HEALTH FACILITIES AND SERVICES REVIEW BOARD

525 West Jefferson Street, 2nd Floor

Springfield, Illinois 62761

217-782-3516

REPORT OF PROCEEDINGS

(June 3, 2014)

Report of proceedings of the meeting of the State of Illinois Health Facilities and Services Review Board held on June 3, 2014, at the Northfield Inn & Conference Center, 3280 Northfield Drive, Springfield, Illinois.

PRESENT:
Kathy Olson- Chairperson
John Hayes
James Burden
Alan Greiman
Richard Sewell
David Penn
Philip Bradley
Deanna Demuzio

ALSO PRESENT:
Courtney Avery - Administrator
Frank Urso - General Counsel
Catherine Clark - Board Staff
Michael Mills - Board Staff
Nelson Agbodo - Board Staff
Claire Burman - Board Staff
Michael Constantino - IDPH Staff
George Roate - IDPH Staff
Bonnie Hills - IDPH Staff
David Carvalho - IDPH
Bill Dart - IDPH
Michael C. Jones - DHFS

Reported by:
Karen K. Keim
CRR, RPR, CSR-IL, CRR-MO
Midwest Litigation Services
115 S. Lasalle Street, Suite 2600
Chicago, IL 60611

START TIME: 9:02 A.M.

CHAIRPERSON OLSON: I'd like to call the meeting to order. May I have a roll call, please.

MR. CONSTANTINO: Thank you, Madam Chairman.

Mr. Bradley?

MR. BRADLEY: Here.

MR. CONSTANTINO: Dr. Burden?

MR. BURDEN: Here.

MR. CONSTANTINO: Senator Demuzio?

MS. DEMUZIO: Here.

MR. CONSTANTINO: Justice Greiman? Absent.

Mr. Galassie? Absent.

Mr. Hayes?

MR. HAYES: Here.

MR. CONSTANTINO: Mr. Penn?

MR. PENN: Here.

MR. CONSTANTINO: Mr. Sewell?

MR. SEWELL: Here.

MR. CONSTANTINO: Madam Chair Olson?

CHAIRPERSON OLSON: Here.

MR. CONSTANTINO: Thank you.

CHAIRPERSON OLSON: Okay. We have a quorum.

The next order of business is Executive

Session. I'd like a motion to go into closed session pursuant to Section 2(c)(1), 2(c)(5), 2(c)(11), and 2(c)(21) of the Open Meetings Act. May I have a motion?

MS. DEMUZIO: Motion.

MR. SEWELL: Second.

CHAIRPERSON OLSON: It's been moved and seconded to go into Executive Session. Can we do a voice vote, please? All in favor?

("Ayes" heard)

CHAIRPERSON OLSON: Opposed, like sign.

(No response)

CHAIRPERSON OLSON: We are now in Executive Session.

(EXECUTIVE SESSION HELD)

THE FOLLOWING PROCEEDINGS WERE HELD IN OPEN SESSION, BEGINNING AT 9:25 A.M.

CHAIRPERSON OLSON: I will call the meeting back to order.

Are there compliance issues or settlement

issues or final orders, Frank?

MR. URSO: Yes, Madam Chair. Thank you.

First thing I'd like to ask the Board to do is close a file on Transitional Care Center of Arlington Heights. After further review, this matter, which was referred by the Board, has been found not to have any compliance issues. So I'm asking for the Board's approval to close that file.

MR. SEWELL: So moved.

MS. DEMUZIO: Second.

CHAIRPERSON OLSON: All in favor?

("Ayes" heard)

CHAIRPERSON OLSON: Opposed, like sign.

(No response)

CHAIRPERSON OLSON: The motion passes. The file will be closed on Transitional Care of Arlington Heights.

MR. URSO: Madam Chair, I have a Legal referral on Project No. 03-054, Grand Oak Surgery Center, Libertyville. It's docketed as HFSRB 14-09. I'm asking for a motion to refer these matters to Legal Counsel for review and filing of any notices of non-compliance, which may include sanctions detailed and specified in the Board's Act and in the Board's Rules.

CHAIRPERSON OLSON: May I have a motion to refer Project 03-054, Grand Oaks Surgery Center, to Legal Counsel?

MS. DEMUZIO: Motion.

MR. SEWELL: Second.

CHAIRPERSON OLSON: All in favor?

("Ayes" heard)

CHAIRPERSON OLSON: Opposed, like sign.

(No response)

CHAIRPERSON OLSON: The motion passes.

MR. URSO: Thank you, Madam Chair. I believe that's all I have at this point.

CHAIRPERSON OLSON: I would like to acknowledge, as we get going, Mr. Mike Mills. We would like to sincerely thank him for all of his help in helping us get caught up with compliance issues. And welcome back to the Board as a valued member of the Staff. Thank you, Mike.

May I have a motion to approve the agenda?

MR. HAYES: So moved.

MS. DEMUZIO: Second.

CHAIRPERSON OLSON: All in favor?

("Ayes" heard)

CHAIRPERSON OLSON: Opposed, like sign.

(No response)

CHAIRPERSON OLSON: The motion passes; the agenda is approved.

May I have a motion to approve the transcripts of the April 22nd, 2014 meeting?

MR. HAYES: So moved.

MS. DEMUZIO: Second.

CHAIRPERSON OLSON: All in favor, please say "aye".

("Ayes" heard)

CHAIRPERSON OLSON: Opposed, like sign.

(No response)

CHAIRPERSON OLSON: The motion passes.

The next order of business is Public Participation. Courtney?

MS. AVERY: Okay. We have for public participation Project No. 13-072, NorthPointe ASTC; Gary Kaatz, Nancy Garry, Edward Green, Lemont Johnson, and Tom Sink can come to the table.

(Pause)

MS. AVERY: Remarks will be limited to two minutes.

CHAIRPERSON OLSON: Nelson will be our timekeeper, and he will loudly tell you when your two

minutes are up.

Mr. Kaatz?

MR. KAATZ: Good morning, Madam Chair, Members of the Illinois Health Facilities and Services Review Board. I'm Gary Kaatz, CEO of Rockford Health System, which includes our flagship hospital of Rockford Memorial Hospital.

I come before you today to join many other members of the Rockford community in registering our strong opposition to the Beloit Health System's application to establish an ambulatory treatment center in Roscoe, which is directly north of Rockford. As you know, this opposition has been expressed in a public hearing, public comment period at the April 22nd hearing, and in the letters that have been submitted to the Agency.

Rockford Health System believes that the Beloit application runs counter to the spirit and specific law and regulations that govern the Illinois Certificate of Need process. Simply put, this project would result in a significant and unnecessary duplication of surgical services in our area. As your staff has documented in the State Agency Report, the Rockford area has substantial excess surgical capacity, and the proposed facility is not needed.

As Rockford Health System looks to the future, we're well aware that we need to become more efficient in the delivery of outpatient surgical services. Rockford Memorial's existing surgical suite was built in 1954, and we're now evaluating how best to address its deficiencies while prioritizing the healthcare needs of our community. As we plan for these necessary improvements, and also acknowledge that our system does not afford an ASTC option to our patients, we have committed to consider only those options that do not increase surgical capacity in the area. In other words, were Rockford Health System to apply for permission to establish an ASTC for our patients, we would be prepared to commit to you that our proposal would not add surgical capacity to area.

If, for example, we were to propose new operating rooms in an ASTC setting, we would couple that proposal with a commitment to reduce Rockford Memorial's operating rooms by the same number. Our plan, taken in total, would respect your Agency's determination that surgical capacity should not be added to the area.

The Beloit project before you today ignores this Board's standards, and the many negative findings in their State Agency Report is an indication of how incompatible this project is with Illinois health facility

planning.

You should be aware that Rockford Health System and our --

MR. AGBODO: Two minutes.

MR. KAATZ: Do I need to stop?

CHAIRPERSON OLSON: You can conclude your remarks quickly.

MR. KAATZ: It would greatly -- it would cause a disruption in the referral patterns of patients. Many patients that need more intense and intensive care would be going to Wisconsin providers. It would cause reputational and financial hardships on the hospitals and the other providers and the medical staff of Rockford; and not to mention that the loss of patients to Wisconsin would trigger economic injury to Winnebago County and our state in the form of lost jobs and tax revenue.

Thank you for this opportunity to offer Rockford Health System's opposition.

CHAIRPERSON OLSON: Thank you, sir.

MS. GARRY: My name is Nancy Garry, representing Rockford Endoscopy Center's opposition to the construction of an ASTC on the NorthPointe campus in Roscoe, Illinois. We have listened to testimony related to this project and our position has not changed.

At the March meeting, Mr. Carvalho voiced concerns about the applicant's plans to duplicate services in the name of an integrated delivery system. Your Chairperson, Ms. Olson, questioned the applicant's conclusion that this project is their least expensive option because their application outlines alternatives on their own campus that are less expensive.

The applicant talks about the need to be more efficient in the wake of the Affordable Care Act. Despite this, Beloit Health System proposes to build a facility to hospital standards with higher than standard construction costs and marginal volume projections. To offset the combination of high cost and low volume, the applicant will need to bill facility services at outpatient hospital rates. These rates are nearly double what ASTC rates would be. The result is that state-line residents will not realize the less costly healthcare facility they are endorsing.

Beloit Health System continues to assert that there's a demonstrated need for better access to healthcare services in Winnebago County, yet they provide no real evidence that this facility is the solution to improve access to care. It is our experience that access is limited to the indigent population. A new facility in

Roscoe is not likely to improve access for the low income residents of either Rockford or Beloit.

We ask this Board to give serious consideration to the opposition you have heard today, some from your own membership. We hope you will stand by your stated goals of promoting cost containment, better management, and improved planning to prevent unnecessary construction or modification of healthcare facilities. We respectfully request that you deny this application.

CHAIRPERSON OLSON: Thank you.

Edward Green?

MR. GREEN: Good morning. My name is Edward Green. I am outside counsel to Rockford Orthopedic Surgery Center. Rockford Orthopedic Surgery Center is a joint venture between OSF-St. Anthony Hospital in Rockford and Rockford Orthopedic Associates.

I speak today in opposition to Project 13-072, Beloit Health System's efforts to establish a multi-specialty surgery center in Roscoe. I do not intend to repeat all of the points that, quite frankly, have been raised over the last couple months in the State Agency Report, raised by various oppositions, all of which, by the way are compelling. Instead, I want to focus on a few theories set forth by the applicants in their application

and to focus on the applicant's own AHQ data, which Dr. Burden did a great job of asking for, because it's very illuminating.

First, I simply disagree with the notion that, according to the applicant, the Affordable Care Act is focused on consolidation. It's not focused on consolidation. It is focused on efficiency, and it's focused on forcing providers to better utilize what they already have. In many respects, the Affordable Care Act is attempting to end the arms race where providers compete to build ever bigger and fancier buildings and buy ever more expensive equipment.

Now, in order to get more efficient, I will stipulate that some providers will have to consolidate. But, just as importantly, I would submit that a number of providers need to divest certain inefficient operations that misallocate limited resources.

In the case at hand, the applicants argue that they need to establish a new, four OR multi-specialty because their current hospital lacks adequate OR space. Noting that at the outset that your Staffers concluded that they don't really need any additional OR's, they posit that they need additional OR's because their current utilization really only allows them to use five or six OR's.

MR. AGBODO: Two minutes.

MR. GREEN: More specifically, the applicants assert that their OR's need to be used for open heart surgeries and cystos. But I did some research on AHQ data. They only did 41 open heart surgeries last year. In the state of Illinois, we require 200 to establish an open heart program. That's less than 20 percent of the average. If they merely discontinue their open heart surgeries, they would have their extra OR, and I'm speculating that that open heart room is a giant operating room and that they could easily convert it to not only one, not only two, but probably three OR's.

CHAIRPERSON OLSON: Mr. Green, with respect, I'm going to have to ask you to conclude your comments.

MR. GREEN: Okay. And the other comment was, on GI, I look at their average daily census, which is only 43. Out of 256, that means they're only using 17 percent of their licensed beds, which I would indicate means they have a lot of space in their hospital.

And then also the notion that they need extra OR's for outpatient surgery when their outpatient surgery, non-GI, hasn't varied by more than two-tenths of one percent from 2010 to 2014.

So with that, I would simply say that the

applicants can look within, fix what they need to fix, discontinue services, reallocate resources within their own hospital, and not negatively impact all of the other providers in Rockford.

CHAIRPERSON OLSON: Thank you, Mr. Green.

Tom Sink?

MR. SINK: Good morning. First of all, I'd like to say thank you to the Board for allowing me to speak today on behalf of the NorthPointe expansion.

My name is Tom Sink. My wife and I are 30-year residents of the Roscoe/Rockford area, and I've seen our community change a lot. One of the most significant improvements to our community is the addition of NorthPointe Health and Wellness Center. NorthPointe provides my family and me with comprehensive healthcare. We are able to get all of our needs addressed at one convenient location. I presently live less than three miles from NorthPointe, and with NorthPointe located near the Rockton Road entrance to I-90, which I travel to and from work every day, it is easy and convenient for me to make my appointments. I consider all of the NorthPointe staff as caretakers. Whether in the Immediate Care, my NorthPointe physician's office, or using the Wellness Center, they are always assisting me in maintaining my

health.

Having an ASTC at NorthPointe to address our future medical needs would not only be convenient but comforting. The addition of an ambulatory surgery treatment center would provide me and other residents of the state-line area with local access to a modernized and well-designed facility that will improve efficiency for the physicians, staff and patients and bring much-needed, temporary jobs for construction and permanent jobs to operate the facility. As Business Manager and Financial Secretary of the Local Union 364 of the IBEW, I know firsthand how much this project will mean for the community. With the long-term unemployment in the region sometimes as high as 40 percent in the construction trades, this development is vital to the recovery of our local economy.

I'm here today in support of this project and hope the Board will provide Beloit Health System the Certificate of Need they are requesting. Thank you.

CHAIRPERSON OLSON: Thank you, Mr. Sink.

MS. AVERY: Next we have Dr. Patel, Dr. Charles, Jim Moore, David Krienke, and Peter Marks, Jason Dotson.

MR. MOORE: Good morning. My name is Jim

Moore. I was born in Rockford Illinois and lived my first 55 years there. Some people claim I should be a bionic man because of all of the surgeries that have been performed on my body. I'm not a bionic man, but I am alive today because of the advances in the medical profession.

A couple of my surgeries were performed at two ambulatory surgery centers. I've learned firsthand that having procedures completed at a surgery center is considerably less stressful, just because I didn't need to go to the hospital.

My primary doctor in Rockford retired. In the meantime, I have moved to Roscoe. I preferred finding a local doctor with an office there. I was pleased when NorthPointe was constructed. I now have a primary doctor located there. The change saved me many 30-mile roundtrips to and from Rockford, which has improved my access to medical care. I have used the services of five other doctors through the Beloit Health System.

Now that I'm in my 80's, the close proximity of my doctors and medical facilities is even more important to me. Like many my age, I am more stressed about things that never bothered me before. I needed to travel to Beloit Memorial Hospital on March 17th for another procedure. I would certainly have preferred doing this at

an ambulatory treatment center at NorthPointe.

NorthPointe feels like my second home. Whether I'm in the business center or the medical side of the building, the staff is very professional and friendly. From my point of view, an ambulatory surgery treatment center at NorthPointe adds another service for me and my friends that, if necessary, could be performed there with minimum stress and much less trouble.

Thank you for your attention.

CHAIRPERSON OLSON: Thank you, sir.

MR. KRIENKE: Thank you. I'm Dave Krienke, Village President of the Village of Roscoe. On behalf of the citizens of the Village of Roscoe and the Village Board, I'm pleased to be here today to speak in favor of the development of the ambulatory surgery treatment to be located on the NorthPointe campus in the Village of Roscoe.

NorthPointe and Beloit Memorial have been very involved in our community to bring community awareness of health and wellness issues to our region, both having booths and displays at local events, fall festival, RoRo, and other events, partnering with Hononegah High School to assist in sports and fitness programs, use of the swimming pool at NorthPointe for the Hononegah swim team, providing athletic trainers for Hononegah sports teams.

Beloit Memorial has filled the need in our community with expanded services, providing high-quality care for our residents, conveniently located and accessible to the residence of northern Illinois, supported by the three northern communities, Roscoe, Rockton and South Beloit that support this.

Then also providing tax base. In 2012 the property taxes, $818,413.88, were provided to the taxing districts, of which Roscoe's portion was $54,000.

In addition, I would like to say that the Village Board earlier submitted a resolution of support by the Village Board and its residents, and I encourage this Board to approve the NorthPointe expansion. Thank you very much.

CHAIRPERSON OLSON: Thank you.

Next?

MR. CHARLES: Good morning, and thank you for the opportunity for me to express my thoughts here. I'm Dr. Pierre Charles, a general surgeon practicing at Beloit Hospital, Beloit Memorial Hospital, as well as the NorthPointe facility. I've been in the area for 17 years. I'm licensed in both Wisconsin and Illinois.

I perform over 400 general surgery cases per year. 60 percent of those are considered outpatient

procedures. A significant number of those people already come from the Roscoe, northern Illinois area.

We currently have twenty surgeons and three endoscopists working in a space that has only six operating rooms and two GI suites. One of the rooms is dedicated strictly to cardiothoracic surgery. The other room is dedicated to urology. Shifting the outpatient case load to an ambulatory care center would give more flexibility in the operating schedule. It will provide the necessary rooms for emergency surgeries, emergency C-sections, and trauma.

The proposed ambulatory surgery center would give us the opportunity to modernize the current operating rooms in the hospital facility while providing the surgical needs for our ambulatory care patients. The ambulatory surgery center will be outfitted with hospital-quality space, equipment, and other standards, giving the surgeons who use the ambulatory center the familiarity and quality expectations of a hospital setting. But more importantly, this will provide and ensure patient care and patient safety.

Finally, many studies have shown that patients report favorable experiences at ambulatory surgery centers. This is because of the ease of access, the ease of flow,

shorter stays, more comfortable environment, and lower costs and, ironically, lower infections.

An ambulatory surgery center is the right thing for our patients and for our community. I respectfully ask that you consider our proposal.

MR. AGBODO: Two minutes.

MR. CHARLES: I respectfully ask that you consider our proposal to develop this ambulatory surgery center. Thank you.

CHAIRPERSON OLSON: Thank you, Dr. Charles.

MR. PATEL: Good morning. My name is Hermant Patel. I'm a gastroenterologist at Beloit Health System since August 2012. I'm here today to support the proposed ambulatory surgery treatment center at NorthPointe facility in Roscoe, Illinois.

At present, we have two GI procedure rooms at Beloit Memorial Hospital for three gastroenterologists, including myself. We performed approximately 3,800 GI procedures in 2013, and about 80 percent of those were outpatient GI procedures. Our current GI suite does need modernization to provide quality and efficient care for our GI patients. The new surgery center will help our patients to get easy access in and out of the facility, provide them more comfort and privacy before, during, and after the

procedure, will (inaudible) the delay in patient care and will also give patients more choices in saying when they can schedule their procedures. The proposed surgery center will really help our patients to get the quality care at a modern facility.

I ask -- I thank you for your time and ask for your support for this project. Thank you.

CHAIRPERSON OLSON: Thank you, Dr. Patel.

Dr. Marks?

MR. MARKS: My name is Peter marks. I'm a cardiothoracic and vascular surgeon at Beloit Memorial Hospital and thoracic surgeon at Rockford Memorial Hospital, having licenses in Illinois and Wisconsin, and I am in support of the ambulatory care center in Roscoe.

With the increase in cardiac and thoracic procedures that we're doing at Beloit Memorial, we need a modernized and dedicated OR suite. At this time, our dedicated suite is 100 square feet less than the guideline standards.

It was mentioned earlier that we did 41 or 44 hearts last year. We are projected to do 100 open heart surgeries this year at Beloit, showing that we are increasing our caseload. We have been performing full-time at Beloit Memorial cardiac surgeries for about a year and a

half, having done cardiac (inaudible) at Beloit Memorial prior to this time. On top of this, our rooms, following cardiac procedures, must be available for several hours post-procedure because of any possibilities of post-op complications. Because of that fact, any outpatient surgery that may be scheduled in that room may be postponed or delayed, which I think is a great inconvenience for those patients.

And for those reasons, I very strongly support this proposal and hope you agree with us. Thank you.

CHAIRPERSON OLSON: Thank you, Dr. Marks.

Is Jason Dotson here?

MR. DOTSON: I am, but not presenting.

CHAIRPERSON OLSON: Thank you, Jason.

That concludes the public participation portion of the agenda for today. Thank you all.

The next item on the agenda is "Chairperson's Authority", and Frank will discuss that.

MR. URSO: Thank you, Madam Chair. What we'd like to do is just continue our discussion briefly of what we had at the last meeting; and I'd like to just make sure that all of the Board members and Staff understand that the Chair, based upon the rules and the Act, has essentially authority to approve permits or exemptions that have met

all of the Board's review criteria. The Chair also has the authority to approve extensions of obligation. The Chair also has the authority, independently of the Board, to approve permit renewals if it's a first request. In addition, the Chair has the authority to approve alterations for permits, if it's the first request for an alteration of a permit.

What we'd like to say, however, is the process that we've been -- we'd like to follow is that none of these approvals by the Chair will be finalized until after the Board meeting, and that's to give all Board members and Staff an opportunity to comment or question any of those projects or applications before they are finalized. So we wanted to just inform the Board members of that process and see if there are any questions.

CHAIRPERSON OLSON: Thank you, Frank.

If you guys would like to mull on this a little bit, maybe Frank could send us some information, or if there's comments or questions about this now, we can discuss them.

Basically, any action that was taken by the Chairperson would not be finalized until after the first meeting after it's been reviewed, but it would include -- at this point, I think we've been doing a lot of the permit

renewals, first permit renewals, but not so many of the no opposition/no findings applications. So, I very much would like Board input on how you feel about that process before we proceed.

MR. BRADLEY: Has this been the practice previously, that it wasn't final until after a Board meeting?

MR. URSO: Based upon the transcript that I found of the 2010 meeting, the Board did approve that process whereby all the Board members would be receiving all of the same documentation as the Chair and then have an opportunity to speak to these Chair approvals prior to them being finalized. So the Board did talk about this in the 2010 meeting as a process.

CHAIRPERSON OLSON: At this point, I've not approved any applications that have no findings and no opposition. That's all come in front of the Board. I haven't done that outside of the Board.

MR. BRADLEY: Well, I would favor anything that would make the process more efficient, and I'm certainly happy to put that authority in the hands of the Chairperson, and I'm not sure it needs to be subject to Board review subsequently.

MR. URSO: I should add that at any time, the

Board Chair can defer to the full Board on any one of these types of approvals, regardless of what area it is or what type it is. The Chair always has that authority.

CHAIRPERSON OLSON: I guess I appreciate your comments, and I guess speaking personally, because I'm the one sitting in the chair at this point, I would feel better -- I don't have any problem with the first permit renewals, but if it's a new application, even if there is no findings and no opposition, I would feel better that the Board was at least aware that those are in my hands and I intended to review them and decide whether or not they should come before the full Board. I would hate to approve something based on that and then find out in hindsight that a Board member had a huge issue or had some information that the State Board Staff didn't have.

So, if that's what the Board requests, that's exactly what I will do. But I just wanted to voice that one concern on my part.

Other comments? If there was opposition -- because we don't know until we have the public participation if somebody is going to come to the meeting to speak in opposition. So, if at that point, if there was opposition, even if I had already reviewed the application, that would have to go back to the full Board. It wouldn't

be just under my purview at that point.

MR. URSO: Could I say one more thing, just to clarify the record in an earlier meeting? There is a definition of "final decision", and I might have misstated that at an earlier meeting. There is a definition in the Act of what a "final decision" is. So, I just wanted to clarify the record.

CHAIRPERSON OLSON: So are we okay with proceeding along the lines of what the statute allows? Did you have something to say Mr. Constantino or George? Do you want to weigh in on this at all?

(Pause)

CHAIRPERSON OLSON: All right. So since that's already part of the statute, we don't need any motion or anything.

The next order of business is Post Permit Items Approved by the Chairman. And, George, would you --

MR. ROATE: Thank you, Madam Chair. There are three permit alterations and one permit renewal that Chairwoman Olson reviewed and approved between these last two meetings.

A. Permit Alteration 13-005, Southern Illinois Hospital Cancer Center in Carterville.

B. Permit Alteration 13-070, DaVita Belvidere

Dialysis, Belvidere.

C. Permit Alteration 11-104 McAllister Nursing and Rehabilitation, Tinley Park.

And Permit Renewal D. 12-022 Resthave Home of Morrison, a 15-month permit renewal from June 1st, 2014 to September 1, 2015. Thank you Madam Chairman.

CHAIRPERSON OLSON: Thank you, George.

The next item of business is Items for State Board Action; and before we go into this portion of the meeting, I just wanted to clarify that we are now changing the process just slightly to follow Robert's Rules to the letter of the Rules. So, what we will do is, I will call the project. The applicants may come to the table. I will then ask for a motion and a second on that project. Once the project has been moved and seconded, I will then ask for the State Board Staff report. Then the applicant can give their comments. Then we'll have Board questions, and then take the vote. This follows Robert's Rules of Order more strictly than we were doing on our own.

And please bear with me. I'm an old dog and this is a new trick. I will restate the motion right before we call.

MR. BRADLEY: Madam Chair, I believe under Robert's Rules of Order, if you make a motion or second a

motion, you are not obligated to vote "yes" on the motion; is that correct?

CHAIRPERSON OLSON: That is correct. Thank you for that clarification.

So I'm going to call Permit Renewal Request Project 10-065, Park Pointe-South Elgin Healthcare and Rehab, to the table at this point. And if you will sign the sheet and be sworn in.

(Pause)

CHAIRPERSON OLSON: For the record there was no opposition and no findings on this application, correct?

MR. ROATE: Correct, Madam Chair.

(Oath given)

CHAIRPERSON OLSON: May I have a motion to approve Project 10-065, Park Pointe-South Elgin Healthcare and Rehab, for a permit renewal?

MR. SEWELL: So moved.

CHAIRPERSON OLSON: May I have a second?

MS. DEMUZIO: Second.

CHAIRPERSON OLSON: It has been moved and seconded to approve Project 10-065. May I have the State Board Staff report, George?

MR. ROATE: Thank you, Madam Chair.

On December 14th, 2010 the State Board

approved Project 10-065. This permit authorized the establishment of a 120-bed long-term care facility in South Elgin. The State Agency notes the project is obligated, and the current project completion date is May 30th, 2014. The project cost is $21.7 million.

The permit holders request a project completion date of May 31st, 2016, extending the project's completion date by 24 months, from May 31st, 2014 to May 31st, 2016.

Thank you, Madam Chair.

CHAIRPERSON OLSON: Thank you, George.

Do you have comments for the Board, or do you want to just open it to questions? What would you like to do?

MS. WESTERKAMP: Kim Westerkamp on behalf of South Elgin.

We're asking for this extension due to the volatility of financing over the last couple of years. This project was a recovery zone bond project that did not have any other backing from the government for those bonds. We have since obligated that project for $22 million. It took a little longer than we had expected, with all due respect to the operation side of things, with Medicaid, trying to get some stability. Now that they've been

stabilized, both sides of this project are now both fully funded.

CHAIRPERSON OLSON: Thank you.

Let the record show that Justice Greiman has just arrived.

Are there questions from the Board?

(Pause)

CHAIRPERSON OLSON: I have just one question. So you have not yet really started construction?

MS. WESTERKAMP: We have not started construction. We do have all of our engineering and site utilities done for the site. The architects are continuing to work on the CD's. We expect those to be done in the next 90 to 120 days. We'd like to break ground by October, but with winter conditions, we don't want to have to pay to heat the ground, especially in light of last year's winter.

CHAIRPERSON OLSON: So you're still confident that you can hit that May 31st, 2016 completion date?

MS. WESTERKAMP: We are. The latest that we would break ground would be February to March of 2015, which they're giving us about 11 to 13-month completion date, which puts it to about March or April of '16.

CHAIRPERSON OLSON: Other questions, comments from the Board?

(No response)

CHAIRPERSON OLSON: Seeing no further questions, may I have a roll call vote to approve Project 10-065, Park Pointe-South Elgin Healthcare, for a permit renewal request?

MR. CONSTANTINO: Motion made by Mr. Sewell, seconded by Senator Demuzio.

Mr. Bradley?

MR. BRADLEY: Yes.

MR. CONSTANTINO: Dr. Burden?

MR. BURDEN: Yes.

MR. CONSTANTINO: Senator Demuzio?

MS. DEMUZIO: Yes.

MR. CONSTANTINO: Justice Greiman?

MR. GREIMAN: I'll pass.

MR. CONSTANTINO: Mr. Hayes?

MR. HAYES: Yes.

MR. CONSTANTINO: Mr. Penn?

MR. PENN: Yes.

MR. CONSTANTINO: Mr. Sewell?

MR. SEWELL: Yes.

MR. CONSTANTINO: Chairman Olson?

CHAIRPERSON OLSON: Yes.

MR. CONSTANTINO: The motion passes.

CHAIRPERSON OLSON: Thank you. I'll let you do the math. Sorry. The motion passes.

Thank you. Good luck.

(Pause)

CHAIRPERSON OLSON: The next order of business, Extension Requests; we have none.

There are no exemption requests, no alteration requests, no declaratory rulings or other business, no Healthcare Worker Self-Referral Act business, no status report on conditional or contingent permits; which brings us to applications subsequent to initial review.

The first one up is Project 13-072. If those applicants could come to the table, please.

(Pause)

CHAIRPERSON OLSON: While they're coming to the table, may I have a motion to approve Project 13-072, NorthPointe Health and Wellness Campus in Roscoe.

MS. DEMUZIO: Motion.

MR. SEWELL: Second.

MR. CONSTANTINO: Please sign the sign-in sheet.

CHAIRPERSON OLSON: Please sign and be sworn.

(Oath given)

CHAIRPERSON OLSON: It has been moved and

seconded to approve Project 13-072, NorthPointe Health and Wellness Campus. May I have the State Board Staff report, George?

MR. ROATE: Thank you, Madam Chair.

The applicant is Beloit Health System, Incorporated. The applicant is proposing to construct and establish an ambulatory surgical treatment center on the campus of NorthPointe Health and Wellness Campus in Roscoe. The applicant will also construct 12,480 gross square feet of shell space with this project. There's an estimated project cost of $16.3 million. The anticipated project completion date is September 16th, 2016.

The summary of findings are negative findings on both 1110 and 1120. There are support and opposition letters in regard to this project. A public hearing was held on February 10th of 2014 with support and opposition presenting. A copy of the Hospital Profile for Beloit Health System is attached to the State Agency Report.

Thank you, Madam Chair.

CHAIRPERSON OLSON: Thank you, George.

Does the applicant have comments for the Board?

MR. McKEVETT: Thank you. Good morning.

My name is Tim McKevett. I'm President and

CEO of Beloit Health System, and with me today at the table is Ed Parkhurst from Prism Consulting, Dr. Pierre Charles, who is a practicing general surgeon and Medical Director for our health system, Evie Rittenhouse, who is our Director of Surgical Services, and Mike Bua, who is our Director of Financial Services for the health system.

I'd like the thank the Board for your time today and for granting a deferral at your Board meeting on March 11. We asked for this deferral to respond to the questions and request for additional data. Those questions were answered in the data provided via supplemental material that was submitted on April 15th, 2014.

In summary, Dr. Burden had asked that our data be presented in the AHQ format. This has been provided and, along with other supplemental information, demonstrates that we are an in-network provider. In fact, 44 percent of our activity for the Beloit Health System comes from residents of Illinois.

Ms. Olson asked whether or not we had evaluated a like option for a service on our campus for a former ASTC, and we did, and that was in the original permit application on pages 122 and 123, as well as we also focused on providing a supplemental submission for data showing that alternative. And that alternative produced an

excess cost of $1 million more than the proposed facility.

Ms. Olson also asked if we would see Illinois Public Aid. We currently do and would plan continue to see Illinois Public Aid at the proposed ambulatory treatment facility. In fact, our percentage of Illinois Public Aid seen at NorthPointe is 15.6 percent, versus other free-standing ambulatory surgery centers in the area being either zero or close to zero. We also have a charity care program that would be instituted at the ambulatory surgery center as well. As a health system, we provided approximately 7 percent of charity care, or $13 million, last year.

In addition, our supplemental information demonstrates our compliance with two issues: Our architectural engineering fees and our ASTC equipment. We've also responded to the construction costs based on local market conditions.

Lastly, we understand the requirements of our physicians performing the procedures at the ASTC needing to have privileges at an Illinois-licensed hospital and have attested to this fact in the supplemental material provided. We are currently in confidential discussions with an Illinois-licensed hospital, who has agreed to work with us to meet this requirement.

I'd like to provide an overview of the project for the Board. The project before you is our request to develop a four-room ASTC -- two multi-specialty OR's and two GI procedure rooms -- at our NorthPointe campus in Roscoe, Illinois, which was approved by this Board at the January 2006 meeting for the campus installation. The project is contingent upon us relocating existing procedural volume from our main campus in Beloit, Wisconsin to the new facility. This will allow us to modernize our existing OR's at the main campus.

We believe we have provided the required information to support the project -- which, again, is based on the relocation of sufficient utilization attested to by our doctors in our application -- to support a four-room ASTC. We have met eighteen of the State Board's criteria. There are six areas of non-compliance which I will briefly respond to in greater detail further on.

Before we elaborate and explain the issues surrounding non-compliance, I'd like to make some comments on some global points in response to comments that have been made.

The Beloit community is located directly on the state line. Our sister city is South Beloit, Illinois. NorthPointe is only nine miles away from our main campus in

Beloit, Wisconsin, or a 14-minute drive time. We are the closest hospital to the NorthPointe campus. We were surprised that a relocation project has created so much opposition from providers that are 20 or 30 miles away.

It has been suggested that we are moving into the market to improve our market payor mix. Our hospital was built in 1928 in Beloit, and since then, it has been providing services to the northern Illinois and Wisconsin -- southern Wisconsin area. Our market characteristics and demographics for our community are similar to those in Illinois-based regional providers in opposition to the project.

We have physically been in the Roscoe area since 1991, and we established our NorthPointe campus, an expansion to the original facility, in 2007. We are not moving to a better market. We are already in place. In 2013, we saw 82,000 Medicaid patients. We provided 13 million in charity care. The relocations of these cases will not pay change or payor mix. We will continue to see all patients who seek care with our institution.

We also ask that the Board consider that we're an integrated delivery system, a system that provides coordinated care, including wellness prevention, physician office-based care, ambulatory and inpatient services, and

long-term care. We have an integrated medical record, and to achieve the greatest effectiveness and efficiency, we need to utilize our own facilities to maximize our productivity.

Now I'd like to briefly address the six SAR non-compliance issues, which were also covered in the response to the SAR report.

From a square footage perspective, we are 1,731 square feet above the State standard. This is at the directive of the hospital for our architects to design the facility to hospital standards. We believe it's a sound policy to provide standardization in a complex environment like an OR for our surgeons and our staff. We believe this will promote the utmost in patient safety, quality and efficiency. We have also allocated more space for the private area for our patients, which we believe will improve their patient satisfaction.

From a market capacity perspective, in the excess capacity within the market, our proposed ASTC will not add capacity, as we are relocating procedures and capacity and volume to be able to modernize our current surgical and GI suites at the main facility. We do have physician attestation letters to support the transfer of these cases.

In addition, we have limitations with other in-market providers to make referrals to, including some of the opposition that is a single-specialty provider, in -- case in point being solely focusing on GI procedures or orthopedic procedures. What we're proposing to do is create a multi-specialty facility that will treat various forms of patients at the new facility.

In addition, we have limitations on our payor acceptance with these other facilities. Some will not see Illinois Public Aid. Some will see minimum Illinois Public Aid. We will continue to see Illinois Public Aid, as well as all of the other payors that present at the facility.

As far as the capacity at our main facility, the SAR indicates that our hospital workload can justify ten procedure rooms by State guidelines. We currently have eight -- six OR's and two GI rooms. In our OR's, one room is dedicated to urology procedures and has a fixed cysto table. The other room is dedicated to cardiac surgery, and we must keep one room available for emergencies or hot C-sections. This brings our actual utilization of OR's to four rooms. When we combine the new proposed two OR's plus the two GI procedure rooms, that brings our capacity to ten, which will meet the State standard because of the limitations in our current OR's.

The construction costs are slightly higher than State Board guideline. This is related to local Rockford and Beloit inflation and market factors. Our architectural and engineering fees on the clinical costs do meet the State guidelines, right at eight percent. Our equipment costs for the entire project, not just the ASTC, is within the State standard from equipment cost perspective.

In summary, the benefit of the project will improve our local access. The transfer of these cases will allow for the modernization of existing OR's for open heart cases and other major surgical procedures without impacting the other providers in the market. In addition to not having an impact on the other providers due to the transfer of these cases, the calculated capacity really doesn't exist, given some in-market providers do not offer the comprehensive services we're proposing for NorthPointe, and there are in-market access constraints due to Medicaid and charity care issues. We will accept all payors.

The project will also improve patient satisfaction and outcome. The project will improve physician satisfaction, recruitment and retention. We will create 28 new jobs for the facility and create construction jobs during the life of the project, which is

projected to be one year.

For these reasons we ask that you approve the project and grant a CON approval for our patients and our staff. Thank you.

CHAIRPERSON OLSON: Thank you.

Questions from the Board?

MR. SEWELL: Some of the opposition testimony suggested that you don't do significant cardiac, open heart surgery. What has been your number of procedures? Is it remaining the same, increasing or decreasing? And did you consider the alternative of getting out of the business of open heart surgery so that you have adequate space to do this project?

MR. McKEVETT: Our open heart procedures are performed in a standard OR which is 100 square feet short. Our actual surgery volumes have grown. We implemented the program about a year ago on a full-time basis, and the program has grown from approximately 50 in the first year to a -- projected to do over 100 in the next year, ultimately growing to 150 cases. So we believe that that program will continue to grow, and thus we do not plan to eliminate that program.

CHAIRPERSON OLSON: Dr. Burden?

MR. BURDEN: Thank you, Madam Chair.

Thank you very much for your response to the questions that we had with your initial presentation here recently.

I suppose my remarks go along with what Member Sewell brought up about open heart surgery and that's -- I'm well aware that Dr. Marks testified that the proposal is to double the number, which is still below the recommended State standard for numbers of cardiovascular procedures -- and you're not the only institution that doesn't meet that standard. I'm well aware that there's significant numbers in the state of Illinois that have open heart programs that don't reach the 200 number, and we haven't, shall we say, interfered with that. That's a hope, that those numbers -- and I recognize the need as an administrator for the income that comes from open heart surgery. It's important.

The two things that strike me in the review are the impact on other facilities and the establishment of the new facility, both of which they're lengthy and they have been responded to by the opposition. I don't know how I can overcome the impact on other facilities without the hospital profiles in front of me, and I don't have them, but you have testified that you felt that moving to the new unit would not impact the other facilities. That's

essentially in summary, as I read between the lines, what you've said regarding what you plan.

As far as the establishment of a new facility, I, like the surgeons have testified, being a retired surgeon, recognize the importance of having adequate space and new equipment and everything that might make the performance for both surgeons and other surgeons more effective and provide satisfaction for retention of surgical staff. I'm sympathetic to that.

I'm also concerned and appreciate the stat that you gave regarding care for the Public Aid population. 15 percent is what I have written down I heard. But what is the overall -- I've driven through Beloit and South Beloit. Like all of our cities that are older, it looks like the numbers of Public Aid might actually be higher in the community. Am I wrong?

MR. McKEVETT: The 15.6 percent is only Illinois Public Aid. We add to that at NorthPointe another 8 percent. So we have 24 percent Public Aid, which is similar to the Rockford market.

MR. BURDEN: I know the Rockford market is high. I can't -- we've seen data, reams of data, but I know it's high, probably in that range or higher; that would be my estimate.

The other thing that I'm impressed with is your charity care. Ambulatory surgical treatment centers are not required by law -- although I often lecture about the need for them -- to provide charity care and Public Aid care, and I appreciate the statement that you have this intention. That impresses me.

Also, I'm impressed by a facility that is built in 1928. That's getting there, and I'm sure that that's a concern, and I recognize how you're attempting to do it. Was there a discussion about rebuilding on the site, tear down and rebuild? Is it beyond the concept of financial prudence, or is it something that you still look forward to considering, even though you have an application for an ambulatory surgical treatment center on board? I'm just curious about that.

MR. McKEVETT: Doctor, for a point of clarification, we established the original hospital in 1928, which is still standing; but we relocated to our new facility in 1969.

MR. BURDEN: So there's a significant improvement from that time frame. A '69 institution does not demand significant repair, or is it in jeopardy or does it need subsequent repairs or additions as we go forward in the very near future?

MR. McKEVETT: Beyond ongoing maintenance of the facility, as far as a replacement facility, we do not anticipate needing a full hospital replacement. The design was in the 1960's. The OR's are small. It was really designed for an in-patient environment. As we move more to an outpatient environment, we want to make the appropriate adjustments for our patients.

MR. BURDEN: Thank you.

CHAIRPERSON OLSON: Senator?

MS. DEMUZIO: Just one quick question. What is the population of Roscoe?

MR. McKEVETT: The population of Roscoe -- I can tell you more when you combine our Service Area. Roscoe, Rockton, South Beloit has a population of around 30, almost 40 thousand people.

MS. DEMUZIO: And how close are you to the -- is it the Minnesota or Wisconsin line?

MR. McKEVETT: You can throw a stone. Our city is separated by the state line, and on the opposite side of the border is South Beloit, Illinois.

MS. DEMUZIO: Okay. So combining all of that, the Service Area would be about 40,000 people?

MR. McKEVETT: Just the population on the opposite side of the border, the South Beloit, Roscoe and

Rockton, is around 35 to 40 thousand. Beloit itself proper is around 36,000.

MS. DEMUZIO: Okay. Thank you.

MR. SEWELL: Madam Chairman.

CHAIRPERSON OLSON: Yes.

MR. SEWELL: Does Wisconsin have a Certificate of Need program?

MR. McKEVETT: No, sir, they do not.

CHAIRPERSON OLSON: Other questions, comments from the Board?

(Pause)

CHAIRPERSON OLSON: I actually have one. I'm still stuck on this. Alternative 3 was to develop the ambulatory surgery center on the hospital campus, and you told me that's a million dollars more?

MR. McKEVETT: When you look at apple to apple, the four rooms that we're proposing at NorthPointe to what we propose and looked at on the hospital campus, it's actually Alternative No. 5 in the application.

CHAIRPERSON OLSON: That's on the NorthPointe campus?

MR. McKEVETT: I'm sorry. 4B, and 5 is the actual proposal. 5 is what we're proposing.

CHAIRPERSON OLSON: But alternative No. 3 was

to develop a six-room ASTC with one procedure suite on the current campus, and that was 19.8 million, but that was six as opposed to four; so that was more rooms.

MR. McKEVETT: That is correct.

CHAIRPERSON OLSON: So if you did it room by room, that's actually -- I mean, my math is not very good, but it seems to me that that's a less-costly alternative. If you did four on your campus, divide it by six and figure out what it is per room, it's still cheaper to do that on your campus.

MR. McKEVETT: Do you want to respond to that, Ed?

MR. PARKHURST: Ms. Olson, I can get the application out; and that was looked at in terms of a per-room basis. The apples to apples comparison with a four-room ASTC on the hospital campus, using the same guidelines and assumptions throughout, in terms of the relativity, the hospital option is 1.3 million more, compared to the actual project at the NorthPointe campus. The reason for that is based on the fact that on the hospital campus, there is more infrastructure and so forth required to develop the facility, and the construction people can talk to that.

The difference between the four-room and the

six-room is that if Beloit was to put all of the ambulatory care cases into a special ambulatory surgery department, if you will, or suite on the campus, it would require six rooms, by the State guidelines. Only a portion of the ambulatory surgery cases are going to be or proposed to be transferred from the hospital to NorthPointe, and that justifies the four rooms, two operating rooms and two GI rooms.

CHAIRPERSON OLSON: So if you move the six, put a structure on the current campus with the six, that would also take a bunch of those cases out of your hospital.

MR. PARKHURST: That is correct. And the proposal is to have a portion of the cases remain at the hospital, in part because of the relationship between, let's say, orthopedics inpatient outpatient cases, to follow as part of the process for those outpatients that are not real good candidates for an ambulatory treatment center because of their severity in illness and so forth. So to transfer those cases out of the hospital is not good practice from a quality standpoint.

Does that help answer your question?

CHAIRPERSON OLSON: Yes, it does.

Justice?

MR. GREIMAN: Yes. You have a remarkable record in charity care and Medicaid, probably the best I've ever seen, frankly, in the state. But what I wanted to know is, do you know what percentage of these people are from Illinois and what are from Wisconsin? Can you tell me that?

MR. McKEVETT: The activity that we have for our health system, 44 percent is provided in the activity to Illinois residents.

MR. GREIMAN: So most -- so the majority of the people, including the charity, is going to Wisconsin?

MR. McKEVETT: But it's real close, 44 percent.

MR. GREIMAN: Right. I understand. Okay. Thanks.

CHAIRPERSON OLSON: Mr. Carvalho?

MR. CARVALHO: Just data. You had a discussion a few moments ago about Medicaid data. Our Public Health Community Map shows Winnebago County being at 36 percent Medicaid compared to the state as a whole, which is 30 percent. So, your instinct that Winnebago County is higher than average Medicaid is correct. The state as a whole is about 30.5, and Winnebago was 36.3.

CHAIRPERSON OLSON: Thank you.

Anybody else?

(Pause)

CHAIRPERSON OLSON: Seeing no further questions, may I have a roll call vote to approve project 13-072, NorthPointe Health and Wellness Campus in Roscoe?

MR. CONSTANTINO: Motion made by Senator Demuzio, seconded by Mr. Sewell.

Mr. Bradley.

MR. BRADLEY: The State Agency Report shows deficiencies in the size in their review, as they looked at the size of the project, the impact on other facilities, the establishment of new facilities, and the reasonableness of the project cost. I find most compelling the impact on other facilities and the establishment of a new facility. I don't see community support for this, and I vote no.

MR. CONSTANTINO: Dr. Burden?

MR. BURDEN: I recognize what was mentioned by Member Bradley and I am concerned. I felt that the argument that -- the impact on other facilities argument being made by the applicant is reasonable for me to accept. I am impressed by their attempt under the establishment of a new facility to address the Medicaid population and charity care. It's a difficult situation in the entire community. I recognize Rockford's economic position as

well.

But I would and -- am voting yes for this project based on the arguments that I just heard.

MR. CONSTANTINO: Senator Demuzio?

MS. DEMUZIO: Yes. I will be voting no due to the scope of the size of the project, the impact on other facilities, and the establishment of new facilities within the Service Area; and my vote will be no.

MR. CONSTANTINO: Justice Greiman?

MR. GREIMAN: I'm going to vote yes. I am incredibly impressed by the safety net information. The 4 percent charity care is about -- is 4 times what we usually see. It's usually one percent, if one percent, and the -- to have 43 percent Medicaid is an incredible number as well. So I'm going to vote yes.

MR. CONSTANTINO: Mr. Hayes?

MR. HAYES: I understand the criteria here of the State Agency Report, and I'm very -- I understand that and -- but I feel this facility also will be able to provide charity care and also be able to develop patients that would come from Wisconsin into Illinois; and the construction of this facility, I think, would be very valuable to the community. So, thus, I'm going to vote yes.

MR. CONSTANTINO: Mr. Penn?

MR. PENN: For reasons stated by Dr. Burden, Justice Greiman, I believe it does provide additional access to care. I'm going to vote yes.

MR. CONSTANTINO: Mr. Sewell?

MR. SEWELL: For reasons stated by Member Bradley, I'm voting no. The application fails to meet the 1110 criteria and two or three of the 1120 criteria.

MR. CONSTANTINO: Chairwoman Olson?

CHAIRPERSON OLSON: I vote no based on negative impact to the providers in the area.

MR. CONSTANTINO: Motion failed to pass.

CHAIRPERSON OLSON: You'll be given an Intent to Deny.

MR. URSO: You'll have an opportunity to come back before the Board, as well as submit additional information.

CHAIRPERSON OLSON: Thank you.

Project 14-002, Physician's Surgical Center in Belleville, has been deferred.

The next project up is Project 14-006, Northwestern Lake Forest Hospital in Lake Forest. May I have a motion to approve Project 14-006, Northwestern Lakeview Forest Hospital in Lake Forest?

MR. BRADLEY: So moved.

MR. HAYES: Second.

CHAIRPERSON OLSON: Would you all be sworn in, please.

(Oath given)

CHAIRPERSON OLSON: It has been moved and seconded to approve Project No. 14-006, Northwestern Lake Forest Hospital.

George, may I have the State Board Staff report?

MR. ROATE: Thank you, Madam Chair.

The applicants, Northwestern Memorial Healthcare and Northwestern Lake Forest Hospital, propose to construct a replacement hospital facility on the existing hospital campus in Lake Forest, Illinois. The total project cost is $377.9 million. The anticipated project completion date is December 31st, 2018. The Board Staff reports there is no opposition to the project. There are support letters in the project file.

There are negative findings restricted to the area of 1110 in regard to size of the project, project utilization, modernization, and performance requirements. The project did undergo a permit alteration -- a modification. The application was modified, and that

information is contained in the project file.

Thank you, Madam Chair.

CHAIRPERSON OLSON: Thank you, George.

Does the applicant have comments for the Board? Would you first introduce everybody that's at the table with you?

MR. McAFEE: Absolutely. My name is Tom McAfee. I'm the president of Northwestern Lake Forest Hospital. I'm joined today by Bridget Orth, our Director of Regulatory Planning; Jim Mladucky, Director of Design and Construction; Matt Flynn, Senior Vice-President and Chief Financial Officer; Dr. Michael Ankin, our Vice-President and Chief Medical Officer; and Rob Christie, our Senior Vice-President of External Affairs and Communications.

CHAIRPERSON OLSON: Thank you. Please proceed.

MR. McAFEE: Good morning, and thank you, Madam Chair and Fellow Board Members. We appreciate you spending time reviewing our project.

We really are glad to be back with you today to advance our two-step process for the construction of a new Lake Forest -- Northwestern Lake Forest replacement facility. As you may remember, last September we received

your approval for our master design permit, and today we are before you respectfully asking for a construction permit.

We are pleased to be in conformance with nearly all of the State standards in utilization and the size of the facility, as well as the State's -- all of the State's financial standards. We designed what we believe is a truly state-of-the-art facility that will take advantage of the resources of the Northwestern system. So it will be enormously efficient and, in fact, will leverage the capabilities of the system so as to not need to add additional elements, like a data center or central warehousing and those types of administrative overhead.

As I had stated in our September presentation, the existing Lake Forest Hospital is absolutely committed to continuing our 115-year legacy of providing comprehensive healthcare to the residents of Lake County. That means that our healthcare facilities need to be continually updated to keep pace with the powerful and, in many ways, unpredictable changes in healthcare. Limitations in our physical plant today are putting our future in jeopardy. We appreciate your acknowledgement of this fact in our last September meeting, that our facility and shared patient showers, for example, down the hallway

or our inconvenient departmental adjacencies that have occurred over the years have really limited us, in addition to our many semi-private rooms that are throughout the facility; and, in fact, even the maintenance of a 75-year-old infrastructure is at the end of its life.

We are committed to making Northwestern Lake Forest Hospital a destination for health in Lake County. We plan to create comfortable spaces, both indoors and out, on our campus. We're also very proud to demonstrate our commitment to provide access to the best health care, regardless of the patient or the family's ability to pay. In fact, we, as stated in the Staff report, consistently provide the highest percentage of charity care based on patient revenue over any other hospital in the county, at 5.5 percent in fiscal year '13. We also provide 25 percent of all charity care in the county, yet are one of the smallest hospitals in the county.

Over two years ago we developed a plan, in collaboration with Lake County Health Department, to help HealthReach, the only free clinic in the county, to merge with one of our Chicago community partners, Erie Family Health. Northwestern's funding and collaboration will save HealthReach from closing, and create a medical home for nearly 6,000 uninsured residents in Lake County.

Moreover, we believe in advancing the academic mission of our enterprise and helping make certain that we have the future talent necessary to take care of our patients and our population.

We forecast that there will be a shortage in primary care in Lake County, similar to what will occur across the country; and, in fact, to combat that issue, we, along with Feinberg School of Medicine at Northwestern University, will be establishing the first family practice residency program in Lake County. Our first residents are due to arrive in July of next year. We believe that this will also allow us to make certain that our population is well cared for on the primary care front as our population ages.

So, at this point, I'd like to now turn the presentation over to Bridget Orth, who will address the few negative findings in our report.

Thank you.

CHAIRPERSON OLSON: Thank you.

MS. ORTH: As stated in the Staff report, of the 29 required criteria addressed in our application, there were only 4 State Board standards that were not fully met. Two of those criteria were addressed in the master design permit. The first relates to the minimum bed

requirement for hospitals within a metropolitan statistical area. The requirement for medical/surgical beds is 100 beds. As we stated last September, LFH has never been authorized for 100 medical/surgical beds. We are currently authorized for 84 beds.

Our proposed project is a replacement project and, therefore, we propose to replace just 84 medical/surgical beds. This number is consistent with our historic and projected utilization.

The second criteria that was not fully met relates to the utilization of non-categories of service. As with the master design permit, the Staff Report notes that there are three non-categories of service that do not meet the Board's utilization standards, out of 28. The three areas are Emergency Department, C-section rooms, and nuclear medicine. In all cases, we are proposing just one room more than we can justify. I provided a detailed justification for each of those extra rooms last September, but I would be happy to provide that information again, if the Board so pleases.

The third criteria that was not met was modernization. Because the project is a replacement facility, the Board's criteria for modernization applied. Specifically, the number of beds are to be justified using

historical volume, not projections. Using historical volume, we can justify 80 medical/surgical beds of the 84 proposed. But using a growth rate of 1.8 percent per year, which is consistent with our historical growth rate and projected population increases, we can justify 90 beds, which are six more than what we are requesting.

Similarly, with obstetrics beds, using historical volume justifies 15 beds, and we are proposing 18. Just under a thousand women travel from northern Cook County and Lake County to deliver their babies at Prentice Women's Hospital in Chicago. We plan to accommodate around 25 percent of those deliveries at the new facility, which more than justifies the additional three beds.

The fourth criteria that was not met relates to the size of the inpatient units. So I will turn the microphone over to Jim Mladucky.

MR. MLADUCKY: Thank you, Bridget.

Good morning. I'm Jim Mladucky, Director of Facility Planning and Construction for Northwestern Memorial Healthcare.

The Staff report notes that our project does not meet the standard square footages set out by the State. It slightly exceeds those by about one percent. There are really three areas or three things that I want to highlight

to justify this. One is to accommodate flexibility and adaptability in the future. Number two is to accommodate patient care at the bedside And number three is to accommodate the family.

So, first on flexibility and adaptability, our inpatient units are proposed as a universal design, and with that, that will give us our flexibility to accommodate changes in in-patient trends in the future. Also, this is a 50-year commitment, a 50-year investment, and as evidenced by the age of our current facilities that Tom had mentioned -- they were built in 1941 with a major expansion in 1957 -- they've served us well. But it's time for a new facility that accommodates future trends and flexibility that's necessary to make sure we accommodate those.

Secondly, care at bedside. As mobile technology continues to advance, we are bringing mobile technology to the bedside. With that there needs to be a parking space or an alcove for that technology so when it comes on the unit, we've accommodated that at the entry of our patient rooms with about 25 square feet. So that's over and above what the standard is today.

And then lastly, accommodating the patient family. So, as we have on our Chicago campus with Feinberg and with Prentice, we have accommodated a patient zone in

our family area or in our patient area so that our families can stay overnight. This adds about 60 square feet to our facility, to our room.

And then lastly, in our Special Care Nursery area, on that Special Care Unit, we have two family rooms that accommodate overnight stays. That's not typical in facilities, and it's not part of the standards, but these two family rooms support families there overnight for extended stays. Also, during the day they can be used as respite as well as lactation rooms. So, with those three things, that's why we are above the standard and, again, that's just slightly over one percent.

So, if there are any other questions, we'd be glad to address that now, on any of the design issues that have come up or any other questions that you may have.

CHAIRPERSON OLSON: Thank you.

Questions from Board members?

(Pause)

CHAIRPERSON OLSON: Okay. Seeing no further questions, may I have a roll call vote on Project 14-006, Northwestern Lake Forest Hospital, for the construction of a replacement hospital?

MR. CONSTANTINO: Motion made by Mr. Bradley, seconded by Mr. Hayes.

Mr. Bradley?

MR. BRADLEY: The State Agency Report shows that they were reviewed on 29 criteria. They failed to meet on four, and I think we've heard -- first of all, I'm not sure those are deal breaker criteria, and I think we've heard very good explanations of why the criteria are the way they are, and for that reason I'm happy to vote yes for this major project.

MR. CONSTANTINO: Dr. Burden?

MR. BURDEN: I share Mr. Bradley's sentiments and his attitude. On a personal note, I remember -- I'm 81, so I can state -- when I was 10 getting off at Sam Cohen's delicatessen and walking all the way to Laurel Avenue to where my granddad lived. It sure has changed in that area.

Anyway, I am impressed by what the application includes, which I think is crucial, as the primary care residency training. Having been involved with the downtown hospital, I think that's a great move, and I heartily endorse this application as a positive yes.

MR. CONSTANTINO: Senator Demuzio?

MS. DEMUZIO: Yes. I will be voting yes due to the fact that I thought that your explanation of the various criteria that were not met certainly was very

impressive, and I appreciate your coming forth and clarifying those, and I'll be voting yes. Thank you.

MR. CONSTANTINO: Justice Greiman?

MR. GREIMAN: I vote yes.

MR. CONSTANTINO: Mr. Hayes?

MR. HAYES: The applicant has met the 29 criteria and have given good explanations for the four criteria they have not met. Also, I think that this could be obviously a great asset to the Lake County area, and I'm going to vote yes.

MR. CONSTANTINO: Mr. Penn?

MR. PENN: Your explanations were very thorough and complete for the four criterias, and that's the reason I'm going to vote yes.

MR. CONSTANTINO: Mr. Sewell?

MR. SEWELL: I'm voting yes. The explanations were very good about the four that we were concerned with in the State Agency Report, and it didn't hurt that you have a Star Family Practice Residency Program.

MR. CONSTANTINO: Madam Chairwoman?

CHAIRPERSON OLSON: I vote yes as well, and I do thank you for addressing very specifically the criteria not met.

MR. CONSTANTINO: Motion passes.

CHAIRPERSON OLSON: That's eight votes in the affirmative. The motion passes. Good luck to you.

It is now quarter to eleven. We will break for 15 minutes. Thank you.

(Recess)

CHAIRPERSON OLSON: The next order -- the next application is 14-008, Neighbors Rehabilitation Center in Byron, Illinois. May I have a motion to approve this project?

MR. BRADLEY: So moved.

MR. SEWELL: Second.

CHAIRPERSON OLSON: It has been moved and seconded to approve Project 14-008, Neighbors Rehabilitation Center in Byron.

(Oath given)

CHAIRPERSON OLSON: May I have the State Board Staff report, George?

MR. ROATE: Thank you, Madam Chair.

The applicants, Neighbors Property, LLC and Neighbors Rehabilitation Center, LLC, propose to modernize an existing 101-licensed-bed facility and add 30 additional nursing care beds, resulting in a 131-bed, long-term care facility. The total cost of the project is estimated to be $9 million, and the anticipated project completion date is

February 28th, 2017.

The application file contains support letters and no opposition letters. A public hearing was held on this project on March 31st, 2014 with all attendees in support. The application file contains a commitment letter from a bank to secure financing.

There are two negative findings in the 1120 criteria in regards to financial viability and reasonableness of project cost.

Thank you, Madam Chair.

CHAIRPERSON OLSON: Thank you, George. Comments for the Board? Would you introduce everybody, John, or tell us who everybody is.

MR. KNIERY: Sure. My name is John Kniery.

MS. BARRISH: Good morning, Ms. Chairman, members of the Board. I'm Kirsten Barrish, Vice-President of Physical Plan.

I'm pleased to have with me Tom Winter, CFO of SIR Management; Louise Bergthold, Executive Vice-President of Operations of SIR Management; Pawn Thammarath, our Administrator of Neighbors Rehab; and John Kniery and Charles Foley, our CON consultants.

CHAIRPERSON OLSON: Thank you.

MS. BARRISH: I would first like to thank Mr.

Constantino and Mr. Roate on their work on the State agency report; and in light of the positive need findings presented by Staff on this project, I will keep my comments brief.

I would like to present a brief history and address the financial findings. To address the financial issues, I would like our CFO, Tom Winter, to briefly address these issues.

MR. WINTER: As the two findings that were negative, first of all, with regard to financial viability related to the historical side of the financial statistics, as the ownership entity and the operating entity are closely held with identical interests, the financial viability of our project really needs to be considered on a consolidated basis. Not to do so gives only a partial picture, as historically the owner carries all of the debt and only receives enough income to meet its cash payments, mortgage payments, while the operator has all of the profits, the surplus cash retained there. So looking at a combined basis, the ratios that we've provided on page 24 and 324 of the application show a more equalized, stable and healthy financial picture.

With respect to the reasonableness of the financial costs, the logic is similar. The entire project

is for the benefit of the residents. Although we've separated the costs into clinical and non-clinical areas -- and on page 15 of the State report, the State is saying that our clinical costs are $6 per square foot higher than the norm, which is about 3 percent above the norm. However, when you combine the clinical and the non-clinical costs together, we fall -- which is referred to on page 28 of the application, we then fall within the State and Board norms.

At this point, I'd be happy to open it up to questions; but if you'd like, we can share with you some unique aspects of the history of Neighbors.

MS. THAMMARATH: Good morning and thank you.

I'd just like to share with the Board the history of how Neighbors came about. It truly was found by a physician, a nurse and a plumber. So they did the study, I believe, probably early '60's and truly looking -- where Byron is located, we're about 13 miles away from Rockford. However, there's Route 2. It's very terrifying for my seniors and aging community now and they don't like to travel Route 2. Everything can happen at Neighbors; that would be their preference.

So, let me take a little step back. The physician was Dr. (inaudible), and Connie Lee (phonetic)

was the nurse, and then the plumber was Jack Colbert (phonetic). I had the opportunity to meet with them since SIR Management took over for Neighbors, and so Mr. Colbert himself comes to our picnic every year, which is held on June 13th. So he handles all of the grilling, the hot dog, and this is truly a community. I have the greatest support, as you can refer to the hearing itself. We have well -- my seniors in the community showed up and gave us the support.

As the need -- I really need to have the expansion, the addition to our services. Right now our facility, I'm very much at a disadvantage to provide to the community itself. We have Jack and Jill bathroom shared by four people. When I got in to some of the jams, because if I have several isolations -- like now my census is 82 and I have seven of those beds are unusable at this point because I have isolations, and this last couple weeks I told seventeen patients alone to go elsewhere to get the services within the community.

So it is important for us to have the expansion. So I felt that my residents and neighbors, they have been great. The facility itself, they treat us as a family, and I have worked at other facilities where it's not well accepted. Long-term care -- the founder of

these -- of this facility have done tremendous job to give the community back. So I, as a newcomer for six years at Neighbors, would like to carry on and continue.

CHAIRPERSON OLSON: Thank you.

MS. BARRISH: So, again, we would like to thank the State Staff for tremendously positive finding, and for the overwhelming community support. So now we ask the Board for its support for this project. Your approval will allow us to proceed with this much-needed renovation and addition in continuing the original three Neighbors mission. We thank the Board for its consideration and would be pleased to address any questions you may have.

CHAIRPERSON OLSON: Thank you.

Questions from the Board?

Mr. Sewell?

MR. SEWELL: I need to hear more about the application's failure to meet the financial viability criteria. The owner and operator don't appear to meet the current ratio of the day's cash on hand. I heard you address that, but I need to hear more about that, because projections going out to 2018 are favorable, but right now things don't look good with respect to those ratios. I need to hear more about that.

MR. KNIERY: Mr. Sewell, we provided some

documentation in the application. One of the big issues was retaining the cash and keeping the cash in the entities. I'd like to have Tom address that a little bit further for you.

MR. WINTER: As far as retaining the cash, we try to effectively manage the cash as best we can. Typically that means we wouldn't retain -- we wouldn't borrow from the bank just to have the cash on hand to meet future obligations. We typically will pay down our working capital lines of credit so that we have available to borrow the money from the bank according to our lines of credit. But the cash itself isn't sitting in the bank, doing nothing, not working for us. It's paid down the line to help us reduce our costs and meet our needs.

We also distribute the cash that we feel is excess to the owners to provide them with other needs of investing in the community or investing in other business interests; and if we need the cash to come back in, then that happens, it comes back in. We've also attached on page 317 to 320 a corporate resolution going forward to retain those excess funds, those surplus funds in the project, as opposed to distributing them, which is what we've done historically.

So I hope that answers your question.

CHAIRPERSON OLSON: Justice?

MR. GREIMAN: Doing this good service to the community, why is it taking until 2017 to do this? Why is it taking three years to do this?

MR. KNIERY: It's primarily the timing of the project. There's extra time factored into this particular project. We've been running -- we've had to file several permit renewal requests on other projects. There's been consolidation in IDPH in their review, the facility review to get the facility up and licensed. We factored probably six, eight months extra in of time to receive all of these things, so hopefully we don't have to come back before the Board.

MR. GREIMAN: So you assume that you will complete it considerably before 2017? Is that what you're saying?

MR. KNIERY: I would think so. Tom, do you have anything further on that?

MR. WINTER: Yes. I think the construction cycle is an 18-month construction cycle. To be able to actually have all of the construction started this fall, especially with the weather concerns, is somewhat questionable. So we anticipate on the outside, if we aren't able to start that fast, this fall, because of those

IDPH changes, at the latest we would be starting in the spring right away. On an 18-month cycle, we figured with the timeline we would put down 18 to 24. That puts us out.

MR. GREIMAN: Okay. Thank you.

CHAIRPERSON OLSON: Anybody else?

(No response)

CHAIRPERSON OLSON: I just wanted to make a comment. I was actually at the hearing for this project, and this project has enormous, enormous community support, and if I'm correct -- maybe you can confirm this for me, because several people spoke to that at the hearing. You guys have a rather long waiting list right now; is that correct?

MS. THAMMARATH: Yes, because we can't accommodate the need, as I identified earlier for isolations and stuff, and then when we do have something open, we do call and say, "Okay, we have a bed available." So, you will see some people go to a neighboring facility for a few days and then transfer to us.

CHAIRPERSON OLSON: And is it also not true that you have several pending life safety issues that this project will address, that you're waiting to address with this project?

MS. THAMMARATH: As far as life safety issues,

I think we're clear on those. But we are addressing some of our bigger items.

CHAIRPERSON OLSON: So modernization with more useful common space and upgrading some of those areas?

MS. THAMMARATH: Yes, ma'am.

CHAIRPERSON OLSON: Other questions?

MR. SEWELL: Does Neighbors Property, LLC own other significant real estate or operations other than Neighbors Rehabilitation Center?

MR. WINTER: No. It only holds title to the land and the building.

CHAIRPERSON OLSON: Other comments or questions?

(No response)

CHAIRPERSON OLSON: Seeing no other questions, may I have a roll call vote for project 14-008, Neighbors Rehabilitation Center in Byron?

MR. CONSTANTINO: Motion made by Mr. Bradley, seconded by Mr. Sewell.

Mr. Bradley?

MR. BRADLEY: The State Agency Report supports a yes vote, and that's how I vote.

MR. CONSTANTINO: Dr. Burden?

MR. BURDEN: Yes.

MR. CONSTANTINO: Senator Demuzio?
MS. DEMUZIO: Yes.
MR. CONSTANTINO: Justice Greiman?
MR. GREIMAN: Yes.
MR. CONSTANTINO: Mr. Hayes?
MR. HAYES: They have addressed the criteria of the State Board report that were not met, and I'm going to vote yes.
MR. CONSTANTINO: Mr. Penn?
MR. PENN: Yes.
MR. CONSTANTINO: Mr. Sewell?
MR. SEWELL: I vote no. I'm not satisfied with the responses on the financial viability criteria.
MR. CONSTANTINO: Madam Chairwoman?
CHAIRPERSON OLSON: I vote yes for the reasons stated.
MR. CONSTANTINO: Motion carries.
CHAIRPERSON OLSON: Good luck to you.
(Pause)
CHAIRPERSON OLSON: Next we have Project 14-009, Highland Park Hospital in Highland Park.
(Pause)
(Oath given)
CHAIRPERSON OLSON: May I have a motion to

approve project 14-009, Highland Park Hospital in Highland Park, to discontinue a 20-station ESRD facility.

MS. DEMUZIO: Motion.

MR. SEWELL: Second.

CHAIRPERSON OLSON: It's been moved and seconded to approve Project 14-009. May I have the State Board Staff report, George?

MR. ROATE: Thank you, Madam Chair.

The applicant, NorthShore University HealthSystem is requesting to discontinue their 20-station End Stage Renal Dialysis facility on the campus of their hospital, of the Highland Park Hospital. There is no cost to this project, and the project completion date is November 30th, 2015.

The applicant cites the reason for the closure as being, they note that chronic dialysis care is no longer consistent with the acute care mission of the hospital, and the requirement to operate three shifts would result in a need for outpatient access to the hospital during typical outpatient hours.

There's no opposition, no findings, there's no public hearing; and this project is related to the project that will be heard next, Project 14-010, Fresenius Medical Care, Highland Park. It is not interdependent, though.

CHAIRPERSON OLSON: Thank you, George.

There is no opposition and no findings. Would you like to give a presentation or open to the Board?

MR. HALL: Yes, Madam Chair. I have some brief comments.

CHAIRPERSON OLSON: Please.

MR. HALL: First, to introduce who I have at the table. I'm Jesse Peterson Hall, and I serve as the President of Highland Park Hospital. To my right is Honey Skinner from Sidley Austin. To my far left is Dr. Stuart Sprague. Dr. Sprague is the Division Head for NorthShore University HealthSystems' Division of Nephrology. Dr. Nancy Nora, the Medical Director of Highland Park Hospital's Dialysis Unit, was unable to attend, as she is out of the state at this time. Dr. Sprague is here representing Dr. Nora in his role as NorthShore's clinical leader of all nephrologists. And to my immediate left is Jack Axel from Axel and Associates.

Highland Park Hospital is seeking your approval for the discontinuation of its ESRD Unit that is located within the hospital. By way of background, you should be aware that Highland Park Hospital established this chronic dialysis unit at a time in the early 1980's when chronic dialysis was typically provided at hospitals

as opposed to free-standing dialysis units. Since that time, provision of dialysis services has changed radically. In Illinois, for example, we believe that there are less than a dozen hospital-based programs still operating.

Approximately 12 months ago, we concluded that the space currently being used for the dialysis unit needs to be deployed for essential inpatient services. Moreover, we came to the determination that certain chronic services, like dialysis, can be appropriately provided outside of the hospital setting.

In the process of evaluating these potential changes, Highland Park Hospital first addressed how to optimize the transition of care for our existing dialysis patients. We concluded that to avoid a disruption of service, our patients would be best served by the establishment of a free-standing facility located near the hospital and which would provide for continuity of care by offering positions to our patients' existing clinical team.

We reached out to various dialysis providers and were impressed by the care provided by Fresenius. We also learned that Highland Park's medical leadership has worked with Fresenius for many years. We are happy to report that our application, and the Fresenius application that follows it, presents to this board a plan for care

that prioritizes the care of our patients.

The proposed facility, as you will learn from Fresenius, is located four minutes to the west of the hospital campus. Moreover, the existing Highland Park Hospital team which is currently responsible for the care of our patients will be offered positions at the new facility, and we expect that most will transition with their patients. We believe that Highland Park Hospital's patients' interests and well-being will be best served by this proposal. The continuation of the patient's current physician and nursing team at the new unit, as well as the continuation of important programs such as nocturnal dialysis, will ensure that the excellent care to which our patients are accustomed will continue after their relocation to the new unit.

Further, their ability to move as a block of patients into the new unit will allow them to maintain their current treatment schedule around which much of their lives revolve. A delay or disapproval of the new ESRD facility application leaves these patients and their families in limbo and is likely to create stress and uncertainty.

As you will note, Fresenius has applied to establish a replacement facility for Highland Park

Hospital's unit without requesting additional stations. At the present time, there are 20 dialysis stations at Highland Park Hospital, and following the completion of these two projects, there will be 20 stations located at the new Fresenius facility. From the beginning, it has been Highland Park's and Fresenius's intention to be clear that there would be no net gain in stations in your inventory as a result of these two projects. To this end we jointly engaged in technical assistance conversations with Agency Staff to ensure that the application documents set forth these explicit commitments.

Throughout this process, the hospital has been in close contact with our ESRD patients and their families through one-on-one conversations as well as letters, and we anticipate that the vast majority of the hospital unit's patients will transition their care to the proposed Fresenius unit in Highland Park and will continue to be cared for by their current team of physicians and nurses in the new Fresenius unit. Dr. Nancy Nora, Medical Director of Highland Park Hospital's Dialysis Unit, will serve as Medical Director at the new facility. Because of the continuity of the clinical team, we envision this transition to occur seamlessly.

The State Agency Report for this project

demonstrates compliance with all review criteria. No letters of opposition have been received in connection with this project or Fresenius's project. As you know, no public comments in opposition were made today and, in fact, not a single area provider even replied to our request for comment on the impact on their facility.

Thank you.

CHAIRPERSON OLSON: Thank you.

Questions from the Board?

(Pause)

CHAIRPERSON OLSON: I just want to make sure that we're clear -- yes?

MR. SEWELL: Even though we were told as a Board that these were separate but -- related but not interdependent, the presentation was about both applications.

CHAIRPERSON OLSON: Well, I just want to clarify with the applicant that the Board will consider these as two separate applications. So you potentially take the risk of us approving your discontinuation and not approving your new facility. Is the applicant prepared to proceed in that manner? Because I don't want the assumption to be made that if we approve the discontinuation that -- I don't know what's going to happen

with the next project, but I just -- because I agree; I think your assumption from your presentation is "close this one; open the other one", and I don't want to put you at risk for believing that that is done. It's not a done deal. It very well could happen; it very well could not happen.

MR. HALL: In the event that ours is approved and Fresenius is denied, we will reevaluate the situation at that point.

CHAIRPERSON OLSON: Once we've approved a closure, you're going to come back and ask us to open it again?

MS. SKINNER: The permit to discontinue is a permit for any purpose establishment, whatever we're requesting the Board. We do not need to complete that -- if we receive a permit, we are allowed to, we are approved to close or discontinue.

CHAIRPERSON OLSON: Okay, you're right.

MS. SKINNER: So, we would -- if that were to happen --

CHAIRPERSON OLSON: You would vacate the permit or approval?

MS. SKINNER: Perhaps. We would listen to your discussion. But we have not made that decision. The

reason we wanted to address with "no findings" and "no opposition", our process is that we wanted the Board to be aware of our efforts to work with the patients and their families to prioritize the clinical. It was not because we were in any way confused about this vote and this consideration.

MR. URSO: Your completion date is November 30th, 2015. So you have time.

MR. AXEL: Mr. Urso, that completion date is consistent with the other application, and our initial thoughts and conversations revolved around the potential of a single application for a replacement facility. That would, however -- and we learned this through technical assistance conversations with your Staff. That is not possible, because what we are doing is we are replacing a hospital-based unit with another unit that is off the hospital site. So we could not do this as a single application.

MR. CARVALHO: Madam Chair.

CHAIRPERSON OLSON: I have a question perhaps to Mr. Urso, Ms. Skinner, Mr. Foley, because something Ms. Skinner just said puzzled me a little bit. If the Board, in fact, approved the closure and approved the new application, would you be allowed to abandon the closure

and run two facilities?

MR. URSO: Say that again.

MR. CARVALHO: Sure. Earlier the Chairwoman asked if the closure were approved and the new facility were not approved, you would be in the situation of having given up the old facility and not gotten approval for a new one; and Ms. Skinner replied, "But we can always abandon the closure, in which case we can continue to operate the old one." And I wanted to take the logic of that one step further. If the Board approved the closure and approved the new one, could the applicant abandon the closure and run two facilities under that same theory?

MS. SKINNER: Right, and thank you for that question. Very specifically, Mr. Carvalho, we engaged in technical assistance conversations with the Agency because of that particular question; and that is, how do we put commitments within our application and create conditions upon this permit that would require the closure of our unit in the event of the approval of the next application? So, we put that -- those specific conditions within the permit, and we would expect that the vote on this project would be -- would have a condition on it, that it would -- our unit would discontinue if the next project is approved, very specifically.

MR. CARVALHO: So that would both solve my dilemma and going forward in the future, because this type of situation could recur. The Board needs to always make sure that the second application has a condition that it's dependent upon the successful -- or the completion of the first one, so that someone doesn't wind up with two permits when the Board only intended one.

MS. SKINNER: Exactly.

MR. URSO: And I suppose the Board can entertain a condition on this particular discontinuation approval that you would be discontinued and not have any other opportunities to reestablish that facility.

CHAIRPERSON OLSON: Okay. Somebody is going to have to -- time out. So now are we putting conditions on the -- because we have a motion and a second on the floor, because of our new Robert's Rules. So do we need to vote on that motion or does somebody want to amend that motion?

MR. URSO: You have to amend that motion, if you want to add conditions.

CHAIRPERSON OLSON: What is the wish of the Board?

MR. PENN: Whoever made the motion has to make the amendment.

MR. BRADLEY: No, that's not true.

MR. URSO: Anybody can make the amendment. It has to be accepted by the individual who initiated the amendment. They have to allow their motion to be amended.

CHAIRPERSON OLSON: Who made the original motion?

MR. CONSTANTINO: Mrs. Demuzio.

MS. DEMUZIO: Is there anyone that has an amendment to the motion?

CHAIRPERSON OLSON: She's open to an amendment.

MS. DEMUZIO: Open to an amendment.

MS. SKINNER: As, of course, are we, the condition that our permit -- just for clarification purposes, that if the next project is not approved, it is our intention to, just to clarify, evaluate the future of our unit. We may proceed to discontinuation. We may choose, because of our interface with our patients and our clinical team, not to discontinue. But that under all circumstances, the approval -- we would not continue to provide this service at our hospital if the next project is approved, and that is, by the way -- just for clarification to Mr. Carvalho, that is set forth in our application documents. We have committed to that. In our follow-up

with your staff and technical assistance conversations, we have also made that commitment.

CHAIRPERSON OLSON: What is your current utilization? Do you know?

MR. AXEL: It's 80 percent, give or take a percent.

MR. HAYES: I have a question. David, should this amendment be made for the next project -- are we kind of confused here in that should this amendment be made for the second project?

MR. CARVALHO: Yes. Let me be clear. The conversation that I had a moment ago with Ms. Skinner totally resolved the concern that I had raised. I wasn't anticipating that any particular amendment to the first project was required, because, again, it is an application to stop doing something, and the -- in the second motion, the one on the second project is where you would embed in there that that second one was conditional upon actually stopping the first one; and Ms. Skinner indicated that that was already in their application, in fact. So, they clearly already indicated that was their intent.

So at least for the issue I raised -- another Board member may have another issue, but the issue I raised is dealt with; dealing with the first project however you

deal with it, and the second project, if you approve it with that condition, you're fine, and if you turn it down again, the applicant then has a permit to close, but has expressed the understandable expectation that they'll then reevaluate their position at that point and potentially -- although not necessarily -- abandon their permit request. I think you're covered, at least on the issue that I raised.

Just to clarify, you don't need a person's permission to amend something under Robert's Rules. Anybody can offer a motion to amend, and then it's just voted on and approved or not.

CHAIRPERSON OLSON: I didn't read that chapter. I'll go back and read it.

George and Mike do you have any -- I'm sorry.

MR. CARVALHO: You may operate on more polite boards than I have.

MR. GREIMAN: Madam Chairman?

CHAIRPERSON OLSON: Yes.

MR. GREIMAN: What I wanted to know is whether there's a condition that requires you to operate your 20 units until there is a similar operation in your area, so that you can't tomorrow morning close down and leave the patients running around someplace.

MR. AXEL: Justice Greiman, we discussed in the application itself that our unit will cease treating patients within 30 days following the opening and certification of the replacement unit.

MR. GREIMAN: Okay. So that's a condition then of your application.

MR. AXEL: Yes.

MR. GREIMAN: And it should be a condition that you vote on, Madam Chairman. We should vote on that, Madam Chairman, that that's a condition of that.

CHAIRPERSON OLSON: That they not close their unit?

MR. GREIMAN: Right, until there's something in the area.

CHAIRPERSON OLSON: Until they have a plan in place to care for the patients?

MR. GREIMAN: We're not tying it up with the second one.

CHAIRPERSON OLSON: But just a plan.

MR. GREIMAN: But say something in the area that does that.

MS. SKINNER: Not to belabor this, but just because you raised this, Justice Greiman, the reason we wanted to go through this presentation is for you to hear

from us about the planning that we have very proactively been engaged in with regard to this issue of replacement. That's why we're here. That's why we had these technical assistance conversations with your State Staff. That's why you're hearing the long version of this.

CHAIRPERSON OLSON: I'm hearing you say you want to amend the motion on the floor to include that they will not close the current facility until they have a plan in place for --

MR. GREIMAN: I think that should be part of the motion.

CHAIRPERSON OLSON: George, did you --

MR. ROATE: Yes. While Board Staff regrets not mentioning the conditional agreement between these two projects, it's to try to keep it -- keep any resemblance of interdependence. Board Staff suggests that this second project, Project 14-010, be approved with the condition that the successful completion of Project 14-009 occur.

CHAIRPERSON OLSON: Okay. Thank you.

So for point of clarification, we have a motion and a second on the floor to approve Project 14-009, Highland Park Hospital, to discontinue their 20-station ESRD facility. It has a provision on it or a condition on it that they will not discontinue that facility until they

have a dispensation or a plan in place for your patients.

Seeing no further questions, may I have a roll call vote on the motion.

MR. CONSTANTINO: Motion made by Senator Demuzio, seconded by Mr. Sewell.

Mr. Bradley?

MR. BRADLEY: I'm just curious how much conversation we would have had if there had been any disagreement or objection to this in any court. I'm astounded at how long it took us to approve a routine application that came in in good form.

I vote yes.

MR. BURDEN: I vote yes for both the motion and Mr. Bradley's observation of the discussion for the last 20 minutes.

MR. CONSTANTINO: Dr. Burden?

MR. BURDEN: Yes, I said.

MR. CONSTANTINO: Senator Demuzio?

MS. DEMUZIO: I vote yes for all of the reasons stated above.

MR. CONSTANTINO: Justice Greiman?

MR. GREIMAN: I vote yes with the appropriate condition placed upon them and it will work out; the area will be served. I vote yes.

MR. CONSTANTINO: Mr. Hayes?

MR. HAYES: I vote yes based on the State Agency Report.

MR. CONSTANTINO: Mr. Penn?

MR. PENN: I vote yes. I was ready to vote yes 20 minutes ago.

MR. CONSTANTINO: Mr. Sewell?

MR. SEWELL: I vote yes for the reasons stated by Mr. Hayes.

MR. CONSTANTINO: Madam Chairwoman.

CHAIRPERSON OLSON: I vote yes. And apologize to the Board for wasting 20 minutes of their time.

MR. CONSTANTINO: Motion passes.

CHAIRPERSON OLSON: Thank you. Good luck.

(Pause)

CHAIRPERSON OLSON: Next we have, to everyone's surprise, Project 14-010, Fresenius Medical Care, Highland Park, to establish a 20-station ESRD facility in Highland Park.

May I have a motion to approve Project 14-010, Fresenius Medical Care in Highland Park to establish a 20-station ESRD facility, with the condition that 14-009 discontinues their 20 stations.

MR. BRADLEY: So moved.

MR. PENN: Second.

CHAIRPERSON OLSON: I have a motion and a second.

Would you please be sworn in and identify yourself.

(Oath given)

CHAIRPERSON OLSON: May I have the State Board Staff report?

MR. ROATE: Thank you, Madam Chair.

The applicants for Project 14-010 are Fresenius Medical Care Holdings, Incorporated and Fresenius Medical Care of Illinois, LLC. The applicants propose to establish a 20-station End Stage Renal Dialysis facility in Highland Park. The proposed project cost is $14.4 million.

There are negative findings in both 1110 and 1120 criteria. Board Staff wishes to note of the negative findings in 1110; they're in the area of Planning Area Need and Unnecessary Duplication of Service or Maldistribution. This is due to there being an excess of 30 stations in the HSA, as well as facilities in the area operating beneath the acceptable State standard.

1120.140(c) where the negative findings exist, they're in the area of Reasonable -- in the area of Modernization and Contingencies. The area initially cited

for Moveable Equipment and Other Costs has since been rectified. There's been a positive finding for that criteria.

Thank you, Madam Chair.

CHAIRPERSON OLSON: Thank you, George.

Comments for the Board?

MR. ASAY: Good morning. My name is Grant Asay. I am the General Manager for Fresenius for the Midwest Group. With me is Clare Ranalli, our counsel, and Lori Wright, who is our CON Specialist; and Dr. Sprague is here representing medical staff, and is also Medical Director for one of our Fresenius units.

First, thank you to Mr. Roate and Mr. Constantino for evaluating those two negatives and turning them into positives. We appreciate that very much.

We are respectfully asking for your approval to establish a 20-station dialysis facility that will replace the dialysis service at Highland Park Hospital, which you just approved for discontinuation. Our facility will be one to two miles away from Highland Park Hospital.

Mr. Hall, the CEO of Highland Park Hospital, has explained why this arrangement best serves their current patients. This is much like a relocation application that you hear on our behalf where a clinic

closes and relocates to a new site with the same number of stations. It will preserve continuity of patient care by retaining the current staffing positions, who will move over to the new location. It will allow the patients to keep their current shifts, travel arrangements, and schedules. This allows us to maintain the best quality and access to care.

There's two negatives that are still existing. That is the need and the maldistribution/duplication of services, and let me just address these very quickly. If this clinic was not to be built, we believe that the patients would undergo a significant disruption in their care, if we put these patients back out into the community without having a large move over to a new clinic, and I think the disruption of care would happen for these reasons. They would not be dialyzing on the same shift, including the night shift. They would not be with the same nurses and very likely the same physicians. The physicians may or may not be able to follow those patients at the clinic, and when a patient is undergoing dialysis, it's a social experience with the people that they're comfortable with, the fellow patients, and if they're not with those fellow patients, they have a social experience removed from them. That's the first reason we'd like to mitigate these

negatives.

The second one is this will likely put -- if we put these patients back in the community, this will likely cause those surrounding clinics -- by distributing a hundred-plus patients into these surrounding clinics, it would probably cause a 90 to 100 percent utilization in these surrounding clinics and we would have to build immediately or come to the Board and ask to build immediately; and we would not have that lead time, really, to address that kind of distribution, because it would take us several months to build a clinic.

And, thirdly, I believe that Highland Park Hospital has a moral and ethical duty to their patients to make sure that they find comparable care and replacement services for their patients. I feel that these three issues would mitigate those negative findings.

We are pleased to have worked with Highland Park Hospital on a thorough transition plan for its staff and patients. Now that you've approved the discontinuation of Highland Park's service, we respectfully urge you to approve our new facility so that Highland Park staff, the patients, and the physicians are not in limbo and we can continue to work on a smooth transition going forward.

In summary, we believe that establishing our

Highland Park clinic in conjunction with the discontinuation of the Highland Park Hospital's service is the best solution for the patients. It mitigates the two negatives raised in the Staff Report regarding maldistribution and need.

I appreciate your favorable consideration, and happy to answer any questions.

CHAIRPERSON OLSON: Thank you.

Questions from Board members?

Dr. Burden?

MR. BURDEN: Thank you, Madam Chair.

The Northfield location, I drive by it regularly. It's not ten minutes. I can go to Highland Park Hospital and get to that one in less than ten minutes on a regular basis. That's my area, my community. That's one thing.

I noticed the new sign there not too long ago. How long has the Northfield Dialysis Unit been in operation? There was an imaging physician there in the immediate area. I don't think they moved out. I go by there daily. My two daughters live in Winnetka, and that's my route. I'm curious how long is that open? It's minimally utilized, so it can't be long.

MS. WRIGHT: No, it was certified about a

month ago, so we are just now beginning to admit patients and round up staff while admitting patients.

MR. BURDEN: Is the Medical Director there Dr. Nancy Nora, or is --

DR. SPRAGUE: Dr. Nora is not the Medical Director at that facility.

MR. BURDEN: So my questions are two-fold. That's a short distance. When you talk about inconvenience, we have much more inconvenience in greater locations. If there has to be a disruption to dialysis services to the patient currently seen at Highland Park Hospital -- this beginning unit isn't even functioning. Is it appropriate to consider that as an option or not? That's my question.

MS. RANALLI: The Highland Park clinic is 20 stations and Northfield is 12. So that's a significant difference. And the Highland Park Hospital unit is over 80 percent utilization, so that would leave a significant number of patients who would not be able to be served at that clinic. Also, it doesn't address the issue of staff. Highland Park Hospital currently employs a number of technicians and nurses. Our plan collectively was to make sure that those individuals remain employed and also continue to treat those patients, because they see them all

the time. I probably shouldn't say this to a physician, but they're as close to as important as the physician providing the care when they (unintelligible) those patients. So, that was the goal, and that won't be accomplished at Northfield.

MR. BURDEN: As a physician, I certainly concur with your thoughts about being close to their physician. No argument there. I'm just looking at what we've got. You've got a beginning unit that's not being utilized, but is beginning to be utilized. You are presenting an opportunity to consider building a new unit -- that's what you're going to discuss with us today -- in time, in time to handle the closure at Highland Park. I'm just saying this certainly looks like an emergency setting for those that might have to drive to Deerfield, which, of course, is still ten minutes away.

We look at this every time we have an application regarding closure and building. It's a distance phenomenon that is taking care of patients, and I think in general you guys take great pride in making sure we know how difficult it is for somebody to get dialyzed daily or weekly or whatever on a regular basis.

My last question and I'll stop. Nocturnal dialysis. We've had applications that make it sound like

nocturnal dialysis is unique. The presentation I just heard makes it sound like we do nocturnal dialysis as a routine. Am I wrong?

MR. SPRAGUE: I would just like to address that, because I think that's one of the other issues about why Northfield can't fit this. Nocturnal dialysis is rather rare in terms of outpatient facilities. If my recollection is right, there is only one other facility in Lake County that offers nocturnal dialysis. The Highland Park unit has been offering nocturnal dialysis, I would guess, for at least ten years, and that unit has been filled with a waiting list to get in to nocturnal dialysis.

My understanding is this new facility is going to transfer patients en masse. So, those patients who do nocturnal dialysis will be able to transfer. There's been of late a lot of clinical data showing the benefit of nocturnal dialysis, such as less hospitalizations, less utilization of erythropoietin, better control of heart failure. So, there's a lot of clinical advantages to it, and I think it would be a major disruption if there's not a place for these patients to go who are part of this nocturnal program.

MR. BURDEN: That's my question. Do you have a -- I'm not aware. Clue me up. This has happened in my

absence. I haven't practiced for 13 years. There is no question -- we've heard nocturnal dialysis presented to us by other applicants, and you've pointed out that it's rare; it isn't available everywhere. Hospitals provide it, and hospitals are getting out of it now as a business. Only 12 in the state that still do it. That's my point. Nocturnal dialysis would certainly take care of anybody who is accustomed to it at a facility that is under utilized, or do you have to do a special rehiring? Deerfield is not going to do nocturnal dialysis, in simple terms.

MR. SPRAGUE: I think there's certain infrastructure that has to be put in a facility. It helps when you're building a facility to set up nocturnal dialysis, such as the comfort of a patient being in a chair as opposed to a bed, the ability to then have the water purified. So you have to have a shutdown period so all the water and everything else can be purified. So you have to have a break in your schedule, in the way you set up the infrastructure of the unit, so you have the water systems and everything else can be addressed so it's safe for the patients on nocturnal. The staffing is different. There's different models of nocturnal, which I don't -- am not involved with, but I know at Highland Park is one where patients actually are there all night. Some of them will

start at six o'clock or seven o'clock at night and go until two o'clock in the morning and send them on their way and then have that down time to renew the water. The way it's set up at Highland Park, these patients come in at maybe ten o'clock at night and stay there until the morning. They sleep there, and then the system is set up to do it that way.

In my understanding and the agreement with Fresenius, they are going to continue that program en masse.

MR. BURDEN: That's important then for the purposes -- I'm glad -- thank you, Doctor, for presenting that, because we've not heard what you just -- at least I haven't heard -- as a practicing urologist, I certainly have dealt with a lot of nephrologists, and this issue is something that is unique, but makes sense. Some of these patients still want to work and get around and do things. So they can go on with their lives. So that feature of nocturnal availability is not available where you currently have a Deerfield operation which is just getting started? That's what I think I heard here.

MR. SPRAGUE: That is correct.

MR. BURDEN: And there is no other reasonable nocturnal dialysis available from the Highland Park

facility, except for the one that you hope to build a mile or two away; is that correct?

MR. SPRAGUE: That's correct.

CHAIRPERSON OLSON: And it's Fresenius' intention to do nocturnal dialysis at that facility?

MR. HALL: From the beginning, yes.

CHAIRPERSON OLSON: Other questions from Board members?

MR. HAYES: I have a question. What about short-term dialysis or inpatient dialysis? Highland Park Hospital -- have you had -- I mean, I'm sure all hospitals have that situation, and has that -- what -- how much have you done of that? And how will they be accommodated?

MR. SPRAGUE: As part of -- as the Chairperson of Nephrology in all of the NorthShore Hospitals, Highland Park being one, we have an acute dialysis services that covers all inpatient dialysis. There has been some times that the outpatient facility will take a patient, but generally we have a service that patients have to be dialyzed 24/7, based on their need, within the hospital, and that service will not change with the moving of this facility.

MR. HAYES: And so basically that comes into the hospital and dialyzes them in the room itself?

MR. SPRAGUE: We have -- depending at the hospital what's going on, they will either be dialyzed in their room, or in some of the hospitals we have a special room to have three or four patients being dialyzed simultaneously.

MR. HAYES: Okay. And that will continue at Highland Park?

MR. SPRAGUE: Yes, it will.

MR. HAYES: Okay. You've talked about the nocturnal, and that's very -- I think that's very important to us, because of the lack of that, the availability of that. You already talked about a waiting list on your nocturnal program there at Highland Park Hospital already. How -- I mean, Fresenius has not -- why haven't others -- and Fresenius and DaVita, the large, you know, dialysis companies have not traditionally been -- I think they've come to this Board and said that, you know, there hasn't been a demand for it. They've opposed applications that have tried to establish those types of programs, and it wasn't even too far. I mean, we have approved programs not terribly far from Lake County there. It would take some time, but there are programs that we've even approved. So, what do you say for that?

And what about staffing? You mention that

your nurses and, of course, the medical staff will be going over and working with this new facility, but your technicians and your nurses, will they -- they will also be offered jobs there? Will they -- are they going to have comparable positions and salaries, and would they be offered -- would they have the same -- when they're replaced -- obviously they may be replaced in a few years with normal attrition. Would they have money -- or would they be replaced by somebody with the same type of skill set and the -- or the same type of, you know, skill set there?

MR. SPRAGUE: Let me address the first part of your question. I'll let them address more about the staffing and what they're offering to the nurses and the technicians.

Nocturnal, similarly to other home dialysis, such as peritoneal dialysis, is driven by two factors, one of which is the availability of a facility's willingness to do it, but the other and bigger factor is the physician and the physician education of the patients. If you look in this country, only eight percent of patients do home type of dialysis, peritoneal dialysis. You go across the border to Canada, they've got 35 percent. You go down to Mexico, they have up to 50 percent. I'm proud to say that in our

program in Evanston, we have over 30 percent doing home dialysis, and that has to do with what the physician believes and what effort -- it is harder for a nephrologist to manage a nocturnal program than it is to manage a regular program. The reason the Highland Park program has been so successful is that they've had a chain of nephrologists, with Dr. Nancy Nora being the current champion, that really believes in and does not mind making rounds at 11 o'clock at night to see patients. You could have a nocturnal program, but if you don't have a physician who is willing to go there at 11 o'clock at night to see the patients, that program is not going to last, and the physician who is going to talk the patient into it or show the patients the benefit has to be willing to do that. I mean, ideally we should see these patients once a week; so that becomes a big commitment. Then there's the commitment about the staff, and I would again say that the staff at Highland Park has had a very low attrition rate and is very expertly trained at doing nocturnal dialysis, and the feedback I get, not from their perspective but from the staff perspective, is that they all want to move, for the most part, and continue being with the patients.

So I think the issue is, just because a facility says we're going to set up nocturnal and it's not

successful really has to have a physician champion to do that, and I would say without a doubt -- I'm not -- I don't have any nocturnal patients. I'm not willing to make rounds at 11 o'clock at night on a weekly basis. I do other things, and there's only so much you can do. But Dr. Nora has been a real champion and it has paid off.

And I think if you look at data across the country and across the world, nocturnal is better than daily in terms of patient outcomes. Home dialysis and home nocturnal -- which I do have patients who do nocturnal dialysis at home -- do better. So I think there's a spectrum of need, and I think they're lucky in this community that Dr. Nora is such a champion to give patients that option. And I have referred my own patients to Dr. Nora so they could have nocturnal dialysis.

And I'll let them address the other issues in terms of staff.

MR. HAYES: Thank you, Doctor.

MR. HALL: I agree, Mr. Hayes. It's very important to the hospital to have the same staff take care of those patients. The patients need that. They need that consistency and continuity from having the same staff. We have agreed that we want to hire the same -- bring over the same staff, same caregivers that are currently with the

Highland Park service. We have agreed to keep their total compensation whole. There will be no net loss in their total compensation. We're having several transition meetings with Highland Park Hospital and with the staff to make sure this occurs and will continue once this is approved.

CHAIRPERSON OLSON: Thank you.

MR. HAYES: At your normal operations, like at your other facilities there, would the staff be paid less or would there be -- would it be different types of staff, technicians, nurses at your other facilities?

CHAIRPERSON OLSON: Are we getting -- I mean, is that -- are we getting into something that we can't really ask or can we ask that question?

MR. HALL: Dr. Sprague, feel free to chime in on the staffing, but we will bring over the same staff at the same ratios and have the same complement of nurses and the patient care techs that are currently there at Highland Park Hospital. They will all be in the same positions and the same roles. So I'm not sure if I'm answering the question.

MR. HAYES: What happens over time then in five years? Would that ratio of nurses and tech staff -- would that be changing, based on Fresenius policies?

MR. HALL: A lot of it is driven by CMS and the certification requirements, but I'm not familiar enough with their program. In terms of all the caregivers, right now we plan to bring them all over and staff, exactly like they're staffing now; and if an evaluation or assessment needs to occur later, we'll take a look at that. As far as I'm concerned, their staffing is appropriate. We don't have any plans for changes.

CHAIRPERSON OLSON: Dr. Burden?

MR. BURDEN: I'm sorry we're spending a lot of time on this, but I have to comment. I think it's been an opening for me. Dr. Nancy Nora's grandfather was a physician who took care of me when I was 8. Her father was an internist who took care of me when I was older. Her uncle operated on me when I had surgical problems. She is uniquely qualified for the third generation, probably fourth. Her uncle -- another one -- practices in Princeton, Illinois. I go back with that family, and I understand what you're saying about dedication and availability. I don't know any nephrologists that I worked with that are willing to run a nighttime program. I can understand.

Thank you for that comment. It may not be appropriate for me, but I go back and laud that whole

family. They are really an outstanding family, and she is too. They're lucky to have her.

CHAIRPERSON OLSON: Other questions from Board members?

(Pause)

CHAIRPERSON OLSON: Seeing no further questions, may I have a roll call vote to approve Project 14-101, Fresenius Medical Care, Highland Park, to establish a 20-station ESRD facility?

MR. CONSTANTINO: Motion made by Mr. Bradley, seconded by Mr. Penn.

Mr. Bradley?

MR. BRADLEY: I think the State Agency Report justifies a yes vote, and I think our vote on the previous project committed us to a yes vote. So I vote yes.

MR. CONSTANTINO: Dr. Burden?

MR. BURDEN: I vote yes. State Agency Report reflects everything that I need to have. I vote yes.

MR. CONSTANTINO: Senator Demuzio?

MS. DEMUZIO: I vote yes for reasons stated.

MR. CONSTANTINO: Justice Greiman?

MR. GREIMAN: I vote yes for reasons stated.

MR. CONSTANTINO: Mr. Hayes?

MR. HAYES: I understand and I appreciate the

medical staff and the hospital working to try to facilitate their patients, and I certainly appreciate that, and I think this is a possible project that may be very good at work in the short-term. So, you know, basically I am going to be -- I am going to vote no based on the Planning Area need and the unnecessary duplication of services. So I'm going to vote no.

MR. CONSTANTINO: Mr. Penn?

MR. PENN: I'm voting no; unnecessary duplication of services.

MR. CONSTANTINO: Mr. Sewell?

MR. SEWELL: I'm voting no. And I want to put on the record that our vote on the prior project in no way obligated us to approve this project; and I think that there are issues in 1110 and 1120 that are not met.

MR. CONSTANTINO: Madam Chairwoman?

CHAIRPERSON OLSON: Well, this is a hard one for me. This is normally a project that I would vote no on based on excess capacity, but I think this is unique. Especially, I appreciate your comments, Doctor, about the nocturnal dialysis. I understand that there truly is a relationship here where you're intending to do nocturnal dialysis. You're intending to use the same staff. It seems like it's very patient friendly. It seems like your

motives are all altruistic, and not only that, but six of the closest facilities that are not at capacity in this area are yours. So really, the only people you're going to hurt is yourselves.

So, while I normally would not vote yes on an application like this one, I am going to vote yes on this application.

MR. CONSTANTINO: Motion carries.

CHAIRPERSON OLSON: Five yes's three no's. Good luck.

(Pause)

CHAIRPERSON OLSON: Project 14-001, Maryville Academy, Scott Nolan Hospital, Des Plaines has deferred.

Our final project this morning is 13-004, Fresenius Medical Care South Elgin to establish a 12-station ESRD in South Elgin.

(Oath given)

CHAIRPERSON OLSON: May I have a motion to approve Project 13-004, Fresenius Medical Care South Elgin to establish a 12-station ESRD station facility? May I have a motion?

MR. BRADLEY: So moved.

CHAIRPERSON OLSON: Second?

MR. HAYES: Second.

CHAIRPERSON OLSON: It has been moved and seconded to approved Project 13-004. May I have a State Board Staff report, George?

MR. ROATE: Thank you, Madam Chair.

The applicants for Project 13-004 are Fresenius Medical Care Holding, Incorporated and Fresenius Medical Care South Elgin, LLC. The applicants propose to establish a 12-station end stage renal dialysis facility in South Elgin. The cost of the project is $3.3 million. There is a project completion date of May 31st, 2015.

State Board Staff recognizes there are three negative findings in the criteria of 1110, those being the size of the project, Planning Area need, and unnecessary duplication or mal-distribution of service. Board Staff also notes that this project has been deferred eight times in previous meetings.

Thank you, Madam Chair.

CHAIRPERSON OLSON: Thank you.

Does the applicant want to give information to the Board?

MS. MULDOON: Good afternoon. My name is Coleen Muldoon. I'm the Regional Vice-President in the Chicago market for Fresenius, and with me today, as you know, is Clare Ranalli, our legal counsel, and Lori Wright,

our CON specialist and Grant Asay.

Since we are here today after receiving an Intent to Deny, I would like to address two crucial points: First, what has changed since we were here before you last; and, second, why we want you to approve this project, even though it does not meet all of the review criteria. I know that if the project does not meet your rules, particularly on important findings, like need and mal-distribution, you must be given compelling reasons to approve, despite the negatives.

Here is what has changed since we were last before you. You can see that the Board -- by the Board Staff report that there are clinics within 30 minutes that are under utilized. However, I would like to focus on the utilization in the Elgin market in the clinics.

When we were here before you, our clinic was at 60 percent with twelve stations, 60 percent utilization. Since that time, we have added two more stations just recently; and as of today, the Fresenius Elgin facility is at 94 percent utilization, and we can only take five more patients at that facility before we are at capacity. The other clinic in Elgin is the DaVita Cobblestone, which was at low target utilization when it was before you last and is now at 82 percent utilization. Combined, these Elgin

facilities have gone from 79 percent to 88 percent utilization in the past year, and if this growth continues, we will be at 98 percent utilization in one year.

The physicians supporting this application have identified 103 pre-ESRD patients who will be referred to the South Elgin facility, and this does not account for the other nephrologists in the area. Of these patients, approximately 50 live right in Elgin, and directly west of Elgin in rural Kane County are another 20 pre-ESRD patients, whose nearest access to treatment is the Elgin units and its two clinics that are close to capacity. If our application is not approved, these 70 patients will have to travel out of the area to go to clinics that are currently under-utilized, although they may be at a later date. Regardless, these patients' have limited shift choices and may choose their current patient/physician relationships.

Our goal is to provide access for them. We are not discounting the other area facilities that have some capacity. We're focusing on just the Elgin market, because of its unique characteristics, which is why we think the clinic is necessary. Elgin is the eighth largest city in Illinois and is experiencing population growth five times higher than the state and is 44 percent Hispanic.

We also provide 20 percent of our treatments to the Medicaid reimbursed, and we expect it to be no different than our South Elgin, and we do have 10 percent undocumented patients treating at our Elgin facility. We have always taken all patients, regardless of their ability to pay.

As mentioned, we have added two stations in our Elgin facility, and we would expand it -- we would expand it further if we could. We just have no more room at that site.

Through patient education, we have doubled the number of our home dialysis patients in the past year, as our goal is for patients to choose home therapies. In other words, proposing this new clinic was not our first solution. Yet the in-center population is ballooning, and we have no more room to expand.

And I do want to address one of the negative findings. It's the size of the unit that we're proposing. It is because we are doubling the size of our home training center. We're adding more PD training rooms, a home hemo training room, and what we're calling Urgent Start. We are putting more patients -- we insert a PD catheter and also a permanent access that would put them on hemodialysis, instead of putting a catheter in their neck and putting

them on dialysis. This allows the patient to be trained to go home, and that's our goal. Even though they're saying they want to go in-center, we feel like if we can put them on and call it Urgent Start; we put them in a room; they sit for eight hours; they're trained how to treat themselves at home. Some choose to stay and go home. Some choose to go to the in-center. More and more nephrologists are going that way to try to encourage the patients to go home. A lot of them are very nervous about the treatment. They are new to dialysis. They don't know if they can do this at home. This provides them the availability to see if that works for them.

So that's the negative finding you have found. We are definitely doubling, if not tripling, the size of home training centers.

So, the DaVita Cobblestone clinic, as I said, is almost full. Our intent is to address the needs of our patients in a proven busy market, which has grown 10 percent in the past year against the average of 4 percent, which is what we generally see an ESRD population. Another facility here will allow these patients the best possible access to care, and we believe there is clearly the need for another facility in the Elgin market.

I want to thank you; and if you have any

questions, please feel free to ask.

MS. RANALLI: I did want to point out one thing because you brought it up, Madam Chair, on the last application, the number of the area clinics that were Fresenius clinics in this particular Service Area. Actually, the geographic market share is pretty well distributed. They're not all Fresenius clinics. However, the doctors that work with Fresenius and who are referring patients and identified 103 work with Fresenius. So, most likely, if this clinic is not approved, their patients will go to Fresenius clinics, because that's where they see patients and do rounds.

So, we would, for lack of a better way to put it, capture those patients anyway. This isn't really about getting those patients. It's about making sure that the Elgin market is served, because in just one year, as Colleen said, utilization went from 60 percent to 94 percent in our current Elgin facility, and we added two stations. And the DaVita clinic, when we were before you previously, was under-utilized and now is over. So those are significant changes from when we were before you previously.

Thank you.

CHAIRPERSON OLSON: Questions from Board

members?

(Pause)

CHAIRPERSON OLSON: No questions? Seeing no further questions, may I have a roll call vote to approve Project 13-004, Fresenius Medical Care South Elgin, to establish a 12-station ESRD facility?

MR. CONSTANTINO: Motion made by Mr. Bradley, seconded by Mr. Hayes.

Mr. Bradley?

MR. BRADLEY: Yes.

MR. CONSTANTINO: Dr. Burden? Absent.

Senator Demuzio?

MS. DEMUZIO: I vote no, due to the State Board requirements, size of the project, the Planning Area, and the unnecessary duplication.

MR. CONSTANTINO: Justice Greiman?

MR. GREIMAN: Yes. I vote no also. The area seems to be well covered and, in fact, they cover most of it and are not up to sufficient utilization. I vote no.

MR. CONSTANTINO: Mr. Hayes?

MR. HAYES: I vote no because of Planning Area need and utilization of other facilities in the area.

MR. CONSTANTINO: Mr. Penn?

MR. PENN: I'm voting no. Unnecessary

duplication of services.

MR. CONSTANTINO: Mr. Sewell?

MR. SEWELL: I'm voting no for reasons stated by Mr. Hayes.

MR. CONSTANTINO: Madam Chairwoman?

CHAIRPERSON OLSON: I vote no for reasons stated.

MR. CONSTANTINO: Motion fails.

MR. URSO: You will be receiving a denial in the mail. You have an opportunity for due process if you seek to do that.

(Pause)

CHAIRPERSON OLSON: There's no Other Business; nothing under Rules Development; nothing under Unfinished Business.

Under New Business, Cook County Health System, Provident Hospital, temporary suspension of category of service, it's tabled until July. We're going to be getting additional information?

MR. URSO: That's correct.

CHAIRPERSON OLSON: Okay. Financial report was in your --

MS. AVERY: If -- when you get the information, if you have questions, please let me know as

soon as possible. We'll get it out via email or regular mail next week. Okay?

MR. HAYES: Courtney, now for this suspension, could you explain --

MR. URSO: Mr. Hayes, we have Mr. Carvalho here, and he should leave if we're going to have a substantive discussion on this.

(Pause)

MR. HAYES: Yes. Could you -- because basically what you're saying here is that at our next meeting, we'll -- we'll be getting more information and at the next meeting, we have to decide whether to accept this extension of time.

MS. AVERY: Correct, because if you recall, we had a rule change, which allowed temporary suspension of service for one year. This facility has been -- I'm sorry -- temporarily suspended services for a number of years. So in the new rules, they have a year to do so, and they may come before the Board and request an extension. So they've done that, but it just wasn't enough time. I just received the request on Friday. It wasn't really enough time to get it to you to evaluate, to see if there were questions, and if you wanted the facility to appear before the Board. So, we have the information for the

Board to say, "Yes, we would like them to come in", "No, this is sufficient information". Then we can discuss it in July and will give them time to make an appearance in July.

MR. HAYES: Okay.

MS. AVERY: But you do have to grant the extension or not.

MR. HAYES: But it has been -- just my understanding, it's been five years since they suspended --

MS. AVERY: Approximately five, maybe a little more, but approximately five since those two categories of service has been suspended.

MR. HAYES: Okay.

MS. AVERY: So we'll forward the reports again and ask you if you want the facility to appear, and we'll notify them of the request to appear for the July meeting.

MR. HAYES: So these reports are significantly more than the information we've already received?

MS. AVERY: You probably received another update on the status, but the other one will be the request and why they're requesting an extension. So you will have two.

MR. HAYES: Okay. All right.

MR. URSO: According to the Board's rules, basically two questions have to be answered by the Board. They have to determine has there been due diligence in the process of this application going forward; and if there has been due diligence, then you have to determine, are you going to allow the temporary suspension to be renewed, to be continued, and for how long. So we'll repeat those questions for you when it's brought up for your consideration at the next meeting.

MR. SEWELL: Based on the length of time, why isn't this just discontinuation and a failure to apply for discontinuation? Is there some plan to reinstate the service? I don't understand this. I've never heard of temporary suspension over a five-year period.

MS. AVERY: Our rules prior to the change did not have an end date. It was open.

MR. SEWELL: I see. So this is our fault.

CHAIRPERSON OLSON: Any questions on the financial report included in the packet?

And I'm sure you all read cover to cover the Office of Auditor General's Performance Report. Any questions or comments on that report?

Courtney, do you have anything to say?

MS. AVERY: No. We'll be addressing the

Report with some rules and possible statutory changes that we will bring before the Board in the next couple of months.

CHAIRPERSON OLSON: And do you want to update us legislatively?

MS. AVERY: Yes. As you all know, House Bill 5968 passed out of both houses. We're waiting on signature from the Governor. And we had another piece of legislation that affected us, and we received it very, very late. We received it one evening and it went to committee the next evening, Senate Bill 0741, which affected us and has to do with Specialized Mental Health Rehabilitation Act of 2013; and it's dealing with the discontinuation and reestablishment in another location for those facilities, and it requires us to establish a separate set of rules for that -- those facilities under Specialized Mental Health Rehabilitation. It prohibits the Board from granting a permit for a Specialized Mental Health Rehabilitation facility unless the facility has a contract with at least one hospital or community health agency, and it also placed a moratorium on those facilities, except in the case of an application for relocation, which can be approved for the previous reasons stated. The Alliance For The Living was behind this piece of legislation, and my understanding is

that they worked with the Governor's office, Dr. Lori Jones, and David Carvalho from IDPH on this part.

So, Terry Sullivan, who is the Executive Director for the Alliance For The Living, has offered to draft some language for us to look at; and I told him that we would take it into consideration and meet internally and then come up with a response to the rules and present them to the Board, and we'll go through the process of JCAR and everything else.

David, I don't know if you have anything you want to add about these pieces of legislation. I did express a concern of us not being brought in beforehand, and I took it upon myself to submit that we were neutral on the piece of legislation, because after I talked with Senator -- no, Representative Harris, he was not willing to pull this part from that bill. So we kind of went with the flow on it, and we'll address it later.

MR. CARVALHO: The only thing I could add is I know the project of how to deal with this particular type of specialized nursing home has been one of ongoing conversations for several years. Mercifully, I haven't been involved in any of it. But two weeks ago a surgical strike was called for. They said, "Could you please draft this one paragraph?" So I drafted this one paragraph and

then I deinserted myself again from the process. So I can't really add anything, other than if you don't like the one paragraph that they requested me to write, sorry. But it wasn't my idea; I was just asked to draft it.

CHAIRPERSON OLSON: Our next meeting is July 14th, 2014. That is a change of date. That is a Monday now instead of a Tuesday, and that will be in Bolingbrook.

May I have a motion to adjourn?

MR. HAYES: So moved.

MR. SEWELL: Second.

CHAIRPERSON OLSON: All in favor say "aye".

("Ayes" heard)

PROCEEDINGS CONCLUDED

END TIME: 12:21 P.M.

CERTIFICATE OF REPORTER

I, KAREN K. KEIM, CRR, RPR, a Certified Court Reporter in the States of Illinois and Missouri, do hereby certify that the proceedings in the above-entitled cause were taken by me to the best of my ability and thereafter reduced to writing; that I am neither counsel for, related to, nor employed by any of the parties to the action, and further that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

Karen K. Keim
Certified Realtime Reporter
Illinois CSR No. 84-1577
Missouri CCR No. 1328

I

U