DRAFT

Planet Depos®
We Make It Happen™

Transcript of Open Session - Meeting

Date: November 5, 2020
Case: State of Illinois Health Facilities and Services Review Board

Planet Depos
Phone: 888.433.3767
Email:: transcripts@planetdepos.com
www.planetdepos.com

DRAFT

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION - MEETING

Held Virtually

Thursday, November 5, 2020

9:12 a.m. CST

BOARD MEMBERS PRESENT:

DEBRA SAVAGE, Chairwoman

STACY GRUNDY

GARY KAATZ

SANDRA MARTELL

LINDA RAY MURRAY

Job No. 257116

Pages: 1 - 78

Reported by: Paula Quetsch, CSR, RPR

ALSO PRESENT:

COURTNEY AVERY, Administrator

MICHAEL CONSTANTINO, IDPH Staff

ANN GUILD, Compliance Manager

GEORGE ROATE, IDPH Staff

C O N T E N T S

P R O C E E D I N G S

CHAIRWOMAN SAVAGE: All right. Well, we're going to go ahead and get started. This is my gavel.

Okay. The first thing I would like to do for our State Board staff meeting is to honor Senator Deanna Demuzio. Senator Demuzio has been on our Health Facilities State Board since 2012 and unfortunately recently passed away. She is a dedicated public servant -- or she was a dedicated public servant to the State of Illinois and her community. At this moment I'd like to take a moment of silence in honor of Senator Demuzio.

(Moment of silence.)

CHAIRWOMAN SAVAGE: And we thank her for her service and may her memory be a blessing to all.

So hopefully everybody has your agenda. May I have a motion to approve our agenda?

(Inaudible.)

CHAIRWOMAN SAVAGE: Okay. So Gary Kaatz has been the first. May I have a second?

MEMBER GRUNDY: Second.

CHAIRWOMAN SAVAGE: Second by Stacy Grundy. Thank you.

Now may I have an approval of our transcripts from our September 22nd, 2020, meeting?

MEMBER MARTELL: I so move.

CHAIRWOMAN SAVAGE: Thank you, Dr. Martell.

MEMBER MURRAY: Second.

CHAIRWOMAN SAVAGE: Second by Dr. Murray.

Mr. Constantino, can you please read into the record the items approved by me, the Chairwoman?

MR. ROATE: Thank you, Debi. I'm going to step in for Mike today. He's got a little bit of a sore throat.

Items approved by the Chairwoman are as follows:

Permit Renewal: #19-049 CGH Medical Center, Sterling, 6-Month Renewal.

Permit Renewal: #17-001 Mercyhealth Crystal Lake Medical Office Building, 39-month renewal.

Permit Renewal: #17-002 Mercyhealth Crystal Lake Hospital, 39-month renewal.

Permit Alteration: #180-16 Transformative Health of McHenry to alter the source of the funds for the project.

Exemption E-042-20, Rush Oak Park Hospital to discontinue a 36-bed long-term care bed category

of service.

E-043-20, Community Care Center to approve the change of ownership.

E-044-20, Swedish Hospital to discontinue an 18-bed long-term care bed category of service.

And finally, E-045-20, Kindred Hospital of Peoria for a change of ownership.

CHAIRWOMAN SAVAGE: Thank you, George.

One second, please.

MS. AVERY: Mike or George, can you see anybody? We're looking for the general public. I can't see anyone.

MR. ROATE: I have a call-in user 6; I have a D-E-L-D-D-I-B.

MS. AVERY: Okay. I can see it on Debi's. Thank you.

CHAIRWOMAN SAVAGE: Next we will have public participation -- oh, I'm sorry -- George, first, could you please do our roll call.

MR. ROATE: Yes.

Stacy Grundy.

MEMBER GRUNDY: Here.

MR. ROATE: Gary Kaatz.

MS. AVERY: Gary?

MR. ROATE: Mr. Kaatz.
MS. AVERY: He's here.
MR. ROATE: Okay.
Sandra Martell.
MEMBER MARTELL: Present.
MR. ROATE: Thank you.
Linda Ray Murray.
MEMBER MURRAY: Present.
MR. ROATE: Thank you.
And Chairwoman Savage.
CHAIRWOMAN SAVAGE: Present.
MR. ROATE: Five board members in attendance.
CHAIRWOMAN SAVAGE: Thank you.
Okay. Now we will have public participation, and we believe we have Dr. Chopra on the phone, if you could unmute him, please.
All right. Dr. Chopra, if you could be sworn in by our court reporter, please.
DR. CHOPRA: Sure. I'm not able to hear the court reporter:
CHAIRWOMAN SAVAGE: Hold on just a moment, Dr. Chopra.
Whoever is our court reporter, can you please make yourself known.

One moment while we find our court reporter.

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

(Witness sworn.)

CHAIRWOMAN SAVAGE: Okay. Dr. Chopra, go ahead. You have two minutes.

DR. CHOPRA: Thank you. I'm an endovascular specialist and interventional radiologist in the Chicagoland area. I've been serving patients in the community on the south side for almost over a decade -- actually, almost two decades. I've served as chairman of radiology and am an attending associate professor still at Rush University.

And one of the challenges we have with our patient population, especially with Mercy Hospital closing, this population is at high risk for diabetes, and they can end up with a lot of peripheral arterial disease as well as on dialysis, and they lead to amputations. This decreases their life span and also increases morbidity. So the quality of life decreases, and also a very heavy on burden cost of the health system.

We've been now performing a lot of these procedures as outpatients, same day. The principle is to do it better, faster, cheaper, prevent the

amputations. Now with Mercy Hospital closing the challenge has been where will these patients go. So we've been identifying outpatient facilities to do this. I'm also at Jackson Park Hospital; I've been at Rosalind Hospital, Advocate Trinity Hospital. We go to about 30-some nursing homes, and the elderly are very vulnerable, especially now with the COVID era where these patients, to get them into a hospital is also tougher. So we've been working very hard and are now able to serve these patients on an outpatient basis in a very safe environment and get them in and out the same day, and it's much better; it's faster for the patient and definitely much cheaper for both the health system, the patient, and the community.

I'd be happy to take any questions, or I could just keep talking.

CHAIRWOMAN SAVAGE: Thank you so much, Dr. Chopra.

Is there anyone else here for public participation? If so, raise your hand.

(No response.)

CHAIRWOMAN SAVAGE: Okay. Hearing none.

- - -

CHAIRWOMAN SAVAGE: So next on the agenda we have a permit to establish the Michigan Avenue Center for Health Multispecialty ASTC, Project H-01.

Mike, can we have the State Board staff report?

MR. ROATE: Thank you, Madam Chair. The applicant Michigan Avenue Center for Health, Ltd., and Michigan Avenue Health Systems, Ltd., propose to establish a multispecialty ambulatory surgical treatment center located at 2415 South Michigan Avenue, Chicago, Illinois.

The cost of the project is $2,135,746, and the expected project completion date is the December 31st, 2021.

Board staff found the project to be not in conformance with three items in the 1110 criteria, that being geographical service area need, service accessibility, and unnecessary duplication/maldistribution of service.

Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Okay. Thank you very much, George.

Now, may I have a motion to approve this permit for the Michigan Avenue Center for Health

Multispecialty ASTC? May I have a motion?

MEMBER MARTELL: I so move.

CHAIRWOMAN SAVAGE: Thank you, Dr. Martell.

May I have a second?

MEMBER GRUNDY: I second.

CHAIRWOMAN SAVAGE: Thank you, Stacy Grundy.

MS. AVERY: Is there anyone to present on behalf of Project 20-025? Please raise your hand. Anne Cooper and you may proceed.

MS. COOPER: Vera Schmidt should also be on the line, as well.

MS. AVERY: What was the other name?

MS. COOPER: Vera Schmidt.

MS. AVERY: I don't see Vera -- oh, I do. Okay. Sorry. Please proceed.

(Witnesses sworn.)

CHAIRWOMAN SAVAGE: Okay. Go ahead, Anne and Vera.

MS. COOPER: Is Vera on?

CHAIRWOMAN SAVAGE: I heard her before. She was on.

MS. COOPER: I did, as well.

CHAIRWOMAN SAVAGE: Do you see her, George?

MR. ROATE: I see her on the attendee list. Okay. She's just been taken off mute.

MS. SCHMIDT: Yes. Can you hear me?

MR. ROATE: Yes, ma'am.

MS. SCHMIDT: Good morning. I'm Vera Schmidt. I'm the chief of operations of Michigan Avenue Center for Health. With me today I have our CON attorney Anne Cooper.

First of all, I'd like to thank the Board staff for its thorough assessment of this planned surgery center and the generally positive State Board report.

This project was conceived this spring to address health care disparities on Chicago's south side. Subsequent to filing of our application in May, Mercy Hospital and Medical Center announced its plan to discontinue its 412-bed hospital by May 2021. Given the impending discontinuation of Mercy, this project is needed more than ever to address the gaps in care that will result in the wake of the cessation of health care services at Mercy.

Michigan Avenue Center for Health is located at 2415 South Michigan Avenue, less than a

quarter of a mile from Mercy. Like many parts of the City of Chicago, the community proposed to be served by this surgery center is economically disadvantaged with 25 percent of the population living below the Federal poverty limit compared to 17 percent in the remainder of the City and 12 percent statewide. It also consists of significant minority populations, which are 30 percent African-American, 33 percent Hispanic, and 5 percent Asian. Due to these factors and despite the presence of a large medical center in the community, it is a federally designated medically underserved population and medically underserved area.

Historically, Mercy performed a total of 2,750 outpatient surgical cases. Of these cases, over 400 were OB/GYN procedures, and 500 were pain management, two of the specialties proposed at Michigan Avenue Center for Health. During the recent public hearings on the Mercy discontinuation, many patients expressed concern as to where they would receive healthcare services once Mercy closes next year and how they would get there, particularly those who are reliant on public transportation.

Importantly, while Mercy plans to develop a care center that will offer diagnostics, urgent care, and care coordination, there is no plan to provide outpatient surgical care. Accordingly, patients who normally have outpatient procedures performed at Mercy will need to travel farther for surgical care if this project is not approved.

I would like to briefly address the negative findings for this project.

Geographic service area need. While the physicians associated with this project have not historically referred a majority of patients from within the 10-mile geographic service area, we anticipate with the discontinuation of Mercy, we will serve a larger percentage of patients from the immediate area. Further, we will have an open medical staff, so physicians who have historically performed cases at Mercy can perform their cases at our surgical center.

Service accessibility and unnecessary duplication/maldistribution of service. Both of these criteria are based on the fact that existing hospitals and surgery centers within a 10-mile geographic service area operate below the State's

80 percent utilization standard.

Utilizing hospitals for procedures that can safely be performed in an outpatient surgery center is not an efficient use of scarce health care resources. Escalation of health care costs have largely been attributed to high prices charged by hospitals. Of the 13 surgery centers located within 10 miles of Michigan Avenue Center for Health, six are operating at or above the State Standard, four are not approved for obstetrics, and the remaining three surgery centers (Grand Avenue Surgicenter, River North Surgery Center, and Western Diversey Surgery Center), provide little to no care for Medicaid patients and are located on the near north and north side of Chicago, which presents a hardship for many patients who lack access to transportation and are reliant on family and friends to transport them to their medical appointments.

Finally, Michigan Avenue Center for Health is committed to improve health care to patients residing on the south side of Chicago who face various barriers to access health care. We will have an open medical staff and will add surgical

specialties to address the needs of the community as necessary.

Historically, over 30 percent of the patients we have served are Medicaid beneficiaries. However, we treated these patients as charity care and did not charge them or the State Medicaid program for services. Going forward, Michigan Avenue Center for Health will be Medicare and Medicaid certified and will accept all patients who are appropriate for outpatient surgery regardless of race, color, national origin, gender, sexual orientation, age, religion, disability, or payor source. We anticipate over 30 percent of patients will be Medicare, Medicaid, or uninsured.

Further, we understand many patients work essential jobs and cannot take time off during the week, so to accommodate patients' work schedules, we will allow patients to schedule procedures on Saturdays and Sundays, as needed. Our extended hours will provide more flexibility so patients can minimize time off from work, thereby making health care more accessible to low-income patients.

Michigan Avenue Center for Health is needed now more than ever to address healthcare disparities

on the south side of Chicago, which will become even more stark with the discontinuation of Mercy Hospital and medical center.

Thank you for your time. We respectfully ask that the Board approve this project to improve access to healthcare on Chicago's south side. I'd be happy to answer any questions that the Board may have.

CHAIRWOMAN SAVAGE: Do the Board members have any questions?

MEMBER KAATZ: (Inaudible.)

CHAIRWOMAN SAVAGE: Mr. Kaatz, can you repeat your question? I'm so sorry.

MS. AVERY: This is only to the presenters. He was in public participation.

MEMBER KAATZ: Okay.

CHAIRWOMAN SAVAGE: I'll rephrase my question. Does anyone have any questions for Anne Cooper and Vera Schmidt?

MEMBER MURRAY: I have a question.

CHAIRWOMAN SAVAGE: Thank you, Dr. Murray.

MEMBER MURRAY: So I didn't really hear an attempt to answer the position from the staff that this service appears to duplicate services and

doesn't meet the criteria that's listed in the report.

MS. COOPER: So we did -- basically, there's -- there are hospitals within 10 minutes of the proposed Michigan Avenue Center for Health, and because of hospitals being much more expensive places of service, Medicare rates are almost twice in a hospital outpatient department than they are in an outpatient surgery center, so we don't think that the hospitals are really good locations for the procedures to be performed particularly given that we're talking about a patient population that is -- has a high -- is low-income, economically disadvantaged.

There are 16 surgery centers within 10 miles and -- I apologize; I need to look at my notes -- six are operating above the State -- so of the 13, six are operating above the State standard, four of them are not approved for obstetrics, and then the other three surgery centers, which are Grand Avenue, River North, and Northwestern, provide almost -- I think only one of those surgery centers provided any Medicare care, and I think it was like one patient in 2019.

Given that one of the purposes of this project is to serve a large percentage of Medicaid population and underserved individuals, those aren't surgery centers. So we didn't really feel there's any hospital or surgery center within the 10-mile service area that can adequately address the needs of this community.

And the other issue, too, a lot of the patients that use the outpatient services at Mercy either walk or take public transportation, and one woman in particular mentioned, you know, she already takes two buses to get to Mercy, and for them to have to travel to the north side -- and she had expressed sort of concern about having to take more than two buses, I would also note that Michigan Avenue is located right next to a bus stop. So it would be much easier for patients to get to Michigan Avenue than it would be to those three surgery centers that offer obstetrics on the north side.

MEMBER GRUNDY: I have a question, as well.

I know I saw we got a list of, I guess the hospitals and the 13 surgery centers within a 10-mile radius, but in the report it said that, I

guess only one of three accept Medicaid services. So out of the 13 that are listed in the 10-mile radius, are you saying that -- how many of those -- are you saying only three of those accept Medicaid?

MS. COOPER: No, of the three that offer obstetrics, only one of the three is Medicaid.

CHAIRWOMAN SAVAGE: I do have a question, as well.

So in relation to your physicians, it was that you didn't have any physicians from Mercy Hospital. Have you talked with them to try to get them on board given the situation there?

MS. SCHMIDT: I think we will. We applied for -- this application was before the announcement of Mercy closing, but everyone in the community knew that this may be happening. We've been approached by other physicians to utilize their facility for some outpatient procedure. Dr. Chopra who had spoken earlier mentioned this would be a great location for him. I don't know -- I don't think he necessarily has patients coming from Mercy, but he does see patients in this area.

CHAIRWOMAN SAVAGE: Okay. Thank you.

Do any of our other Board members or State

Board staff have any questions?

MEMBER MARTELL: It's more of a procedural question.

CHAIRWOMAN SAVAGE: Hold on, Gary.

Go ahead.

MEMBER MARTELL: Again, kind of taking a look, I mean, because there was new information that would have come out afterwards regarding the closure of Mercy and probably a recalculation of referral resources, what are the provisions then from a staff -- a State staff report -- I'm sorry?

CHAIRWOMAN SAVAGE: It's a tongue tie, yes.

George or Mike, can you speak to that?

MR. ROATE: As far as the information that was -- any of the information that could be gleaned from the closure of Mercy Medical Center, the applicants are welcome to supply that at a later date. They have an option to defer if they'd like to add that to the report and possibly affect the findings. That's entirely up to them at this point and entirely up to the Board to make a decision whether they'd like to defer or not.

CHAIRWOMAN SAVAGE: And, Mr. Kaatz, did you have a question? Yes, please. Dr. Chopra is

not a presenter. He was public participation.

MEMBER MURRAY: Let me ask another question to set up --

CHAIRWOMAN SAVAGE: Hold on, Dr. Murray. Mr. Kaatz is speaking.

MEMBER MURRAY: Oh, I'm sorry. I can't hear him.

CHAIRWOMAN SAVAGE: Go ahead, Mr. Kaatz.

MEMBER KAATZ: First of all, is Dr. Chopra a fellowship-trained, board-certified interventional radiologist?

MS. SCHMIDT: That is correct, Dr. Chopra is a board-trained interventional radiologist.

MEMBER KAATZ: I believe I understand the description of the project, but for that level of interventional radiology I think you need biplane system imaging, and a biplane system is about $3 million, so I'm curious how you're going to be able to do interventional radiology without biplane system imaging in the facility.

MS. SCHMIDT: You know what? I'm sorry; I'm not familiar with that procedure. I do know that the facility does have a (indiscernible) table and all the other things that are needed

for -- can you hear me okay?

THE COURT REPORTER: Not really.

MEMBER KAATZ: And then my last question is, Dr. Chopra, I see his main hospital privileges are in Gottlieb Hospital, and, boy, that's a long distance from where this project is located.

CHAIRWOMAN SAVAGE: Anne, can you address that, or Vera?

MS. COOPER: He also serves patients in Jackson Park, and I believe he also had offices located on the south side of Chicago. Even though he has admitting privileges at Gottlieb, he does have offices in -- on the south side.

MEMBER KAATZ: Okay. He mentioned that he was on the staff at Rush. Does he not have any privileges at Rush?

MS. COOPER: I can't speak to that. Vera -- I don't know. Vera, I don't know if you know.

Is Vera on the line still?

MS. AVERY: Vera is on.

CHAIRWOMAN SAVAGE: Vera is on somewhere.

MS. SCHMIDT: I don't know his status at Rush.

MEMBER KAATZ: Okay. I asked the question

because he mentioned that he was an associate professor there.

My last question is, what do you have in the plans if something goes wrong here? What if you get a surprise hemorrhaging, other complications? What are you going to do at this location? What are your plans? What do you have in place?

MS. SCHMIDT: What we have in place is that we try to obviously manage the condition at the facility, and if not, we have to transfer and would have to decide what hospital would be the closest hospital for a transfer.

MEMBER KAATZ: And are you going to be administering anesthesia at this facility?

MS. SCHMIDT: Yes, we're going to do MAC-monitored anesthesia care.

MEMBER KAATZ: Who is going to be responsible for that? Is that an anesthesiologist?

MS. SCHMIDT: Yes, an anesthesiologist.

CHAIRWOMAN SAVAGE: Did you have a question, Dr. Murray?

MEMBER MURRAY: Yes, I did. It's a question to the presenter, but also, let me just put it out there for our Board to consider.

So here we have a situation where we know a public -- a major hospital is discussing closure, plans to close. We also are in the midst of a global pandemic. So I've already mentioned at several meetings I'm concerned about how our criteria are -- how can I say this nicely -- out of date, and we don't really have a easy mechanism to revise them.

So one of the factors that goes in here is what we think is going to happen over the next few years -- and let me emphasize a few years; I'm not talking about a few months -- with COVID and the ability of our inpatient facilities to flex their staff and work to cover what we normally would consider routine procedures that contemplate would be handled by a facility like this.

So my first question is whether the presenters and the applicant might want to consider a revision to their application taking into account some of these factors, especially the closing of Mercy but also the general situation that's going on, ability to have inpatient procedures.

So that's one question to them. But my

question for the rest of us is, again, we have to have an agenda and a time for us to discuss all these other issues in terms of how we evaluate this kind of application.

CHAIRWOMAN SAVAGE: Go ahead, Anne and Vera.

MS. COOPER: With respect to the issue with the pandemic, which like I said, I think everybody is -- all the public health officials that I've kind of been listening to indicate that we're not really going to be out of the woods until sometime next year, maybe 2022. And with the COVID cases spiking right now, and with hospitals, you know, getting overwhelmed with COVID-related patients as cases spike, hospitals are going to have to once again postpone elective surgeries.

These procedures that are being performed at Michigan Avenue are technically elective procedures, but that having been said, sometimes an elective procedure, while it's not emergent, a patient really can't put it off for multiple months because their condition may continue to deteriorate over that time.

So I think that a surgery center like

Michigan Avenue will actually assist with the COVID issues where we can take some of those patients that cannot be seen in a hospital setting and take them in a safe setting which is a small facility with no restrictions. You won't have to worry about any issues with cross-contamination with COVID. So I think a facility such as Michigan Avenue will be beneficial to the healthcare system in light of the pandemic that we see ourselves currently in.

CHAIRWOMAN SAVAGE: Thank you.

Any other questions from the Board or the staff?

(No response.)

CHAIRWOMAN SAVAGE: Okay. George -- oh, I'm sorry -- Mike, were you saying something?

MR. CONSTANTINO: I'm just curious. 30 percent Medicaid, are you going to be able to hit that target that you're telling the Board that you're going to provide?

MS. SCHMIDT: Yes, between Medicare, Medicaid, or uninsured or charity care.

MR. CONSTANTINO: No. You had told us that it was going to be 30 percent Medicaid and

5.-something charity care. Is that correct?

MS. SCHMIDT: Let me take a look at my notes.

MS. COOPER: I mean, historically that's what Michigan Avenue has provided. Over the last several years it's been about 30 percent, they've treated about 30 percent Medicaid patients.

MR. CONSTANTINO: I don't have anything to confirm that, Anne, because they weren't licensed as an ASC before now. It was our understanding, it was the staff's understanding that your intent was to provide 30 percent Medicare -- care of 30 percent Medicaid patients. Is that still the case?

MS. SCHMIDT: Anne, are you there?

MS. COOPER: Yes, I am.

MS. SCHMIDT: Historically we've seen these Medicaid patients. And you're right, because there's no license you wouldn't have that data. I can just tell you that's the number of patients that we had seen. Actually, it could be even more.

MR. CONSTANTINO: And that's what you're intending to do here?

MS. SCHMIDT: Once we receive Medicare and

Medicare certification, then we can continue that volume.

MR. CONSTANTINO: Once licensed how long do you think it's going to take to get Medicaid/ Medicare certified?

MS. COOPER: I can speak to -- because it's a new application for Medicare, it's going to take probably 9 to 12 months.

MS. SCHMIDT: I agree.

MS. COOPER: That's how long it takes to get a new facility Medicare certified, and because it's a new application, they generally go to kind of the bottom of the list. But like you have to go through -- once you submit your application, the Medicare contractor has 60 days to review. Then it goes to the State agency, which in this case is IDPH, and they do their review, and they have about 60 days. Then it goes to the Central Office, and they have, you know, 60 or so days to review. And plus, you have to schedule a survey during that period of time.

So it's going to probably take, you know, 9 to 12 months just because I don't know how backlogged IDPH or Medicare is in terms of

COVID-related issues.

MR. CONSTANTINO: So they're not going to rely on the certification you already had done?

MS. COOPER: It's not Medicare certified, I don't believe.

MS. SCHMIDT: No, the facility has to be licensed and accredited in order to be done.

CHAIRWOMAN SAVAGE: Go ahead, Dr. Martell.

MEMBER MARTELL: In kind of looking at, as well -- of course, the data is based on historical procedures. I also looked at, you know, in terms of referral resource the OB/GYN coming from the Access Community Health Network it looked like from the FQHCs. Are there any more formal commitments for referral for what would be ASC-type procedures from them?

MS. SCHMIDT: I'm not sure I understand the question. Could you help me, Anne?

MS. COOPER: Are you asking if the FQHCs are going to be a referral source for this project?

MEMBER MARTELL: Correct. Because I look at the OB/GYN procedures that are being referred, and they're coming predominantly -- you know, we've got, again, what we know the historical

provision was by Access Health Center with Dr. Goyal and Dr. Ventura.

MS. COOPER: I think that that's a correct statement that they will continue to come from those types of facilities, but Vera can expand on that.

MS. SCHMIDT: I think when they gave us those referrals, I remember speaking to them about it, those numbers are -- those patients were the ones that were located close to the south side of Chicago close to Michigan Avenue Center for Health.

So Access is in a south suburb. However, a lot of the patients were coming from the Chicago area. So the numbers that they gave were the numbers based on their zip code studies.

CHAIRWOMAN SAVAGE: Any other questions?

(No response.)

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

MR. ROATE: Thank you, Madam Chair. Motion made by Dr. Martell, seconded by Ms. Grundy.

MEMBER GRUNDY: Based on the report my vote is to deny this application, but I do want to say that there is information, key information

especially with the closing of Mercy Hospital that I feel is missing that wasn't included in this report that I would like to see.

MR. ROATE: Thank you.

Mr. Kaatz.

MEMBER KAATZ: I vote no and my reason is from a patient safety perspective.

MR. ROATE: Thank you, Mr. Kaatz.

Dr. Martell.

MEMBER MARTELL: I vote no based on the staff report concerns that have been expressed regarding patient safety and referral resources and given the historical background information of referrals, as well.

MR. ROATE: Thank you.

Dr. Murray.

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

MR. ROATE: Thank you.

Chairwoman Savage.

CHAIRWOMAN SAVAGE: And I vote no based on the State Board staff report and concur with the comments that Stacy Grundy made, as well.

MR. ROATE: Thank you. That's 5 votes in

the negative.

CHAIRWOMAN SAVAGE: And so you will receive an intent to deny, and the Board staff will follow up with you.

MS. COOPER: Okay. Thank you.

CHAIRWOMAN SAVAGE: Okay. At this moment we're going to take a 30-minute break for some technical issues, and we'll come back at 10:30. So if everybody can return at 10:30.

(Recess taken, 9:57 a.m. to 10:41 a.m.)

- - -

CHAIRWOMAN SAVAGE: Welcome back everyone. Okay. Our technical issues seem to be resolved, so we do have Gary on the phone, Gary Kaatz, just so you know.

So next up on our agenda we have Project H-03, 20-034 -- I'm sorry -- H-02, 20-034, the UroPartners Prostate Center at the Glen, the purchase and installation of their linear accelerator.

Now, may I have a motion to approve the UroPartners Prostate Center at the Glen to purchase major medical equipment?

MEMBER MURRAY: So moved.

CHAIRWOMAN SAVAGE: Thank you, Dr. Murray.

A second.

MEMBER GRUNDY: I second.

CHAIRWOMAN SAVAGE: Thank you, Stacy Grundy.

George, would you please present our State Board staff report?

MR. ROATE: Thank you, Madam Chair.

The applicant, UroPartners, LLC, is proposing to acquire a new linear accelerator for its existing physician offices located at 2634 Patriot Boulevard,

Unit J, in Glenview. The anticipated completion date as stated in the application for permit is July 2nd, 2021. Project cost is $4,980,149.

There were negative findings associated with this report in regard Part 1120. There were two, one being financial viability and two being reasonableness of project cost.

Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you, George.

Paula, would you please swear in our applicants.

(Witnesses sworn.)

CHAIRWOMAN SAVAGE: And will our applicants please state your names for the court reporter, please.

MR. MORADO: Absolutely, members, Chair Savage. I'll go ahead and just start by saying good morning everybody. My name is Juan Morado, Jr. I'm CON counsel for this project. I'd like to thank the Board and their staff for all their assistance through this review process for this application and for the overwhelmingly positive staff report.

With me today for today's presentation I

have William Andre, director of radiation services for UroPartners; I have Nick Radonjic, general counsel and chief operating officer for UroPartners, and Mark Silberman, my partner from Benesch Law.

Members of the Board, this a unique project and we recognize you don't often see applications for the acquisition of major medical equipment. In this case we are here for the acquisition of a linear accelerator to treat cancer patients, and I believe everyone would agree there is an absolute need for these services, and our presentation today is going to focus on why the application is before you and why this machine is needed to continue providing life sustaining services to the community.

Nick will provide you with a background on UroPartners, the history of the practice and their impact in the state in terms of patient volume. He's also going to touch on this particular facility, the types of conditions and patients treated, and finally, he will discuss the healthy and robust financial condition of the practice and how and why the practice manages its cash flow.

William will discuss the existing machine and its utilization, the new proposed machine and why that one was chosen, and he's also going to describe to you the build-out required for the machine and finally, will finish up by discussing the phaseout of the existing machine.

Mark is going to walk through the unavoidable but limited findings, and we're confident that you're going to find that this project is well designed and will provide the necessary quality care in a way that will meaningfully impact the lives of the patients and benefit the communities that we currently serve without interrupting access.

So with that I would say, members of the Board, that this is a strategic decision by the practice to stay ahead of the curve and to ensure that our patients are able to consistently be provided with services that are life sustaining.

And with that I'm going to hand it off to Nick.

MR. RADONJIC: Thank you, Juan, for the introduction.

Ladies and gentlemen of the Board, thank

you for your time and attention to this very important matter. My name is Nick Radonjic, and I am the chief operating officer and general counsel for UroPartners.

UroPartners was formed in 2005 to provide the greatest urological care to its patients in the state of Illinois. The practice consists of 60 urologists, five radiation oncologists, as well as four pathologists, and we serve 220,000 urological patients annually in addition to 3300 surgical candidates at our ambulatory surgery center.

The types of patients and the conditions that we treat include bladder cancer, testicular cancer, kidney cancer, prostate cancer, men's health, Peyronie’s disease, as well as erectile dysfunction.

The Prostate Center at the Glen was formed in February of 2009 to serve its patients via radiation primarily prostate cancer. I'd like to discuss the financial condition of the practice.

The members or the physician members of this limited liability company UroPartners, LLC, received distributions at the end of the year

because we have a covenant with Bank of America, our lender, that all operations and costs associated with these operations need to be met before distributions to the membership or the shareholders takes place. This transaction will be financed with Bank of America with whom we have a very long-standing relationship because it affords us the flexibility of doing so especially while these rates, interest rates remain very low.

The finances of the company are doing extremely well. In particular our balance sheet remains strong, the practice is healthy, and the acquisition of this machine will not have any negative impact.

Based on this I'd like to hand off to William to discuss the condition of the current machine and the need for a new one. Thank you.

MR. ANDRE: Thank you, Nick. Thank you, member of the Board, for hearing us this morning.

Our current machine is a Varian IX. It's 11 years old now. We've worked it very hard. We do try very hard to take good care of it. However, just like anything else mechanical and electronic, things wear out and it is nearing the

end of its expected life. Somewhere in the 10- to 13-year range is when these machines get replaced, and we have noticed a problem with this machine. We've seen more down time having to have service people come out and fix it. We cannot fix it ourselves; we do have to use the manufacturer's service engineers to fix things and get the parts that are needed. However, that negatively does impact our patient care.

Radiation treatments are designed to be provided Monday through Friday. Interruptions to that treatment have a negative impact on outcomes for our patients. As such, we are trying to get ahead of the curve here, as Juan mentioned, and replace this machine before we end up with a major failure that could put us down for a couple of weeks.

We have done some research and looked in this issue, and we have decided on a Varian TrueBeam as our next machine. This machine offers us some advantages over our existing technology. It does have a cone-beam CT on it. It also has the ability to do stereotactic radiosurgery. Some of our patients unfortunately do have metastatic prostate cancer and benefit from having their

lymph nodes treated. We are not currently able to do that. We would like to do that for our patients for continuity of care, but currently our machine is unable to do that, and we do send our patients elsewhere for that care then.

The cone-beam CT lets us look at the patient every day and make sure things are lining up, and again, is something that didn't really exist hardly when we purchased our original machine.

We also are getting in addition to the TrueBeam machine a 6 Degrees of Freedom couch. This allows us to tilt the bed the patient lays on to match the angle of the prostate. The prostate does sit between the bladder and rectum, and as such the relative fills of those organs can change the orientation of the gland, and this couch will enable us to provide more accurate and precise treatments and reduce side-effects to our patients.

Now, putting in a machine like this is a very complicated process. These machines do use very high-energy photons for treatment similar to an X-ray but about 1,000 times stronger. As such, to protect both staff and the public who walk past

our building, we are required by state law to provide adequate shielding from the radiation. Typically we need between 4 and 6 feet of concrete that needs to be poured in addition to a very substantial base put underneath the machine to support all that weight. You can imagine that much concrete going into a building is expensive, and we have a lot of engineering things to get accomplished that all add to the cost.

And with that -- oh, one other thing I'd like to address is we are planning with the age of the machine to phase it out, our existing machine, and transfer care to our new machine as it will be more reliable. We can treat --

MR. SILBERMAN: Did we lose William?

MS. AVERY: We lost him.

MR. SILBERMAN: Juan, you'll send him a text? And in the meantime, what I will tell you is William was going to point out that there are a variety of conditions that can be treated with this machine. The primary at this facility is with regards to prostate cancer, but there are, as you see on the slide here a variety of other treatments that can be provided and are provided

at other facilities, and at the end of the day this is a fundamental example of being able to increase access to care and to broaden the access to care being provided by an exceptional group, and that is one of the reasons that this project is being undertaken.

Juan, if you want to advance to the next slide.

What I wanted to do, members of the Board, is I really wanted to address three specific points with regard to the negative findings that were contained in the State Board staff report.

With regards to the financial ratio, there was a negative finding because UroPartners found itself -- on the historical days cash on hand it found itself slightly below the Board standard, and with regards to the current ratio they found themselves for 2019 2/100th's of a percent below the Board's standard. We don't challenge the findings of the staff; those were the correct findings, but we want to assure you that the board does have the financial wherewithal, the ability, and the desire to provide this care and to complete this project.

When you're considering that financial criteria, we'd ask you to realize that, as Nick pointed out, the issues of days cash on hand was simply a result of the distributions that are paid out to the physician owners, but during the course of the year based on their covenants and their way of operating the funds are there for the operation of the project, for the operation of the practice, and for the ability to ensure providing care.

The other thing to please consider is this. When you look at the forward looking ratios, all of the ratios with regards to how the financials will play out, all of them were in conformance with this Board's standards.

Then as a final matter, there was reference to the fact and Board staff can verify that since the presentment of the State Board staff report we have provided the audited financials to be able to provide the backup documentation for all of the financial representations that were made in the application.

We do not believe and we hope that you will conclude that the very limited findings would provide any basis for concern to inhibit the

approval of the project, especially when you consider we met all of the need criteria and all of the other financial criteria but for those two.

The other issue with regards to the financial criteria related to the project cost. And with regards -- actually, if you can go back for one second, Juan.

With regards to the costs, there were two areas, modernization, which are our construction costs, and the equipment costs. And as much as I would like to provide you a great explanation as to why that is the case, the State Board staff provided the best explanation that could be provided, and it's contained in your own staff report.

In the staff report it specifically points out that the cost overages for the modernization and movable equipment are inherently high due to the type of project when you consider its limited size and the vault construction and then the cost of the linear accelerator itself. When you look at the picture on the right, the vault requires a significant amount of concrete fabrication and the employee protective media, and the linear accelerator

has a cost premium based on the advanced technology. That's the reason for the negative finding.

And, again, we don't challenge the standards. The acquisition of a linear accelerator is not a common enough project to justify its own standards, but at the same time they don't fit well within the standards that are utilized for these types of projects. There's no way that we could conform -- you can't build the necessary vault for $260 per square foot, and the linear accelerator itself exceeds the acquisition of equipment standards by three times.

But, members of the Board, this is the very reason that you're given the authority to approve projects when they don't comply with each and every criteria. And as I mentioned earlier, we don't want you to overlook that this project has met all of the other criteria of this Board. The only ones it hasn't met are those that it just simply couldn't comply with based on the nature of the project.

One other thing with regards to access of care and the importance of the care that's being provided. IDPH statistics show that prostate

cancer is the number one cause of cancer in Illinois, and they talk about having 97 percent of men diagnosed with prostate cancer have a good prognosis.

UroPartners is very proud to be a significant part of these statistics because approximately 1 out of every 5 diagnoses in the state of Illinois are patients of and being treated by UroPartners, and we'd like to continue that.

As a final matter, we'd just ask that when you consider this project realize there has been absolutely no opposition to this project. As Juan mentioned, this is a strategic decision to provide ensured access to care as one machine is phased out and another machine is phased in. We think it's fundamentally necessary to not only maintain but increase the access to healthcare, and we hope you will feel comfortable utilizing your authority to approve this project.

So with that we are happy to answer any questions that the Board or staff might have regarding our project.

CHAIRWOMAN SAVAGE: Okay. Do we have any questions for the applicants?

MEMBER KAATZ: I do, Madam Chairman.

CHAIRWOMAN SAVAGE: Go ahead, Gary.

MEMBER KAATZ: My name is Gary Kaatz, a member of the Board. Just a couple light questions.

I think in your -- excuse me -- my assessment of the project is really you're replacing a very old, antiquated piece of technology with something that is pretty much state-of-the-art. Is that correct?

MR. MORADO: That's correct.

MEMBER KAATZ: And the real benefit to the patients of the Varian is that it will destroy less healthy tissue. Do I have that right?

MR. ANDRE: Yeah, it should be a much more precise machine. It's been proven to do that in studies, and as such we can reduce side-effects especially to the bladder and rectum.

MEMBER KAATZ: UroPartners, is that the name of your group? I'm sorry if I got that wrong.

MR. ANDRE: That's right.

MEMBER KAATZ: That's an impressive group, 50-plus urologists. Will you also provide the

physicist and the dosimetrist for this technology?

MS. AVERY: Hi, this is Courtney. When you're speaking, please identify yourself for the court reporter.

MEMBER KAATZ: I'm Gary Kaatz. I'm still asking my questions.

MS. AVERY: I'm sorry, Gary, the person that's responding to you.

MR. ANDRE: This is William Andre. UroPartners currently does provide the physics and dosimetry services for the current patients and will continue to do so with the new machine. They will undergo additional training that utilizes the new technology, as well, and that has been included in our purchase of the equipment, the training.

MEMBER KAATZ: Smart, smart. I think you know how complicated this is going to be in terms of building this vault, and I was surprised that even though the standard is 2400 square feet, you're really thinking that 1350 is going to be adequate for the project.

MR. ANDRE: This is William again. We do. We have brought in Sam Stole & Company. They have extensive experience in putting in linear

accelerators in various places throughout the country. They have done measurements and preliminary drawings to help us make sure that this will fit within the space that we have.

Fortunately for us, the TrueBean footprint is slightly smaller than our existing, so we are able to fit it into our existing space.

MEMBER KAATZ: Oh, okay. That explains it.

And then with your group of urologists, do you have several of those individuals who are, let's say adequately trained on providing surgery on the da Vinci robot so that this really continues to be just one arm of your total portfolio of services offered for patients with prostate cancer?

MR. ANDRE: This is William. We have a variety of physicians. In fact, our physicians do more robotic surgeries than we do cancer treatments with radiation. We also do use watchful waiting where appropriate treatment for patients, as well as combination therapy, external beam radiation combined with LDR, low-dose radiation brachytherapy for our patients. We customize all our treatments to the patients' needs based on patient and their

actual cancer.

MEMBER KAATZ: Last question. It's unfair; if you are uncomfortable answering it, I understand; that's fair game. What makes you more nervous about advancing this project if approved?

MR. ANDRE: This is William again. I'm excited about the project. I'm looking forward to about learning how to use this technology to its fullest, and I am confident in my discussions with the vendor about the capabilities of the machine, with the construction company Sam Stole that we may be using. We haven't decided yet for sure on that, but we are in the process of getting drawings done to make sure this project can go forward.

Working with radiation is always a risk. We constantly monitor both our staff and patients for exposure and doing everything in the right way here to make sure this project is safe and benefits our patients.

MR. RADONJIC: I'd like to add, as well -- this is Nick Radonjic replying, as well. I'd like to share William's excitement, as well. Because we've spoken to William and a radiation oncologist who shared the enthusiasm with the new technology

and the new machine, and we strongly believe that this will better and further patient care with its utilization.

MEMBER KAATZ: I thank you for the answers to your questions. Well thought out. Thank you.

CHAIRWOMAN SAVAGE: Do we have any other questions from the Board members or the State Board?

(No response.)

CHAIRWOMAN SAVAGE: State Board staff, any questions?

I'm sorry; whoever is speaking we can barely hear you. It could be background noise.

Anybody else want to say anything?

(No response.)

CHAIRWOMAN SAVAGE: Okay. I do not hear any further questions. So, George, would you please call our role?

MR. ROATE: Thank you, Madam Chair.

Motion made by Dr. Murray, seconded by Ms. Grundy.

Dr. Murray.

MEMBER MURRAY: I vote yes considering the staff report and most importantly the testimony.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes, based on the staff report and the testimony and additional information provided today.

MR. ROATE: Thank you.

Mr. Kaatz.

MEMBER KAATZ: I vote yes based on the Board staff report, but I'm really impressed with the presentation, the testimony, the answers to the questions, and I really enjoy hearing the enthusiasm behind this project. So yes, I vote yes.

MR. ROATE: Thank you.

Ms. Grundy.

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

MR. ROATE: Thank you.

Chairwoman Savage.

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

MR. ROATE: Thank you. That's 5 votes in the affirmative.

- - -

CHAIRWOMAN SAVAGE: Now, for other business I will call on Courtney Avery.

MS. AVERY: You all received a financial report. I would ask that you look over the report, and any questions you have, if you can get those questions to me, and I can get those to IDPH.

And the second item, Dr. Grundy, I think you have the correct 2021 meeting dates. I ask that you look over those one more time so that I can get the meeting locations and sign off on the contracts to make sure we don't have any conflicts for the 2021 meeting dates. If there are any conflicts, please mail me.

MEMBER MURRAY: I have a question about the meeting location. And I don't know what -- again, I'll be shocked if we're able to meet in person, so I'm not quite sure -- we seem to be having problems with technology out there, so I'm just raising a question of why we're pretending we're going to the golf club.

MS. AVERY: Well, it's not the golf club, it's us. But I did talk to the Chair, we had a very successful experience with an outside company who set up the technology for the public hearing

for Mercy Hospital, so I'm going to meet with them next week to get some projected costs in order to make sure that we don't have the problems that we experienced today. And those were at my hand.

MEMBER MURRAY: Okay.

MS. AVERY: There will be an option for the December meeting to appear in person but, of course, adhering to whatever executive order is in place for in-person meetings, but there would still be an option for the virtual meeting attendance.

So, again, I apologize for all the technical difficulties we had today.

CHAIRWOMAN SAVAGE: Does anybody have any questions about anything?

MEMBER KAATZ: Madam Chairman, it's Gary. I think if we can get back to the face-to-face, I think that things would be better. I find it difficult with the technology. I think it's a little more difficult to assess the projects. I would just prefer in person.

MEMBER MARTELL: I have found that the electronic -- and I do most of my board meetings remotely. If there's a presentation like we saw today in a PowerPoint format, that is one of the

more effective. I think we really need to train individuals -- and this is going to be much more common to do more electronic. I'm going to be honest with you, I don't see pandemic numbers decreasing even with vaccination efforts well underway. I think we should encourage our presenters to do like today, I mean, just supplement with their presentation in a PowerPoint format.

I'm not sure -- we seem to have more problems than usual in this, but I'm hoping that the company that did the same for the Mercy Health -- you know, that public hearing was very well supported, and it was something that those of us could participate in that would allow some of our individuals who can't make it to board meetings to be able to listen into our decision making and deliberations.

MS. AVERY: They were really, really good.

CHAIRWOMAN SAVAGE: I agree, Dr. Martell. I don't see at least for a year or more for us to be probably having this pandemic get any better or enough better that we could all meet in a big room with everybody coming like we used to. But we'll see what happens for our December meeting, but every anticipation is that we're going to try to

meet in person given the cases that we're going to have if at all possible.

MEMBER GRUNDY: I agree.

CHAIRWOMAN SAVAGE: Thank you. Any other questions or issues?

Yes, Sandy.

MEMBER MARTELL: Is there a way that we can send our flash drives back to -- if someone can send off an email. For those of us who are State, email seems to be the biggest technology challenge, if you could send an email where I can send back the flash drives, George, because I now have three of them in my possession, and I really don't need them.

CHAIRWOMAN SAVAGE: Yes, George, please tell us how to send them back.

MR. ROATE: I will send the address once we adjourn from the meeting. Okay?

CHAIRWOMAN SAVAGE: Oh, bless you. Thank you.

MEMBER MURRAY: Don't forget, George, many of us have no access to the State email, so use a real email that works.

I know this is some internal matter with

the State, but let me say that even -- so let me just express this frustration for the whole Board. It would be nice to be able to participate fully in this. It's really difficult when this is a fourth email for many -- this is a unique email to this particular Board, that's the first problem. And it appears not to work aside from the problems with changing the password every 30 days.

So I think there's a confusion between being a State employee sitting at a State desk where this may not be as onerous, but the way we do this now, I mean, this is not an email I ever routinely look at unless we're getting close to a meeting, and even then like this time it didn't work. I mean, I got in but it was not -- I didn't have the authority to look at emails is what it said.

MS. AVERY: Dr. Murray, since the last administration -- and I don't know where it came from, but our Board, as you mentioned, do have the state-issued emails. So my calls -- all the hours I spent over DoIt yesterday, and I worked with DoIt and Mike Mitchell to come up with some kind of link just to click on for you all to get to your emails a lot easier. I also experience the

same thing sitting at my desk and at home, so I'm hoping to have that resolved by next week.

MEMBER MURRAY: So, again, I don't know where we are with legal counsel. I'm sure some of this is done with the idea of legal counsel in mind, except the IT people seem to only consider the fact that people are employees. I don't mind having an email, but, again, you have to change the password every 30 days, which I would argue is onerous.

MS. AVERY: It is and I agree, and we have to do the same. But when I had the conversation yesterday was to ask the question can we have a link that you would just click on and be able to access your emails quickly, and there's a possibility that that can come through just accessing the website and then clicking on.

MEMBER MURRAY: The problem is not trying to get -- I mean, I know how to get onto Office 365. The problem is --

MS. AVERY: No, that's not -- so you would not have to change your email addresses -- I mean your password. Hopefully it would just be a link.

MEMBER MURRAY: That would help. Every

six months or every year, but I just point out to me that that's a problem, and I can speculate trying to solve a problem that probably doesn't exist and doesn't get resolved anyway.

MEMBER GRUNDY: Courtney, I think there's a change. So when I go to my email now you have to identify your agency, and all of them say employees.

MS. AVERY: There's one that says partner, but I'll call you and talk to you about it.

MEMBER GRUNDY: Okay. I haven't seen it. Every time that I try and log in partner is not available.

MS. AVERY: Okay. We'll find out about it.

MEMBER GRUNDY: Okay.

MEMBER MURRAY: Then I have another question just -- not to get the answer today, but I keep bringing it up. We talked about this before, and, you know, we just finished our budget.

We have out-of-date standards and we are -- I keep asking about a review of those, and also even more importantly an issue of planning. So originally, this Board was supposed to deal with

planning. I can't remember the last time any of our budget was spent on that.

I would argue that the closure of Mercy, for example, was not a surprise, and I expect to see more hospitals close around the state because of COVID over the next three to five years, and we have other planning challenges even ignoring COVID.

So, again, I think it would be -- I would like us to have a meeting where we actually -- where the agenda was to talk about that and what to do -- what we can do about planning issues.

MS. AVERY: Dr. Murray, at one time there was a Center for Comprehensive Planning that was put in under IDPH, and that was an unfunded mandate, and I think it was one of the recommendations that came from the task force.

So we are internally looking at it and trying to figure out how to do exactly what you're saying and to come up with that, but one of the big issues was that when that task force looked at it that there was no incentive for Mercy to stay open. There was no State funding for it.

So even though we have our planning areas and we know where there's a lack of service

accessibility, we could not say, "Hey, System X, Y, and Z, we need you to put a center here; we need you to do this." But the Center for Comprehensive Health Planning, their purpose was to come together and have a state -- have a plan for the entire state.

So we are discussing it internally and trying to figure out what's the best way to look at that besides our inventory which dictates our planning.

MEMBER MURRAY: Again, I don't want to be confused. I wasn't really speaking about Mercy.

MS. AVERY: I just used Mercy as an example, but looking at the entire state.

MEMBER MARTELL: I think that that's going to be critically important as we move forward because as we have -- we're starting to see the pinch points for those of us who are in the trenches right now where hospitals have been licensed for beds but not staffed for beds.

So it's very hard from a planning -- I think that's the other part that we have to be cognizant of, especially, you know, as we open up more, for instance, I'm going to say ASCs or approve

those through the process is that one of the areas we're kind of finding now is we might be able to provide care -- and I'm going to give a very practical example -- for COVID providing infusion therapy for the remdesivir and the dexamethasone, not inpatient for those who are not -- with monitoring after their initial start.

So the problem is and the challenge that we have is that we're not really -- it's really a coordinated planning system. So to echo Linda's point is I don't know where we go with that because when I look at these as one-offs each one in its entirety and we look at capacity in different areas, it's very challenging, as really the landscape has changed from inpatient to outpatient and independently held. You know, even like when we talked today a little bit about, you know, the interesting machine. And, again, a linear accelerator is so far from public health, trust me, that it was very interesting to learn about it, but, again, when they said it could be used for other treatments like breast cancer, things like that, how is that being used in the off hours. Right? That's such an expensive --

MEMBER MURRAY: I want to be clear. I would like this Board to discuss this. It's not that I don't have faith in the internal discussions of IDPH. Theoretically they're busy with some other things; at least hopefully they are.

So I want to be clear. We don't have to replicate what used to be that didn't get funded. Planning can go on and there's something to be said for a plan that says we should be spending resources here or there even though we don't have the authority to actually spend resources. Ideally it would be great if we had authority but we don't. But I do think somebody, groups of people -- and this would not be the only organization that would do that -- thoughtfully thinking about our medical system is critical. It's going to be under strain, and I just can't accept the notion that we wouldn't spend some resources looking at this and discussing it. If the only thing we do is tell the politicians you need to put some money into planning, I mean, who knows what we'll say if we have a chance to discuss it.

What I'm asking for is a mechanism to be

clear on the agenda a time to talk about this. And let me also suggest that when we schedule such a time on the agenda we could bring in from around the state various professionals mostly in academia who do this kind of stuff for a living and who are already involved in these planning activities. So certainly, we could be informed by their testimony and their thoughts about ways to approach this.

I'm not sure that requires a motion. I'm asking really the Chair to schedule some time on one of our agendas with enough advance notice --

MS. AVERY: Dr. Martell, I'm sorry, I was muted and you didn't hear everything I said.

MEMBER MURRAY: I didn't hear anything you said.

MS. AVERY: But, again, I totally agree with everything you're saying. And to try to recap the brilliance I just had, the Center for Comprehensive Health Planning, exactly what you described, that's what was supposed to have occurred. Again, it was under the Department of Public Health, but it was going to be funded, they thought through the HFSRB, but we couldn't do that because the law restricted it, and it was an

unfunded mandate.

So what I'm suggesting that we do is to go ahead, finish those discussions internally, do some kind of white paper or suggestions of who should be involved, bring them to the table, probably would look like one of the Senate committees or something because we do have to make sure that it is funded, and we will continue to have that discussion and go forth, and it probably wouldn't be attached to our regular meeting agenda; we'd probably do something separate.

So we'll get started on that and hopefully come up with something.

MEMBER MURRAY: I'm thinking that would still have to be a public meeting. I don't care if it's an additional meeting.

MS. AVERY: It would be a public meeting. We'll just figure out who those panelists should be that you're recommending. And we do have a footprint for it because we had the Center for Comprehensive Health Planning in the law, so we would just have to go back and look at that.

MEMBER MURRAY: All right.

MS. AVERY: Thank you for your input.

CHAIRWOMAN SAVAGE: Mr. Kaatz, did you have something you wanted to say?

MEMBER KAATZ: Madam Chairman, yes, I had two questions, but I'd like to follow up, as the Board member who is on the other side of the table on the issues for about 40 years, I can tell you that in addition to Courtney and Mike -- George, I don't think you were around back then -- but it was also added that David Carvallo and there was an attorney from the Board. And I can remember, Dr. Murray, some of the points that you're bringing up, they would come to the table and they would be pretty prepared on, and it was really tough to kind of get something by them. They were prepared on issues of incidence and prevalence, loss of population dynamics, et cetera, et cetera.

As a relatively new member of the Board, I look at the current rules, and the rules are so outdated it's ridiculous. So I think the first thing that maybe all of us look at when a project is presented is the staff report, do Mike and George -- through Avery do they recommend this or do they not, and then we kind of go into the meat of the project.

But I think number one, the standards, or the criteria, or whatever we call them are way, way outdated. And number two, as I look at the history of this, this goes back to Public Law 93641 if I'm not mistaken, Courtney, Mike. Wasn't it a reason for us to exist to be able to demonstrate the cost savings?

MS. AVERY: Exactly. Not so much the planning part of it but the cost savings.

MEMBER KAATZ: Yeah, and I get a kick out of the fact that I think the last research that I've looked at states without certificate of need legislation were cheaper than states with certificate of need legislation, and I would just applaud any effort to go back to that as a reason why we exist. We don't seem to really spend any time on that. And they present the capital costs -- don't get me wrong, they present the cookbook, but I think in terms of the cost I think that we need to get back and say what is this group doing to at least manage the growth of expense or perhaps decrease it, as other towns have done, not a lot but others have done.

So, Dr. Murray, I would add to what you

said, but I would go back to that issue, what are we doing as far as our existence goes.

MS. AVERY: That goes back to a very important component, the unnecessary duplication of services as laid out in our statute. And I would have to respectfully disagree. We keep on top of the rules, the staff do, on a regular basis, and there are some things that we have to follow like RSMeans where we get our calculations from, the need calculation, which is self-reported data from those facilities. The only challenge that we really have is when a long-term care facility downsizes their bed numbers but doesn't tell us. We don't have the resources to go out and count beds and, you know, figure all of that out with the inventory --

MEMBER KAATZ: Sure.

MS. AVERY: -- but we rely on the facilities to give us that information, and when it doesn't show a need, we don't show a need. George uses the latest -- we pay for that service, which is RSMeans. When an applicant disagrees with something that is calculated, we look at it, we discuss it, and we present it to you not as a recommendation

but as information.

So if we wanted to kind of redesign and look at how this Board should operate, then we should probably do that with a task force that changes it. Because if you recall, the name planning used to be in the title of this Board, but planning was not one of the functions of the Board by law, so that's why that was removed and the Center for Comprehensive Health Planning was created because that's a whole different service.

But, again, it doesn't say we can't look at it. It doesn't say that we can't do what Dr. Murray has suggested and ask for some kind of platform and collaboration with other State agencies and health systems around the state to look at those issues that Dr. Murray brought up.

MEMBER KAATZ: Would you agree, though, that our committee does (inaudible).

MS. AVERY: And that's what we do.

MEMBER KAATZ: You're thinking that (inaudible).

MS. AVERY: On a finding, no recommendation.

MEMBER KAATZ: Findings. I believe this Board -- I would have loved to have had the

accelerator group, UroPartners, what the price of one of their treatments is compared to one of their competitors at one of the hospitals.

MS. AVERY: (Inaudible) you sent to us beforehand we sent directly to the applicant, and we asked those questions, and they get back to us with an answer. And if it comes up, I'm pretty sure the applicant would have no gripe about any of that.

MEMBER KAATZ: I think this Varian therapy -- and I defer to the physicians on the Board as -- as it becomes -- as that technology becomes more and more precise and you're not destroying healthy tissue, you have less patients coming back with complications of burns and other related things that really, really escalate the cost of treatment of linear accelerator therapy. And I would love to just -- okay. So you're saying I have fair game to --

MS. AVERY: Yes, you do.

MEMBER KAATZ: -- ask your cost base, what are your readmission rates perhaps?

MS. AVERY: Yes, and they should be prepared to answer that.

MEMBER KAATZ: Good, good.

And, Madam Chairman, I do have two questions if I may proceed.

MS. AVERY: Sure.

MEMBER KAATZ: The first one, going to Courtney's report, I remember in the June meeting, which was my first meeting, there was a little consternation about the budget, what was in the budget, staff raises, the fact that we have a position that's not filled. And if I'm out of order on this as a new member of the Board, tell me to back off, but are those still burning issues, or are those issues that we have come to resolution on?

MS. AVERY: I'll give you an update. We have had a resolution. I think at the last meeting you all went into executive session, and if you don't have those minutes, we'll get them to you. They were -- was it the last meeting? Yeah, it was the September meeting. So I'll get that recording to you -- well, Debi would have to get it because I deleted it and forwarded it on to her, but we'll get that to you.

We just have a little bit of a snag with

the hiring of the general counsel, and I hope to have that resolved this week. I misunderstood. The referral for the hire came from the governor's office, so I thought that the governor's office had vetted this person by checking references. Apparently, they thought I did but I did not; I was not instructed.

And now that's resolved, so today and tomorrow I'll be following up on references and reporting back to the governor's office. In the past their staff has taken the lead from posting the position, collecting résumés, interviewing -- we interview as a team -- and not making an offer but saying to IDPH, "This is the person we want to hire, this the salary that we're hiring this person at," and they take over and formalize everything. That in some kind of way changed, and I wasn't alerted to that.

So I think that the situation will be resolved, and we should have our candidate on board by the next meeting.

MEMBER KAATZ: Good.

Last question. I have a corollary to Dr. Murray's question maybe from a different

perspective. When I started in this business, I started at Rush Medical Center in the '70s. I know it's hard for anybody to believe that I'm that old -- you're supposed to be respectful. I remember -- and I'll use the current day's request. I remember when Michael Rees was operating 100 beds, Mercy had 150 or thereabouts and they were busy. And I'm sure the population on the south side is greater today than it was in the '70s, and I'm kind of appalled at the drift into for-profit medicine that is a replacement for what used to be not-for-profit medicine.

I don't know if it's good or bad or right or wrong, but I'm really -- I'm really as a Board member I sit back and see these for-profits moving in, and I don't know if that's -- I don't know the effect that it's had, and I think it probably goes back to --

MEMBER MURRAY: Well, one thing, let me just tell you that the population numbers have decreased especially in that part of the city since 1970, so don't -- that's why we need a planning function, so we can easily keep up with this stuff. Not only has the population decreased

but the demographics of who lives there has changed, also.

But in any case, I agree with the basic point you're making, and we need to find a way to be able to discuss that. So I look forward to being told when this is going to be, when we're going to have a special meeting on it or whatever.

CHAIRWOMAN SAVAGE: Not in November but in the new year hopefully.

MS. AVERY: We'll get those dates -- we'll get those who we suggest to be at the table, we'll circulate that to Board members and we'll get it done.

I want to go back to something that you mentioned, Gary, about Dave Carvallo being at the table. David was an ex officio member to the Board, similar to -- well, just like Dan and Dulce. And I agree David had a lot to contribute. Some I agreed with, some I did not.

So when I -- by law the directors of those three agencies are to appoint an individual as the ex officio. And over the past we've had really good ex officios, and you'll notice Dan and Dulce always contribute and have something to say about

different applications in a field that they know of that has to do with long-term care, that has to do with mental health. Whatever it is they give us great feedback on that.

IDPH usually appoints the assistant director or an equivalent. So I don't think that the David Carvallo position as it looks today is the right person to have at the table, but what I shared with them is please send us someone that can talk about programming, that can talk about statistics. We don't just want somebody to come and have a seat holder.

Unfortunately, we lost our last two ex officios from IDPH, and we now have the assistant director who I think will be fantastic because she has a background in local health and will probably be, if not better, just as good as David Carvallo.

So once we get her up and running and up to speed -- today there wasn't anything on the agenda that I thought any one of them could contribute to, but I think you'll be pleased, and we'll get that kind of support and information again. I think she's a Ph.D. I'm not sure but she will be great.

MEMBER KAATZ: Thanks for the update.

MS. AVERY: And she has been through the orientation and everything, and she may be on the phone.

MEMBER KAATZ: That's all I have, Madam Chairman.

MEMBER MURRAY: So, Madam Chairman, I don't know if it's okay to move to adjourn if we have no other new business. I can't hear you.

CHAIRWOMAN SAVAGE: That would be fine for you to motion to adjourn by Dr. Murray. And may I have a second?

MEMBER MARTELL: Yes, I second it.

MS. AVERY: Thanks everyone.

CHAIRWOMAN SAVAGE: All right. You guys have a great week, and be safe and have a lovely Thanksgiving, and we will talk to you soon.

MEMBER GRUNDY: Courtney asked me to look over the tentative dates. They're fine.

CHAIRWOMAN SAVAGE: Okay. Thank you.

(Off the record at 11:40 a.m. CST)

CERTIFICATE OF SHORTHAND REPORTER

I, Paula M. Quetsch, Certified Shorthand Reporter No. 084-003733, CSR, RPR, and a Notary Public in and for the County of Kane, State of Illinois, the officer before whom the foregoing proceedings were taken, do certify that the foregoing transcript is a true and correct record of the proceedings, that said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision, and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 14th day of November, 2020.

My commission expires: October 16, 2021

_____

Notary Public in and for the
State of Illinois