to look out in the crowd and see that, you know, everyone has their own agenda and wants to basically work together -- I hope.

When we left last time, we asked that you work together, collaborate. Unfortunately, I didn't hear that all across the board today. I've heard it some but not completely.

And so, therefore, I'm going to be voting no on the QMC.

MS. AVERY: QMG.

MR. ROATE: Thank you.

Mr. Gelder.

MEMBER GELDER: I vote yes based on both the analysis and the testimony earlier today as well as the -- from the Applicants.

This is a complicated area, but I feel that the -- overall -- the benefits of the people of Illinois weigh in on the side of granting this.

MR. ROATE: Thank you.

Ms. Hamos.

MEMBER HAMOS: Oh, man. I didn't think that at eight o'clock I could listen so closely, but I have all day, 40 witnesses, I think, on behalf of Blessing.

So I am persuaded by those numbers, that there is a continuing demand for service in that part of Illinois, and I am worried that if the one ASTC doesn't have capacity, that it's going to be the hospital beds that are filled for surgery, and that is not a good result.

I think that there has been a lot of talk

about collaboration, and, quite honestly, I came -- before we heard from all of you, I thought that you were the bad guys because you refused to collaborate, but I'm now convinced that actually goes both ways.

And it's unfortunate that there's so much vitriol in one small community, and, hopefully, you'll deal with it and you'll work together when you have two ASTCs.

So I'm voting yes.

MR. ROATE: Thank you.

Ms. Hemme.

MEMBER HEMME: I'm voting yes.

My biggest concern coming in was your financial viability, and I think you successfully answered exactly how you're going to meet your costs, which is important for moving forward.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes.

I'd like to extend a little bit what Mr. Gelder just said.

We're here to grant or deny a certificate of need, and I do think that there's -- a need

greater than maybe all the rest is to change health care and the cost of health care in the United States.

So I think the people of Quincy and the state of Illinois and the United States in general are -- the enemy is the status quo, and we need to change the status quo. And if we don't, woe is us.

MR. ROATE: Thank you.

Dr. McNeil.

MEMBER MC NEIL: Based on the testimony and the report, I vote no.

MR. ROATE: I'm sorry?

MEMBER MC NEIL: No.

MR. ROATE: Thank you.

MS. MITCHELL: Can we go back to Mr. McGlasson?

Can we get a yes or no?

MEMBER MC GLASSON: I'm sorry.

Yes.

I apologize.

MEMBER GELDER: We didn't hear that word.

MR. ROATE: Madam Chair.

CHAIRMAN MURPHY: Thank you.

I voted yes last time, and I'm going to

vote yes again tonight.

We're concerned with the application. We're not concerned -- we can be concerned with the collaboration and everything else we've heard. It's unfortunate that the situation is what it is, but our job as the Board is to look at the application you've presented, the findings that our staff has presented to us, and then your explanations of those.

And I'm more than satisfied that we should approve this application so I vote yes.

MR. ROATE: Thank you.

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

CHAIRMAN MURPHY: The motion passes.

Your application is approved.

DR. PETTY: Thanks.

CHAIRMAN MURPHY: Congratulations.

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CHAIRMAN MURPHY: All righty. We're almost done.

Okay. There's no rules development.

There is no unfinished business.

Under other business we have a financial report and a legislative update.

MS. AVERY: Okay. As far as the financial report is concerned, it is in your packet. If you have any questions, feel free to give me a call or email and we will review it.

Thank you.

CHAIRMAN MURPHY: Thank you.

MS. MITCHELL: Legislative update, Ann.

CHAIRMAN MURPHY: Legislative update.

MS. GUILD: You have a one-pager. I think it --

MS. MITCHELL: Use your microphone.

MS. GUILD: You have a one-pager. I think it's self-explanatory. You don't want to hear from me tonight.

And if you do have questions, pick up the phone, give me a call, and I'm happy to talk to you about it.

CHAIRMAN MURPHY: Thank you. We're always

happy to hear from you, Ann, but -- thank you.

MEMBER GELDER: Just a quick question here.

What would be the process -- I found that issue on the Medicaid utilization that we talked about during the -- we got earlier today --

MS. AVERY: We'll look back at the minutes.

MEMBER GELDER: -- just to make sure our questions are -- that we're asking for the information --

THE COURT REPORTER: I'm sorry. I can't hear you.

MS. MITCHELL: That we're asking for the questions that we -- the information that we really want.

MEMBER GELDER: Yeah. I'm just asking for some clarification from the staff about what questions we ask the applicants about their -- in this case -- the Medicaid utilization.

You said they were reporting a different number and we saw in our documents a 20 percent number, and I think that just needs to be some -- the process might need to be clarified -- the

question might need to be --

CHAIRMAN MURPHY: No --

MS. AVERY: No, it's not about this application. I'm sorry.

CHAIRMAN MURPHY: It was about a previous application with the ophthalmology center?

MEMBER GELDER: Right.

CHAIRMAN MURPHY: So we'll --

MS. AVERY: We'll look back.

MR. CONSTANTINO: Mr. Gelder, that's one --

MS. AVERY: Mike, use your mic.

MR. CONSTANTINO: I'm sorry.

That 20 percent figure that was in the application, I don't know where that came from.

The only thing I have to provide you was five years of historical data for all ASTCs in the state of Illinois. And that's what I was trying to tell you, that's what it provides, 2 percent.

MEMBER GELDER: Okay. I have my -- we can talk about this off-line. We don't --

CHAIRMAN MURPHY: Can I get -- I'm sorry. Go ahead, Mike.

MR. CONSTANTINO: What has happened is the

ASTCs come before the Board to say they're going to provide Medicaid, and then, after they're up and running, that doesn't turn out to be the case.

MEMBER GELDER: Okay.

CHAIRMAN MURPHY: Can I have a motion to adjourn?

MEMBER HEMME: So moved.

MEMBER MC NEIL: So moved -- second, third.

MEMBER DEMUZIO: Second.

CHAIRMAN MURPHY: All those in favor?

(No response.)

CHAIRMAN MURPHY: The meeting is adjourned.

Thank you. Our next meeting is June 4th.

(Off the record at 8:04 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 May, 2019.

My commission expires July 3, 2021.

MELANIE L. HUMPHREY-SONNTAG
NOTARY PUBLIC IN AND FOR ILLINOIS

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