Transcript of Open Session Meeting

Date: September 17, 2019
Case: State of Illinois Health Facilities and Services Review Board

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

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION - MEETING

Bolingbrook, Illinois 60490

Tuesday, September 17, 2019

9:28 a.m.

BOARD MEMBERS PRESENT:

RICHARD SEWELL, Acting Chairman

SENATOR DEANNA DEMUZIO

SANDRA MARTELL

LINDA RAY MURRAY

DEBRA SAVAGE

KENT SLATER

Job No. 223750

Pages: 1 - 353

Reported by: Melanie L. Humphrey-Sonntag,

CSR, RDR, CRR, CRC, FAPR

EX OFFICIO MEMBERS PRESENT:

DAN JENKINS, Department of Healthcare and Family Services

DULCE QUINTERO, Department of Human Services

ALSO PRESENT:

COURTNEY AVERY, Administrator

MICHAEL CONSTANTINO, IDPH Staff

ANN GUILD, Compliance Manager

GEORGE ROATE, IDPH Staff

JUNAID AFEEF, Department of Public Health Attorney

C O N T E N T S

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

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

P R O C E E D I N G S

CHAIRMAN SEWELL: We're going to call the meeting to order. I apologize for the late start.

Could we have a roll call?

MR. ROATE: Yes, sir.

Senator Deanna Demuzio.

MEMBER DEMUZIO: Present.

MR. ROATE: Dr. Sandra Martell.

MEMBER MARTELL: Present.

MR. ROATE: Dr. Linda Ray Murray.

MEMBER MURRAY: Present.

MR. ROATE: Ms. Debra Savage.

MEMBER SAVAGE: Present.

MR. ROATE: Mr. Kent Slater.

MEMBER SLATER: Present.

MR. ROATE: Mr. Richard Sewell.

CHAIRMAN SEWELL: Present.

MR. ROATE: Six members in attendance.

CHAIRMAN SEWELL: Thank you.

On behalf of the Board, we'd like to thank Barbara Hemme for her service. She has resigned from the Board, so we thank her for her service.

May I have a motion from the Board to table the executive session until the October 22nd

meeting.

MEMBER DEMUZIO: Motion.

MEMBER MURRAY: Second.

CHAIRMAN SEWELL: All in favor say aye.

(Ayes heard.)

CHAIRMAN SEWELL: Okay.

May I have a motion to move Item C-03, E-033-19, Anderson Hospital, Maryville, to be heard after Item H-05, 19-026, Anderson Rehabilitation Hospital, Edwardsville.

MEMBER DEMUZIO: Motion.

CHAIRMAN SEWELL: Is there a second?

MEMBER MARTELL: I'll second.

CHAIRMAN SEWELL: All in favor?

(Ayes heard.)

CHAIRMAN SEWELL: Okay. Given that, may I have a motion to approve the September 17th, 2019, meeting agenda.

MEMBER SAVAGE: So moved.

MEMBER DEMUZIO: Second.

CHAIRMAN SEWELL: All in favor?

(Ayes heard.)

CHAIRMAN SEWELL: May I have a motion to approve the August 6th, 2019, meeting transcript.

MEMBER MURRAY: So moved.

CHAIRMAN SEWELL: Is there a second?

MEMBER DEMUZIO: Second.

CHAIRMAN SEWELL: All in favor?

(Ayes heard.)

CHAIRMAN SEWELL: I want to advise all of us present that members of the Board will take approximately 20 minutes to review some handouts before we proceed.

So that's why we will be sitting here not saying anything.

MS. AVERY: I didn't pass them out. Sorry.

(A recess was taken from 9:30 a.m. to 9:48 a.m.)

CHAIRMAN SEWELL: Okay. We're going to come back to order. I hope that Board members have had a chance to read the handouts.

- - -

CHAIRMAN SEWELL: Next on the agenda is public participation.

MS. GUILD: All right. We're going to start with MetroSouth, and I'm going to call five people at a time. If you have anything in writing, leave it on the end of the table for the court reporter.

And you have two minutes. And I'm sure George will do a very good job timing you. We have a lot of public participation this morning.

Okay. Domingo Vargas, Kevin Dulehide -- and I apologize about pronunciation -- Laurie Gordon, Guillermo Font, and -- how many do I have? One more.

-- and Sean Rupelyen.

And you can speak in any order.

MAYOR VARGAS: Do you want me to start now?

MS. AVERY: Yes.

MAYOR VARGAS: Good morning, everyone. My name is Domingo Vargas. I'm the mayor of the City of Blue Island.

No one wanted this hospital to close, but we understand that under the rules of this Board that result was inevitable and unavoidable.

For that reason we engaged in discussions with Quorum about how best to manage this situation so as to protect the interests of the community and create a win-win from the otherwise unfortunate situation.

Quorum proved willing to listen to the concerns of the community, exhibited an openness to identifying solutions. Together with the advice of our certification of need counsel from Benesch, we believe we have a solution that makes a bad situation better.

After multiple discussions we have reached an agreement with Quorum wherein, if they receive approval today to discontinue, they agree to pursue the temporary suspension of the facility. This will preserve the license and create a period of time in which the City can continue to pursue identifying another operator to maintain an acute care hospital for this community.

If those efforts are unsuccessful, we have also identified a process by which various assets, including the property, can transfer to the City so that it can continue to identify how to improve access to health care for this community. We also

ensured that the severance paid -- payments to the employees will be honored.

Based upon the good faith that Quorum has shown in our discussions and our belief that we have created the best results for the citizens of Blue Island that the circumstances allowed, we would withdraw any and all objections to the Board's approval of this discontinuation.

We will continue to fight for Blue Island and try to make sure our residents have access to health care, that this hospital may cease operating today, but we have positioned Blue Island to continue the fight.

Since I am in a room full of health care executives and the media is here, as well, if anyone knows someone looking for a hospital, we are here and ready for discussions.

Thank you.

DR. GORDON: My name is Dr. Laurie Gordon.

I've practiced dentistry in Blue Island for over 31 years. I'm a second-generation health care provider. My father practiced general surgery for 47 years. My brother's an obstetrician practicing here for 35 years. My

brother-in-law's an orthopedic surgeon for 30 years.

My family has a combined 150 years of providing health care in this community, but I'm not here to talk about the sentimental reasons why we should keep this hospital open.

I can also talk about this case as a small business owner and the devastating impact this would have on the many businesses along Western Avenue and the community, the people whose livelihoods will be destroyed by the closure of the hospital, not to speak of the 800-plus health care providers whose jobs will be lost. This would have a crippling, devastating effect on the Blue Island economy, but I'm not here to talk about that.

I'm here to talk about access to care, the creation of a hospital desert. If this State Board allows this exemption, it will allow this facility to close now. I've worked for over 30 years in the health care facility, providing emergency dental care from the hospital's emergency room and within the hospital, whether it be rebuilding dental health for victims of car

crashes or violence on the streets.

I know firsthand how important it is to have a health care center in this location so emergency care can be treated in a timely fashion when every minute could be the difference between survival or death.

By forcing this exemption through, this corporation is limiting the patients' access to care and removing their ability to receive the urgent treatments they require for the very near future.

We were originally told that they would keep the health care facility open until the end of the year or until they could help sell the hospital, but recently we were told we have less than a month before the building will be closed.

By closing three months prematurely, this corporation is forcing patients to abandon dental care midtreatment with no place to complete this necessary work.

Who is going to take responsibility when my 89-year-old patient is unable to complete the necessary treatment to receive dentures that will allow them to eat healthy food or the 90-year-old

patient that requires gum treatments that, without, will not be able to keep their diabetes under control? Who will care for the many geriatric patients who walk to their medical and dental appointments because transportation outside of Blue Island --

MR. ROATE: Two minutes.

DR. GORDON: -- is not a viable option?

I'm urging the Health Care Board to do the right thing and not grant this exemption and do proper due diligence before allowing this company to close the hospital.

This shouldn't be about --

MR. ROATE: Two minutes.

DR. GORDON: -- the bottom line.

CHAIRMAN SEWELL: Could you end your remarks?

DR. GORDON: I believe the Health Board owes it to the people of Illinois and the residents of Blue Island in this underserved area, and I beg them to do the research necessary before making a drastic decision that could negatively impact an entire community.

Thank you.

DR. DULEHIDE: My name is Dr. Kevin Dulehide. I'm a gastroenterologist on the South Side of Chicago.

My dad and my uncle worked at St. Francis when it was St. Francis in the 1950s. I've walked through -- probably like you, Dr. Gordon -- through the doctors' parking lot since 1973. I'm sorry to see what's going on. It's unfortunate.

State reimbursement is part of the problem for why hospitals like this are closing. It's only 10 cents on the dollar State reimbursement for a public aid patient. I was on the board of trustees of MetroSouth, so I understand what's going on.

But I understand there's a credible buyer, but I'm not sure if this is really a credible buyer. I don't want to use his name; I don't want to use, necessarily, the hospital, but it will -- I worked for them down in Douglas, Arizona. So I'd fly down to Tucson, drive to Douglas, come back after doing two days of endoscopies, and get paid.

I went down the next time and this credible buyer -- who says he's a credible buyer.

I'm not sure if that's really true, and I want to be careful from a litigation point of view I don't say anything I can get hurt by. Well, he didn't pay me the second time because he said that he went bankrupt.

And I don't have any of this documented, but I sure as heck could tell you my wife remembers that weekend I went down there and came back without a paycheck. She wasn't too happy about that.

So as far as being a credible buyer, I'm not sure. And, again, I don't have to pay a legal price because I know the Quorum Corporation's here listening to me up in front here.

But I think it's not credible, and then to find out a few years later that he was up for a potential litigation for $21 million in fraudulent billing, potential -- that's why I say "potential" is important. I didn't feel too happy about that, so I don't think somebody like that is credible.

Thank you.

DR. FONT: Sorry, Kevin.

DR. DULEHIDE: That's all right.

DR. FONT: My name is Guillermo Font. I'm

the director of maternal/fetal medicine at MetroSouth Hospital. I've been the director there for 11 years.

I would like to share with you that MetroSouth has a very advanced obstetrical unit which is unique in the area that we practice. Not only do we service Blue Island, but we draw patients from the neighboring communities.

Units such as us are basically found at Christ Hospital, at University of Chicago. We have 24-hour anesthesia coverage, 24-hour neonatology coverage, 24-hour obstetrical coverage, and myself, as a high-risk obstetrician, supporting this unit.

With the support of Quorum we have been growing this unit. And currently, while other units have been decreasing their numbers, our unit has been increasing numbers. We currently perform approximately about 1400 deliveries. Last month we performed 111 deliveries, even with all the bad press that we're having.

We currently have done 46 deliveries, and we have 3 mothers in labor and we have 2 older patients which are high risk. We service about

40 percent of high-risk patients in these communities.

I don't know if you're aware, but our perineal morbidity and mortality is equivalent to the maternal death that a country such as Afghanistan has, and we're one of the developed countries and leaders in the world, so we're not doing very good work.

My concern as a high-risk obstetrician is that, by closing this unit, we're going to leave an area where our mothers and babies are going to be placed at risk. Personally, as a physician and as an individual, I feel that the mothers from the South Side deserve better.

Thank you very much.

MR. RUPELYEN: Hello. My name is Sean Rupelyen. I'm the deputy chief of staff for external affairs for the Office of the Governor.

I'm submitting for the public record a copy of a letter provided by the Governor yesterday by email to the Health Facilities and Review Board, MetroSouth Medical Center, and Quorum Health Corporation. [See attached.]

Governor Pritzker asks that the Board

permit the submission of this written material so that it may be included in the public record.

Thank you very much.

MS. GUILD: Thank you.

Next group, Representative Bryant, Representative Rita, Anne Siedlinski, Chris Alise, and Ari Scharg.

MS. BRYANT: Good morning, members of the Board. I'm Representative Terri Bryant. I represent the secondmost southern legislative district in the state.

I am here today, really, just to ask you to keep in mind that often when we have private entities such as Quorum, the government gets in the way of them remaining healthy.

In the case of deep southern Illinois, there are four Quorum hospitals that -- should you decide to keep open the hospital in question today, it can strongly affect in a negative way the four Quorum hospitals that are in deep southern Illinois.

Often, when we talk about health deserts or medical deserts, we have to keep in mind that in a more rural area there are people who have to

sometimes travel 30 miles, 40 miles, 50 miles just to get health care, and so it's very important for the hospitals that we have in rural areas to remain healthy.

The dollars that would be going, in this case, to the Blue Island hospital would be dollars that would have to be supplemented from those rural hospitals in deep southern Illinois, where we already have trouble getting nurses, doctors, dental health care, and so much other health care.

So I'm here today to ask you to allow the closure of this, although from my heart I truly understand the issues that are being talked about here today and the need for this hospital. But we have four hospitals in the more rural area of Illinois that also have to be considered, so I ask you to give consideration to keeping those hospitals healthy.

Thank you for your time.

MR. RITA: I'm Bob Rita, State Representative of the 28th District, which represents Blue Island, and I'm also a resident of Blue Island, where MetroSouth Hospital is located.

I know you have a lot of -- you're going

to hear a lot of testimony. There's been a lot of testimony in terms of the public hearing.

One of the things I've been asking for and what I request here from this Board is to give us some time to come up with a reasonable solution to provide the health care to the Southland region -- in the south suburbs, on the South Side of Chicago -- to come up with a reasonable solution.

I understand that health care has changed and the way health care is provided. As it was stated as an advisory board member, that they were looking at the end of the year for closure, and then they filed it to be in November and then, later, now changed it to September.

What we need is some time to put something together, to look at not creating a health desert, to protecting the lives and -- because there's over -- almost over -- almost 50,000 emergency room visits at this facility -- and how is that going to get absorbed into the surrounding hospitals? -- along with the other services that they're providing there.

I know there's interested parties that have tried to talk with Quorum, and my request is

that we delay this to a future date to give us some time to come up with solutions so it's a win-win for everyone. This will be devastating to not only the city of Blue Island but the surrounding communities that this hospital serves.

And so my request is that we delay this, come up with a reasonable solution with a health care provider to provide the necessary health care needs so that we can continue to save lives and to provide the services that are needed in the community.

Thank you.

MR. SCHARG: Good morning. My name is Ari Scharg. I am a lawyer for the People's Choice Hospital.

I'm here with a representative from the hospital, who will speak next, but I'm here to let the Board know that People's Choice yesterday afternoon filed a lawsuit against Quorum alleging fraud and breach of contract, and that stems from facts that Chris will get into in just a second.

But People's Choice thought they had a deal to buy this hospital for $20 million, and they stand ready, willing, and able to go through

with that purchase.

Under 77 Illinois Administrative Code Section 1130.560(b)(2), the Board is required to defer consideration of an application for exemption when the application is the subject of litigation until all the litigation related to the application has been completed.

This litigation alleges that Quorum committed fraud through their application and that the application contains fraudulent misrepresentations by stating that they're -- that they've searched far and wide to find a buyer and were unable to find one. They have been negotiating with People's Choice since March. They had a deal for $20 million on July 16th. And as recently as a couple weeks ago, they agreed to move forward to allow People's Choice to review some of the financial records and to move forward with the deal.

So it seems like a win-win for everybody. It seems like folks want time to consider alternatives. Well -- and the Board is required to defer consideration.

So I'll just leave it with this: There's

a hospital closing; 800 jobs are going to be wiped away from Blue Island; a hundred thousand people are going to need to find alternative health care options every year. And there's a rule that says the Board must defer consideration, so it seems like that's what the Board should do.

Thank you for your time.

MR. ALISE: Good morning. My name is Chris Alise.

I'm here representing People's Choice Hospital. I realized time's limited so I'll get straight to the point. This is a prepared statement where we would like to very concisely recap some of the key points in our efforts to acquire the hospital.

In March of 2019 we began negotiating with Quorum Health and by July 9th of 2019 agreement was reached on all material terms, including a purchase price of approximately $20 million.

The agreement was papered, with drafts going back and forth through the end of July 2019, then on August 1st Quorum unexpectedly demanded a $1 million nonrefundable deposit in order to move forward.

Several days later Quorum agreed PCH's team to review financial due diligence documents and provided all the requested financial information. On August 9 PCH advised Quorum that it would pay a $450,000 deposit even though that was a new term that was never previously mentioned in the contract until after PCH agreed to pay Quorum its requested $20 million purchase price.

On August 13 PCH's financial partner approved financing for the purchase of MetroSouth, and Quorum was notified accordingly. Nonetheless, Quorum demanded a $750,000 nonrefundable deposit and then halted communication with PCH and its attorneys.

We'd like to be very clear about this: People's Choice is very enthusiastic about purchasing MetroSouth and stands ready, willing, and able to do so. PCH asks for the opportunity to save the hospital by deferring consideration of Quorum's application.

Thank you.

MS. SIEDLINSKI: Good morning. My name is Anne Siedlinski, and I am a longtime employee of the hospital.

I was born there at the old St. Francis Hospital, and I represent over 800 employees there and not just those dedicated employees but the people -- the disadvantaged people who live in the neighborhood.

I am here to urge you to please save the hospital and -- this hospital is like the heart of Blue Island. I think many people here are very much attached to the hospital, the things that -- the health care services we provide for the neighborhoods, not just Blue Island but Calumet Park, also Crestwood. If you ever would talk to any of the ambulance drivers, the people who live there, and the seniors, the people -- without this hospital, I think the whole community will not be able to survive.

And I just urge you, please, to keep the hospital open in honor of all the people in the community.

Thank you.

MR. SIEDLINSKI: My name is John Siedlinski, and I'm the husband of Anne Siedlinski.

And there's many advantages to keeping the hospital open, but one of the advantages to

closing a hospital -- let me get it straight. It's easy to close a hospital. One advantage is my wife won't have to get up at 3:00 in the morning anymore to drive the 38 miles to the hospital one way, 38 miles back. We live in Naperville. That's a huge impact.

Secondly, it's going to have a huge financial impact on those businesses, restaurants, et cetera, that are in Blue Island today, Iversen's Bakery, Beggars Pizza, and all the other ones that are along Western Avenue. So I challenge each one of you that votes to close the hospital to visit it five years later.

I did some work at St. Francis Hospital in Pittsburgh, St. Francis Hospital Medical Center, well-funded by Liberace, who had a huge picture of himself as you walked in the main door, gave tons and -- thousands of dollars, millions of dollars to the hospital to keep it open and it closed. The community turned into a toilet.

And I don't want to see that happen. I don't want that to happen to Blue -- excuse me. I don't want that to happen to Blue Island, so I urge you to keep it open. If nothing, then for

the sake of those that still live in the community and use the hospital every single day.

MS. GUILD: Thank you.

The next group is Shane Watson, Gwen Stanley, Anne Igoe, Norman Stephens, and Ed Cunningham.

MS. STANLEY: Good morning. My name is Gwen Stanley.

I work at MetroSouth Medical Center. I've been there for 14 years, and I'm here today to ask you guys to please, please let MetroSouth stay open.

It would be really, really sad if it closed because people really need to have care in the area -- I work in behavior health. Okay? And we work with elderly people who like have dementia and stuff. And it would be really sad if it closed because I would -- I just can't imagine them going to another place. They're being taken care of. They love the place; they love the care. And I just -- it would just be sad if you guys closed it. Please.

Thank you.

MS. IGOE: My name is Anne Igoe, and

I serve as the vice president for hospitals of SEIU Healthcare Illinois Indiana, and we represent the service and maintenance workers at MetroSouth Hospital.

I am here to request that the Board delay the closure or the request for the certificate of exemption for MetroSouth. As required under administrative code, when there is an aspect of the application which is not correct, the Board is required to delay the request until that application can be corrected.

The application was not -- did not provide correct information about the proposed closure date and has not provided correct information about a lack of potential buyers.

No hospital system or corporation, including Quorum Health, should be permitted to make a mockery of the Health Review Board's authority that stipulates how a hospital is supposed to be closed.

Let me lay out some facts. Quorum Health leadership decided to expedite MetroSouth's closure in an apparent attempt to appease investors displeased by the company's lousy

financial performance and dropping stock price.

In August Quorum leadership attributed a decrease in year-over-year second quarter revenue directly to MetroSouth. Metro's results will remain on the books until Quorum sells or closes the facility, which likely accounts for Quorum's urgency to secure the necessary certificate of exemption prior to October 1st. Reporting a delay in Metro's closure could further roil investors and sink Quorum's stock. It will also deny health care to those in the area.

Quorum's attempt to secure a secret, unilateral, last-minute deal with Blue Island to which we -- I'm sure we will hear about today -- attests to the company's leadership urgency to ditch Metro before reporting its third quarter results in October.

We understand that there is a potential request to continue to shut down the hospital but suspend a license for six months; however, as Board members and under State law, you can't suspend a license for a hospital. You lose that license once the hospital closes down.

Quorum Health attributed a 5.6 million

year-over-year decrease in the second --

MR. ROATE: Two minutes.

MS. IGOE: In closing, we have concerns about Quorum's actions. We're asking a mere request to delay it one more -- one month until you can properly investigate the claims and keep the hospital open to find a credible buyer.

Thank you.

MR. CUNNINGHAM: Good morning. My name is Ed Cunningham.

I'm the CEO of Gateway Regional Medical Center, a safety net hospital with over a hundred psychiatric beds serving Granite City and the southern region of the state as well as patients through the state, including Chicago.

We're a vital resource to so many at-risk members of our community. About 50 percent of our patient population are Medicaid recipients. We also provide a high level of charity care for not only our community, surrounding communities, and throughout the state with our outreach. I also serve on the board of directors of the Illinois Health and Hospital Association, and I'm a board member on the Illinois Hospital Licensure Board.

My hospital, along with six others represented here today, are affiliated with Quorum Health. Collectively, Quorum employs over 3,000 people in the state and provides an economic impact of over $400 million.

Many of us provide care in a community with few health care options or in which we are the sole provider. I know firsthand the types of pressures our hospitals are managing, declining reimbursements and increasing demand on outpatient services. I also know how hard we are working to remain a critical resource for our community and throughout the state.

As we previously expressed in an August 26th letter to the members of the Board, I am concerned that any delay in approving this exemption application would put in jeopardy Quorum's ability to meet specific financial obligations within our facilities and put our operations and our communities at risk.

While you are conducting your due diligence, I would ask that you please consider the broader implications your decisions would have on other rural and nonurban facilities in the

state.

Thank you very much for your time.

MR. WATSON: Good morning. My name is Shane Watson.

I am the CEO of Red Bud Regional Hospital, a critical-access hospital facility located in the southwest corner of the state.

As my colleague Ed Cunningham mentioned, our hospital is also affiliated with Quorum Health. We are a small facility that provides crucial medical services in a rural area with little access to health care resources.

Blue Island and the South Side of Chicago is fortunate to be home to eight other hospitals and multiple physician clinics and health centers. By contrast, the closest larger hospital to the Red Bud community is over a half hour away. This truly could mean the difference between life and death for a patient in distress.

I want to express my concern that any delay in approving this exemption could have a far-reaching impact on other regions and the provision of care to the resident in the other communities of the state.

I ask that you consider these circumstances when making your decision today.

MR. STEPHENS: Good morning. I'm Norman Stephens.

I'm the CEO of Vista Health System and Vista Medical Center East in Waukegan, Illinois, one of the -- actually probably the sister hospital of MetroSouth. We are in the same general Chicagoland area.

I've been there for 2 1/2 years, and during that time I've seen Vista move from losing as much -- if not more -- money than MetroSouth into the point where we are now above breakeven, and we are very fragile financially. I've also seen them try to do the same sort of rehabilitation, if you will, for the MetroSouth facility, and there's some differences.

In Vista we happen to be in an area where we are fairly isolated, and if that hospital failed, there would be a -- I've heard the word "health desert" used. The difference, though, is MetroSouth is surrounded by competitors who have prevented that hospital from succeeding and -- while all the strategies that we've employed in

both hospitals when it comes to cost control and evaluating service lines and whatnot have been -- they've been employed in both locations. So I will tell you the real difference is the ability for a hospital to succeed in such a competitive environment is just not there.

The other is that this group -- the company, Quorum -- is being vilified somewhat unfairly because, in fact, they have tried and struggled and had to absorb tremendous losses over the last 2 1/2 years that I've been there and even before that. And to continue, it's not going to have much of a different outcome, and it's only going to continue to destabilize the rest of the company.

It's a big enough loss overall that it does threaten all of our hospitals, and, in fact, it's stopped us from being able to get access to capital that we need to remodel our hospital. There's a lot of things that are on hold right now because, simply, the company is fragile enough right now that we just don't have the financial stability to be able to pull it off.

And so I would ask that you honor the

exemption and allow Quorum to take steps to, basically, save the company and to save services to these other six communities that we -- are desperately needed.

Thank you.

MS. GUILD: Thank you.

The next group, Bob Moore, Jim Farris, Melisa Adkins, Amanda Basso, and Carol DiPace-Greene.

MS. BASSO: Good morning. My name is Amanda Basso. I am the CEO of Crossroads Community Hospital in Mount Vernon, Illinois.

Mount Vernon is a deeper south hospital, and I have been a lifelong resident of southern Illinois myself. So not only do I see what Crossroads gives the community from a professional standpoint, but I also see it very much from a personal, and I would just ask the Board to consider this exemption today. Crossroads is a Quorum facility, and as a company we will be impacted by this decision.

Thank you.

MS. ADKINS: Hello. Good morning.

My name is Melisa Adkins, and I'm the CEO

of Heartland Regional Medical Center in Marion, Illinois.

You probably remember me. I was here about a month ago. And we are a Quorum facility. We're a 106-bed hospital that is a Quorum facility.

What I want to say is, because of the decreased reimbursements, we've recently had to close our OB, so it is impacting our hospitals. So what I ask you to consider is that our hospital is the heart of our community, too, so -- we do feel for MetroSouth Hospital because -- two of us up here, we're also CEOs but we're also nurses, so we provide a lot of care over the years.

And so what I would ask is that you please consider the closure of MetroSouth Community Hospital.

Thank you.

MR. FARRIS: Good morning. My name is Jim Farris, and I'm the CEO of Union County Hospital, located in downstate Anna, Illinois.

We are affiliated with Quorum Health --

MS. AVERY: Bring your mic closer, please.

MR. FARRIS: We are affiliated with Quorum

Health.

I've been in my position for 16 years, so I've had an ample opportunity to see how much our community is impacted by our hospital.

We're a 25-bed critical-access hospital with a 22-bed attached nursing home. We have a service area of about 17,000 people in a very rural area of the state. We have about 200 employees or 160 full-time equivalents, making us the second-largest employer in the county.

There are 15 primary care providers in our county, including 7 physicians and 8 midlevel providers. We are Joint Commission accredited in both our hospital and our nursing home.

We have been really focused on providing great care. Our services are typically primary care in nature. We have acute medical/surgical services, a swing bed program. We have all the ancillary services that our doctors require.

Our emergency room has tried to upgrade itself by becoming chest pain accredited, stroke ready, and we have developed a senior-friendly ER. So we're trying to serve the needs of our community.

Our affiliation with Quorum has allowed us to improve our services and our facility and improve the quality of the care that we are providing. We hope to continue being a successful critical-access hospital in the future and working with our sister facilities to improve the health in our communities.

So I hope that you would respect -- I would respectfully request that you consider the impact of your decision on our hospital.

MR. MOORE: Good morning. My name is Bob Moore.

I'm the CEO of Galesburg Cottage Hospital in Galesburg, Illinois. We're a 143-bed hospital located just off of Interstate 74 in northwest central Illinois. Our hospital's been around for 126 years.

We are an affiliate of Quorum Health. Our hospital's the only hospital within a 50-mile radius that provides mental health services to the older adult population, so it's critical to that portion of Illinois to have services like that available.

We serve Knox County and Warren County.

It is a rural area. We have a service area of about 50,000. It's a farming area, not a lot of industry that's left in that area. But we are one of the largest employers in that area and critical to our economic future in Knox County.

So today I respectfully ask you to consider what's before you. I know it's a tough decision, but the decision that you make has impact that's far-reaching throughout all of our facilities, and I thank you for that consideration.

MS. GUILD: Thank you.

Next group, last group for MetroSouth, Gerald Dagenais, Jack Axel, Kevin McDermott, Randy Heuser, and Carol DiPace-Greene.

MR. MC DERMOTT: Sit anywhere?

MR. AXEL: I'll get started.

I'll get started -- is this working?

AV TECH: Yes, it's working.

MR. AXEL: Okay.

MS. AVERY: You just need to hold it close.

MR. AXEL: My name is Jack Axel, and I'm giving testimony on behalf of Karen Teitelbaum, president and chief executive officer of Sinai

Health System.

Sinai Health System is pleased to have the opportunity to testify to the Board regarding the situation at MetroSouth. We are not testifying in support or in opposition to the matter before you but, rather, we are providing you with information.

Sinai is one of the largest safety net providers of health care in Illinois. We have been contacted by representatives of the State of Illinois, including Representative Rita, and asked if there was any possibility of offering assistance to preserve health services in the MetroSouth community.

We want to say in the strongest possible terms that any solution for the future of MetroSouth must be one that is driven by community needs and has the support of the community's stakeholders.

While Sinai Health System is not in a position to take ownership of MetroSouth, we have proposed to Representative Rita, Senator Jones, and others that we would be willing to consider the development and management of a freestanding

emergency center at MetroSouth, along with ancillary services.

While, over time, additional health care and other uses for the MetroSouth campus could be developed, we believe that a freestanding emergency center could at least maintain some of the crucial services for the community while additional alternatives are developed.

Referral agreements for patients requiring services beyond those that -- beyond those provided by -- a freestanding emergency center would provide could be implemented with other health care and social service providers as well as our own health care system. Obviously, this plan would require the input, support, and approval of many stakeholders in the community as well as additional analyses and certainly could not be implemented by the end of this month.

Thank you for your consideration of this information.

MR. MC DERMOTT: Hi. My name is Kevin McDermott.

I'm on the board of MetroSouth. I've been there since the inception, after St. Francis left.

And I've called on 35 -- or for 35 years I've called on all the hospitals in the Chicagoland market. I'm very familiar with all that's happened throughout all of the Chicagoland area.

And I listened to all these -- the CEOs that came in here from Quorum speaking on behalf of trying to shut it down, but please understand Quorum was just formed only about four years ago.

CHS was the parent company. They spun off Quorum because they were the not-profitable side of their stock options. So they needed to put this to the side, so that's why Quorum is where it's at.

I followed this thing through the whole thing, and all I'm asking is, if you talk to the hospitals in the immediate area -- from Christ, Palos, Ingalls, Roseland, Little Company of Mary -- right now Little Company of Mary and Pa- -- and Christ have gone on bypass all the time.

How are we going to support our needs in our community? Where are they going to travel on a bypass hospital? They're going to have to go all the way to U of C or someplace else. Our town

only has an EMS service. We do not have paramedics. We can't support something like this on a rush deal.

I'm asking you to delay it. I'm asking to go with a clear head. This is -- it seems like this deal is going to close faster than a real estate deal on a house in Blue Island and it's sad.

MR. DAGENAIS: Good morning, everyone. My name is Gerry Dagenais. I am not a CEO. I'm a retiree and a resident one block from MetroSouth Hospital.

My first comment is, in listening to all the statements today, it's interesting to see how corporate America can manipulate sections of our state, one against another. I have no solution for that.

Also, all I can say to you, as a resident in Blue Island -- I live one block from the hospital. And you get a busy weekend -- excuse me -- a weekend, a holiday weekend, ambulances are coming one after another after another after another, day and night. And I'm only repeating what's already been said here many times. Where

are these people going to go?

Please consider our community of Blue Island. We respect the other communities in the state. We have the same problem, it seems. And I just wish that corporate America would consider what they're doing and how it affects the population.

Thank you very much.

MS. GUILD: Thank you.

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

MS. GUILD: Is there anyone else from MetroSouth?

MS. IGOE: We have two.

MS. GUILD: Okay. If you'd like to speak, you can come forward now.

MS. LEWIS: Hello. My name is Katrina Lewis, and I've been with MetroSouth --

THE COURT REPORTER: I can't hear you. Hold it really close and spell your last name for me, please.

MS. LEWIS: My name is Katrina Lewis, and I've been with MetroSouth for 12 years.

I live directly across the street from MetroSouth. September 3rd -- I have a 1-year-old.

I was there at work from 2:30 to 11:00. My 16-year-old daughter called me to say he stopped breathing. I told her "Run him across the street immediately to MetroSouth Hospital."

We don't have a peds unit at MetroSouth Hospital, but the emergency room was the closest thing we could have got him to. If he hadn't been -- we hadn't been right across the street, where would I have took him to? Christ is like five minutes away.

It's like we -- I mean 5 miles away.

And like Dr. Font said previously, I was a high-risk patient, also, in 2011. He took care of me with my 7-year-old daughter. If I hadn't had that privilege to be at MetroSouth and have his care, I wouldn't have my 7-year-old child. So I was under Dr. Font's care, who previously spoke.

And thank you if you can just consider keeping MetroSouth open.

THE COURT REPORTER: Would you spell your last name for me, please.

MS. LEWIS: Lewis, L-e-w-i-s.

THE COURT REPORTER: Thank you.

MS. BOYD: I will die. I will die.

I'm 67 years old. My name is Sharron Boyd. That's S-h-a-r-r-o-n B-o-y-d.

THE COURT REPORTER: Thank you.

MS. BOYD: I am a resident of Calumet Park, which is attached to Blue Island on the -- excuse me -- on the north side -- I'm sorry -- the east side.

Over a seven-month period, I was admitted to the hospital 13 times. 13. 12 of those times I died. I was gone. Dead. They had to resuscitate me. Eventually, I had to have double-hearted surgery.

I need this hospital. I have grandkids who need me. I am full of life.

I can't do a handstand anymore. I can't jump up in the air anymore. But I can still roller-skate. I can go bowling.

(Laughter.)

MS. BOYD: If I had to travel to 95th Street, if I had to travel to South Suburban Hospital, I would be dead. D-e-a-d. Dead.

I need this hospital. The people in my community need this hospital. Blue Island needs this hospital. I'm selfish. I don't want to die.

I don't want to die.

I'm done.

(Applause.)

MS. GUILD: Thank you.

The next project is MIRA Neuro Behavioral Health Center for Children.

And there's seven people who have signed up for public participation, and it looks like there's seven chairs up there, so I'm going to call all of you.

Senator Hastings, Joseph Bullington, Vijay Chand, Mary Pat Ambrosino, Jyoti Randhawa -- sorry -- Anthony DeJoseph, and Scott Hullinger.

SENATOR HASTINGS: Thank you very much. And distinguished members of this Board and Senator Demuzio, it's always great to see you again.

MEMBER DEMUZIO: Nice to see you.

SENATOR HASTINGS: My name is Senator Mike Hastings, M-i-k-e H-a-s-t-i-n-g-s. I'm the chairman of the Senate executive committee, but more importantly, I proudly represent the greater southwest suburbs of Chicago, 218,000 people, from Lockport to Joliet, all the way east to Markham,

down south to Matteson.

It's an awesome community. It's diverse. It's -- you name it, we have it. We're really excited about the south suburbs, but the one thing we don't have is adequate mental health treatment facilities. We had Tinley Park Mental Health Center, which provided mental center services to countless Illinois residents, whether they're from the north part of the state or the south part of the state and that was closed.

Those people who received services for mental illness were dispersed to local community providers and hospitals throughout our south suburbs.

If you ask any of our hospital providers in the south suburbs what their emergency rooms are like, they will tell you that mental health issues are flooding the emergency room. We've had people sit in triage; we've had people sit on gurney beds outside the emergency room for hours upon hours before they get treatment. It's unfortunate.

And I will just say that Dr. Higgins and the MIRA organization have been nothing but very

excited to provide services to youth and adolescent people within our community.

If you look at the proximity of this facility comparatively to other facilities in the area that do provide treatment, Silver Oaks is the closest possible to the eastern part of my district. I will also add that Silver Oaks is owned 80 percent by the opposition, 20 percent by the hospital itself.

The hospital, Silver Cross, who's been here before, the CEO specifically didn't sign the letter in opposition for a reason. Why is that? Well, because the adolescent components of Silver Oaks is primarily filled, so there is a need.

The other thing is that --

MR. ROATE: Two minutes.

SENATOR HASTINGS: Thank you.

The other issue is that the equity company that owns Silver Oaks Hospital is a private equity company. They're a profit -- generated profit-motive business, and I think it's a shame --

CHAIRMAN SEWELL: Please conclude your remarks.

SENATOR HASTINGS: Thank you, sir.

I think it's a shame that we have a profit-motive company trying to get dictate community care, especially something as much needed as mental health.

Thank you for your time.

MR. BULLINGTON: Thank you.

Good morning. My name is Joseph Bullington. I'm a commercial banker and senior vice president at First Midwest Bank. I'm here to support MIRA Neuro Behavioral Health Center for Children & Adolescents, Project No. 19-014.

I'm here to address the negative finding as it relates to the bank providing a detailed term sheet for the loan but not a formal loan commitment letter.

The issuance of the term sheet rather than a commitment letter is due to timing and cost as it relates to the formal approval process. The bank has had a banking relationship with some of the principals for over 10 years. We've been working closely with the MIRA group for many months, reviewing business plans, construction costs, project demand, personal guaranties,

et cetera, all part of the lending process.

The loan process can be very expensive and time-consuming. Direct and indirect fees and costs associated with obtaining a formal loan commitment could easily surpass a hundred thousand dollars. We believe it not prudent to incur these costs until after the CON has been approved.

On a personal note, I'd like to share with the Board that the south suburbs where I reside is in desperate need of this project.

Several years ago one of my children, unfortunately, needed help. My wife and I traveled daily over one hour each way to see our child and meet with therapists, et cetera. As you can imagine, this travel and the arrangements that came with it compounded an already stressful situation for my family. The children and the families of the south suburban area deserve to have professional care in close proximity to our conferences.

Thank you.

MS. AMBROSINO: Good morning. Thank you for allowing me to testify today in support of MIRA Neuro Behavioral Health Care.

My name is Mary Pat Ambrosino. I am the executive director of Community Services Foundation, a not-for-profit, community-based organization supporting over 500 adults with intellectual and developmental disabilities in day program and residential settings.

Historically day programs -- or you may know them as shelter workshops -- were mainly housed in very large industrial buildings and built for the purpose of providing adults with disabilities the needed vocational skills.

I'd say over the past five years the State of Illinois, under the direction of the Center for Medicare and Medicaid Services, has strongly encouraged community-based providers, like ourselves, to downsize these large facilities and to find more suitable locations that support community integration.

I'm very proud to say to you today that our organization has made great strides in our efforts to find facilities that are, indeed, more conducive to the needs of the individuals we support.

In 2015 we had four facilities, each over

20,000 square feet. Today we only have two. We moved a hundred -- 210 individuals from these two buildings into six smaller locations we now call humans of choice.

We now set our sight on our Prosperi location that has 180 individuals enrolled. This is our 40,000-square-foot building that was originally built in 2001 for our sheltered workshop needs with one back door and only 20-foot-high work floor ceilings, which by today's standards is 18 feet shy of the standard 36-foot desired height.

Trying to sell this to a commercial buyer has proven to be very difficult, but our need to sell is great, one that will allow us to stay on the path to provide the best supports and environments that will deliver the best outcomes.

If we are able to sell this building, we have our wish list ready to go. We will take all these individuals into -- move into four new sites within the suburban landscape.

MR. ROATE: Two minutes.

MS. AMBROSINO: Our smallest program -- sorry.

Basically, the sale of this building is a win-win situation. Of course, the first win being children and adolescents and families receiving needed services; the second win, 180 individuals now housed in a large building will be able to find home into smaller settings, and community integration is our key goal.

Thank you.

DR. DE JOSEPH: Thank you.

My name is Dr. Anthony DeJoseph. I'm the group CEO for the three US HealthVest hospitals in Illinois, and we are here to approve -- oppose Project 19-014, MIRA Behavioral Health Center.

You know, it was interesting in the Applicant's responses. They tried to raise in a negative way a negative issue that US HealthVest is a for-profit entity, and I'd like to point out that they, themselves, are a for-profit entity.

Moreover, US HealthVest does have a documented history of committing to Medicaid patient populations, where the Applicant is proposing a minimal commitment to Medicaid, instead proposing to cater to a private-pay and

private-insurance client base.

The Board should not approve a project with such a bare minimum commitment to Medicaid that does not actually do much meaningful to help the obstacles that Medicaid patients face in getting care. If approved in this way, it will allow them to cherry-pick high-reimbursement patients and leave caring for indigent patients to others, other providers in the area who are already meeting the needs of this community.

I'd like to add to the State's own determination from the SBSR of concern about financial viability. There is a substantial cost of the core management/administration part of the structure that has to be in place whether you're a 30-bed hospital or a hundred-bed hospital. This cost is overcome by economy of scale.

Those of us that manage acute care psychiatric hospitals know that it can be very difficult to even break even on a bed complement of this size. It may require a hundred percent occupancy at all times to do so, and that is very unlikely. Their own projected referrals lead to 53 percent occupancy on 30 beds. It's highly

doubtful that this occupancy will sustain this hospital financially.

To follow up on bed availability and access and point out that we are 12 miles away at Silver Oaks, we do provide this care, we have capacity to expand in this care, and we have available beds for this population.

So if there's -- speaking practically, rather than using an arbitrary 10-mile rule, we are accessible within the community of Tinley Park, as well.

MR. ROATE: Two minutes.

DR. DE JOSEPH: All the hospitals in the planning area and the State itself determined that there are 65 excess beds --

CHAIRMAN SEWELL: Please conclude your remarks.

DR. DE JOSEPH: -- and that none of those hospitals are meeting the State's own target utilizations.

There are 38 other adolescent beds at 11 and 16 miles, respectively. Today, census in those is 50 percent at one and 38 percent at the other.

Thank you.

MR. HULLINGER: Good morning.

I'm Scott Hullinger. I'm the chief executive officer of Silver Oaks Behavioral Health, and I'm here in opposition to MIRA Behavioral Health, Project 19-014.

US HealthVest has saved two hospitals in the state from closure, Lake Behavioral and Chicago Behavioral, and has now opened another hospital in a joint venture with Silver Cross.

As Dr. DeJoseph said, MIRA Behavioral is a for-profit company. The negative findings point out a significant concern regarding the project, that it is not financially viable. The Applicant's entire application rests on the ability to pick private-insurance patients and not serve those in the community without the means to afford private insurance.

Your SBSR indicates that the Applicants believe they will serve 91 percent private-pay patients and only 7.5 percent Medicaid patients. That does not increase access to care. That is an outright block on the ability of area residents to receive care unless they have private insurance.

If the Applicants don't adhere to the payer mix described, the rest of the application may begin to unravel. Without servicing a high number of private-pay patients, the Applicants will not generate the necessary revenue to meet the debt obligation that will, in turn, leave them failing to meet the financial viability ratios listed within the application.

The only way the facility can be sustained is if Medicaid patients are limited to only two beds in the facility. This is in stark contrast to how we operate our hospitals. Within our hospitals, Medicaid payer mix ranges between 30 and 60 percent. Our model does not require that we primarily serve private-pay patients.

Silver Oaks recently opened at the beginning of the year, and our hospitals have at least 65 beds across all three facilities that can serve the patient population. We know there is ample access to acute mental illness services for this population in the community. This project does not appear to be the right one at the right time for the community, and we ask that you do not approve --

MR. ROATE: Two minutes.

MR. HULLINGER: -- Project 19-014.

Thank you.

DR. RANDHAWA: Hello. My name is Jyoti Randhawa. I'm a board-certified child and adolescent psychiatrist at Silver Oaks Behavioral Hospital, and I provide child and adolescent inpatient services in this area.

And just to follow my predecessors here, US HealthVest is a national leader in providing behavioral services across the country and for the entire spectrum of patients. We can transition adolescent patients who are -- who age out of our programs into the appropriate adult plans at the same facility to prevent any type of unnecessary disruption in the delivery of care.

And most importantly, we do have the capacity to take the youth and the patients in this area. We still have capacity not only within our own facility but the facilities within our entity to take patients. As Dr. DeJoseph said, there's still beds open for the community.

At this point we do not -- we are not aware of the Applicants having any track record of

owning or operating an inpatient hospital facility.

The facility will be having physical limitations, as this is a modernization of an existing office suite, and there's no indication that the building meets the request requirements for the IDPH licensing of a health care facility providing AMI service. These patients deserve the ability to receive care in modern facilities that are specifically built to address their needs.

With significant financial issues and many other questions involving this application, we would ask that you not approve Project 19-014. While this is a worthy effort to provide these services in the area, a larger spectrum in both age and those utilizing Medicaid can be serviced via US HealthVest facilities that are already open in their communities.

Thank you.

DR. CHAND: Hi. My name is Dr. Vijay Chand, and I'm a board-certified child and adolescent psychiatrist.

I believe that this hospital is greatly needed, as it fills a void for acute psychiatric

services in the southwest suburb areas. Nearly 1 in 5 children have a mental, emotional, or behavioral disorder. To help ensure favorable prognosis and outcome, early treatment and diagnosis is needed.

Unfortunately, this is not the reality. The reality is families struggle to access quality mental health services, especially when they're in acute crisis. Some families must travel far or be placed on long waiting lists. This is not acceptable, as many children are suffering and many children are dying.

Suicide is the second leading cause of death for children, adolescents, and young adults. Recent data shows that suicide rates continue to rise; thus, it is absolutely critical that we establish this hospital.

Professionally, I see that when my patients become hospitalized, they can be waiting in an emergency room for 16 to 20 hours, if not longer, until a bed becomes available.

Oftentimes families end up leaving against medical advice, as sitting in the ER for that long can be very traumatic for their child. This is

not therapeutic and this needs to be changed.

Another thing I often see is that there is a communication deficit between the inpatient and outpatient systems and, due to this lack of coordination, inappropriate medication changes are made. Our goal is to change that and to help create continuity between the inpatient and outpatient systems.

We have an opportunity today to make a change and to do something really, really amazing. And in return, we're able to help a lot of children and a lot of families. I strongly urge your support for the MIRA project.

Thank you.

CHAIRMAN SEWELL: Before we call the next group, we're going to take a five-minute break.

(A recess was taken from 10:52 a.m. to 11:05 a.m.)

CHAIRMAN SEWELL: Let's come back to order.

MS. GUILD: The next group of speakers is from Blessing.

I have Dr. Joe Meyer, Harsha Polavarapu --

sorry -- Penny Noble, Carol Brockmiller, Phil Conover, and John Simon.

CHAIRMAN SEWELL: You can start.

DR. MEYER: Good morning.

My name is Dr. Joseph Meyer, and I am president of Quincy Anesthesia Associates.

I'm here to speak to you today regarding the relocation of Blessing Hospital's surgery center to the hospital campus with attachment to the hospital via a sky bridge.

Over the past many months, administrators, staff, and physicians have participated in creating the design and layout of the new surgery center. From our collective experience, we have discussed ways to make the surgery center run both efficiently and effectively. Blessing's goal is to build a center that provides a comfortable, positive experience for our patients as well as ensuring competitive prices.

Blessing has provided the residents of Quincy four separate public viewings of the plans. Blessing administrators attended each of the viewings to welcome input and ideas from the public, to answer questions and receive feedback

from individuals on their personal outpatient surgical experiences.

The current project meets the State requirements on both square footage and cost. In regards to the number of recovery rooms, the current plan offers six Phase I recovery rooms for three operating rooms. There are 18 Phase II prep/recovery rooms. 2 of these 18 rooms are designated for bariatric and special-needs patients.

The prep/recovery rooms will serve a dual purpose. They will provide prep areas as well as Phase II recovery rooms. A lack of prep/recovery area hinders the efficiency of the ORs, creating bottlenecks and delayed start times. These issues are costly and negatively impact patient satisfaction.

Blessing has taken great lengths to design a contemporary, safe, and dynamic surgery center. The number of prep/recovery areas is proportionate to the volume of cases that three operating room suites will produce.

As CMS moves more and more procedures to the surgery centers, the concept of prep/recovery

rooms is sensible for today's dynamic outpatient surgery centers.

It is for these reasons that I urge the Board to approve Project 19-029. Thank you very much.

DR. POLAVARAPU: Good morning. My name is Dr. Harsha Polavarapu, and I'm a surgeon with the Blessing Physician Services. I operate at the current surgery center in Quincy, which is owned by the Blessing Hospital.

I am here today requesting that the Review Board approve the Blessing Hospital's ASTC relocation and modernization application.

As a surgeon, I am enthusiastic and excited about this modernization and relocation project. We will be able to work with the same staff and equipment that will be relocated from Hampshire Street to the Blessing Hospital campus. It will also be attached to the hospital by a walkway, which gives us additional peace of mind.

The number of ORs and procedure rooms remain the same, and no new services are being proposed. I'm also excited to mention that any physician wanting to operate in the center will be

able to apply for privileges.

The Quincy-area community wants choice, access, lower prices, and safety. The proposed project is being designed to meet these needs.

I respectfully urge the Review Board to approve the relocation of the Blessing Hospital ASTC to its hospital campus.

Thank you.

MS. NOBLE: My name is Penny Noble. I am a citizen from the Quincy area and a consumer of health care services.

I am a medical first responder with the local volunteer fire department, and I am here today to express the perspective of a patient and to support Blessing Hospital's proposal to relocate its surgery center to the hospital campus.

As more and more types of services are being performed in the ambulatory surgical setting, a direct connection from the surgery center to the hospital will give patients a comfort level that they are close to the hospital.

The Adams County Ambulance reported 13 dispatches throughout the 12-month -- last

12 months from the current ASTC to the hospital. I know staff does everything they can to make a transfer go smoothly for the family and the patients, but the anxiety of having to wait for the ambulance will be avoided in these circumstances with a surgery center that is connected directly to the hospital.

Even going into a surgery procedure, this stress will be reduced, knowing that being on the hospital campus will help in addressing the unexpected emergency situation.

The relocated, modernized center will provide easy access and convenience for the patients, while also addressing safety concerns for those patients who tend to worry. As a first responder as well as a patient, I understand both sides of the patient safety concern.

For those reasons especially, I respectfully urge the Review Board to approve the CON Project 19-029.

Thank you for your time.

MR. CONOVER: Good morning. My name is Phil Conover.

I've served as a financial adviser and

president of the Great River Economic Development Foundation, dean of John Wood Community College, and I'm now president emeritus of Quincy University.

I'm here today in support of Blessing Hospital's application for the relocation of their ambulatory surgery center in Quincy, Illinois.

Blessing Hospital's ongoing commitment to our area is quite impressive. They have supported many educational endeavors. Without the revenue from the proposed surgery center, I'm afraid this critical investment in our local economy will be compromised.

For as long as I can remember, Quincy University and Blessing Hospital have been partners. For the past 20 years we have worked tirelessly to educate students to become nurses in our region. We have also had the good fortune to have many students complete internships in the health system.

Blessing employees have been readily available to speak on our campus in various classes, and their Be Well At Work clinic has served QU employees and their families in times of

sickness and crisis. Together, we are working to meet the workforce needs for today and the future.

In addition, many of the faculty and staff at both QU and Blessing serve on boards and committees in our town that benefit the mission of both organizations.

I would urge the Illinois Health Facilities and Services Review Board to approve this application as the city of Quincy and the entire tristate area will greatly benefit.

Thank you very much.

MR. SIMON: Good morning. My name is John Simon, and I'm the chief of Adams County Ambulance and Emergency Medical Services in Quincy, Illinois.

Thanks for the opportunity to share my support for relocating Blessing Hospital's ASTC. Our community depends on Blessing Hospital and the critical services it provides to our residents, visitors, and businesses.

At Adams County Ambulance, we value the collaborative partnership that we've built over the last 45 years with Blessing to provide high-quality emergency medical care. Their

commitment to our community has made Quincy, Illinois, a regional destination for health care. And as fellow emergency medical providers, we work together identifying community and regional solutions that result in positive impacts and great outcomes for the patients that we serve.

Throughout the past year, Adams County Ambulance has responded and transported 13 patients from the current ASTC at 1118 Hampshire to Blessing Hospital. A relocation of this facility to the hospital campus that's connected to the hospital and to the surgery room, it benefits our patients. It reduces our burden on a taxed ambulance system. It maintains a continuity of care for the patient, and it eliminates further financial burden from yet another medical provider.

Adams County Ambulance and Blessing Hospital continue to partner and be proactive to meet the needs of the community, advancing capabilities, improving overall wellness of our patients and the region. We support Blessing Hospital's desire to relocate its existing ASTC because our patients come first.

Thank you.

MS. BROCKMILLER: My name is Carol Brockmiller, B-r-o-c-k-m-i-i-l-l-e-r.

I'm the CEO of Quincy Medical Group or QMG, a physician group in Quincy, Illinois. I'm speaking today in relation to Project 19-029.

Earlier this year the Board approved QMG's application to establish a surgery center in Quincy, making it the second one in Adams County. As a few members of this Board will recall, our project was aggressively opposed by Blessing.

Less than two months after our project was approved, Blessing filed an application to discontinue its existing surgery center and construct a new one on its hospital campus. Blessing says that without a new, much larger surgery center -- with more than half of its square footage characterized as nonreviewable space -- that it won't be able to compete with QMG.

QMG is and always has been pro competition. Competition increases efficiency, improves quality, increases patient choice and access to services, and reduces health care costs.

I am not here today to oppose the project.

In fact, QMG has never opposed any of Blessing's CON projects, including two last year with a combined $90 million cost.

While we are not opposing the project, we do have serious concerns with the application and the disregard for the Board's rules and procedures. We expressed our concerns during the public hearing and in written comments to the Board.

Two concerns relate to Blessing's failure to include a necessary party as a Co-Applicant -- that is, the parent company, Blessing Corporate Services -- and Blessing's failure to submit mandatory physician referral letters, a requirement that goes to the heart of the Board's planning process, as it requires providers to submit documentation to justify its facility.

If a provider improperly or imprudently plans and overbuilds, it adds to the provider's expense structure and leads to higher prices for patients and payers. We believe that project should be assessed objectively and that Blessing should be required to comply with the same rules applied to other Applicants.

We support the work and the efforts of this Board. It's my sincere hope that the concerns we've raised today will be addressed when the project is up for consideration later.

Thank you.

MS. GUILD: Thank you.

The next project is Dialysis Care Center, Chicago Heights. I'm going to split this one into two groups. The first, John Byce, Dawn Thomas, Demarys Karson, Seddrick Ware, and Stephanie Shumate [phonetic].

MR. BYCE: Hello. I'm John Byce, an operations director with DaVita in Chicago. My region includes DaVita's Chicago Heights facility, operating a mile from the facility on your agenda today.

DaVita does not take lightly the decision to oppose an application, and we only do so when it's clearly obvious additional stations are unwarranted and will create serious financial losses for a clinic.

We oppose Dialysis Care Center's application for a third facility in Chicago Heights, as it will replicate the services of

facilities operating in Chicago Heights already, which have ample capacity to admit more patients.

While DaVita did not oppose this group's CON to build another clinic in nearby Hazel Crest last year, reviewing the overlapping data supporting the two projects, it would be absurd for them to build another facility so close to Hazel Crest. That previous application suggested sending patients to Hazel Crest from many miles away. This is unfair to the patients that treat three times a week.

Your staff's report found this facility is not needed because there is ample access in the immediate area as well as an excess of 57 stations in the planning area. If approved, the excess would increase to 71 stations, and this would be the largest station excess in the state.

There are currently 10 dialysis facilities within 5 miles of the proposed site, and Fresenius Kidney Care just began treating patients last year at its new Chicago Heights clinic. Average utilization is 62 percent, well below the 80 percent target. There is plenty of appointment availability, and, more importantly, utilization

rates are not increasing.

This facility is guaranteed to draw patients from the existing Chicago Heights clinic. Dialysis Care Center's physicians admit patients to our clinic, and they clearly plan to transfer patients out.

The care patients receive with us is excellent. The patients that Dialysis Care Centers want to move to a new facility are currently receiving services in our locations in Chicago Heights, Hazel Crest, Country Club Hills, and Olympia Fields. Taking these patients will further reduce the utilization in the clinics without adding any benefit. There is no need for another Chicago Heights service at this time.

MR. ROATE: Two minutes.

MR. BYCE: Please deny the application.

MS. THOMAS: Hi. I'm Dawn Thomas, an operations director in DaVita's Chicago region.

DaVita opposes DCC's proposal today to establish a dialysis facility in Chicago Heights. As your staff report concludes, there is no need for a third dialysis facility in Chicago Heights. Similarly sized communities usually only have one.

Because the 57-station excess does not support more facilities, DCC maintains a false narrative that an exception should be made for them because they are somehow unique because affiliated physicians have a preference for home dialysis. This is an insult to the many other area nephrologists diligently working to expand patient use of home therapies.

Under your rules there are five variances an applicant can satisfy to demonstrate a project will address a unique need, such as an access barrier. As discussed on page 11 to 13 of the Board staff report, DCC does not qualify for any such variance.

For the record, DaVita readily accepts Medicare and Medicaid, and over 85 percent of the patients at our Chicago Heights facility are people of color. The other existing Chicago Heights facility has similar demographics and payer mix. There are no access barriers in this area.

Notably, DCC has not documented a track record as a safety net provider and claims dialysis services are not safety net services. We

disagree. DaVita is a safety net provider for a generally vulnerable patient population with a relative lower socioeconomic status.

This provider cannot support claims of superior outcomes. DaVita gets consistently high ranks in CMS' ESRD quality incentive program, and DaVita's CMS star ratings for the past five years are outstanding despite its specialization in managing high-risk patients.

I ask the Board to deny this proposal.

MS. KARSON: Hi. I'm Damarys Karson, DaVita's area home facility administrator.

Due to excess supply in the immediate Chicago Heights area, I oppose DCC's proposed dialysis clinic. There is an excess of 57 stations in this area, so by your rules, clearly, there is no need for another clinic here.

Despite this large excess, DCC wants to build more stations. To counter the obvious and material obstacle to approval, DCC tries, without evidence, to lay claim on being an innovative home services provider with superior outcomes to the exclusion of other providers, but this proposal offers nothing beyond what the providers in this

community are already doing.

Further, DaVita is the national leader in home dialysis, and its treatments work hard -- or its teammates work hard to get patients to elect home dialysis, citing its flexibility and convenience, the ability to maintain employment, and its excellent outcomes.

DaVita consistently invests in technology to support patients at home. Our program, Home Dialysis Connect, includes home remote monitoring, using Bluetooth technology to transmit patient vitals to help clinicians get ahead of destabilizing events.

With our telehealth platform we conduct online appointments with our patients in the comfort of their own home. Our mobile app also supports video visits, customized education, reminders, secure texting and image sharing, allowing consistent and immediate communications with our patients' care teams.

We also use predictive analytics to help avoid costly hospitalizations and allow patients to stay on home dialysis longer.

We've recently implemented a training

model for nurses to become comprehensive health managers for patients with typical comorbid conditions like diabetes, cardiovascular disease, and hypertension, improving our patients' chances of continuing dialysis at home. These innovations shift more care to the home setting, and just over the last year our home program grew at four times the rate of our outpatient program.

Beyond all of this, the Board staff report speaks for itself. There is an ample supply of clinics in the Chicago Heights area. Please vote no on the DCC proposal.

Thank you.

MR. WARE: Good afternoon -- good afternoon. My name is Seddrick Ware. I'm here representing the Dialysis Care Center in Olympia Fields.

I just wanted to speak from the heart. I had congestive heart failure and kidney failure, and I wasn't educated on my condition. And I really am appreciative of Dialysis Care Center because they're really educating me on my condition.

And when you have a business or a company

that's informing you on your condition and helping you get healthy, I think it's very important for them to be around even more, putting out more businesses like that because, you know, a lot of people are not educated on their condition and things like that.

And I'm very grateful that they informed me of my condition and I've been healthy ever since I've been on dialysis, and I've been doing a lot better. They've been informing me on my healthy eating, and I'm just grateful.

And I just want to just thank you for this time, but I just want to also recommend that -- do whatever you have to do to keep people healthy.

Thank you so much for your time.

MS. GUILD: Thank you.

Next group, Cary Bolton, Kristin Lukey [phonetic], Moren -- no -- Matthew Moreno, Alexandra [phonetic] King. And Stephanie Shumate.

MR. MORENO: Hello, everyone. Thank you for your time.

My name is Matthew Moreno. I have been working for Dialysis Care Center as a project manager for 2 1/2 years. I've been in the

operations side of the medical field for a long time and enjoy patients' responses to quality care.

I experience -- the experiences I have encountered while working for Dialysis Care Centers have been great. My coworkers and patients are nice people to be around every day. I have seen many staff members concerned for the well-being of their patients above and beyond the normal scope. The dedication of our team is outstanding in many levels, from delivering medical supplies to patients' homes for our home program to patient care techs' schedules and flexibility. Our nurses and patient care techs form good relationships with our patients to provide personal care.

Our Dialysis Care Centers are another great service we provide for patients. We have been fortunate to have strong growth in Illinois and other states. Our idea of personalized and quality patient care for dialysis treatments is working well. Our in-centers have state-of-the-art equipment and great personal conveniences for our patients. I audit our offices all over the

United States on a regular basis and look for ways to improve our facilities.

My interactions with our patients have been very rewarding. I have delivered machines and supplies to patients when the regular drivers were booked for our home program. I finally was able to meet the people I spoke with on the phone and helped them out there with their schedules. The happy expressions I see when I meet the patients is very rewarding. I'm helping their day become a little easier.

Dialysis Care Center would appreciate your vote in favor of our Chicago Heights location for a few reasons. The Olympia Fields Dialysis Care Center has added a fourth shift due to high demand for our service in the area. Demands are putting undue hardships on many of our patients, who are losing their options for treatment times. The reasonable hours needed to treat our patients are well being exhausted. Patients have limited options for their dialysis treatment and want to live as normal a life as possible.

MR. ROATE: Two minutes.

MR. MORENO: Our Chicago Heights location

would alleviate the current situation and will have room for future growth. This new location will allow patients in the area to have more flexibility --

CHAIRMAN SEWELL: Please conclude your remarks.

MR. MORENO: To conclude, we appreciate the Review Board to vote in favor of our Dialysis Care Center for Chicago Heights location.

Thank you again for your time and consideration.

MR. BOLTON: I want to just say good morning to the whole Board. My name is Cary Bolton.

I'm -- I present myself to you the second time. The first time I was before you I was a patient. But upon the decision that you made for DCC, Dialysis Care Center, I was a recipient with them with the home dialysis program.

I graduated from peritoneal to home hemo to in-center immediate care. But due to the decision that you made to allow this small company in a medical competitive market to thrive, I am now a graduated kidney transplant recipient.

(Applause.)

MR. BOLTON: But that could not happen without your care, concern, and compassion for allowing someone else -- not commercialized because I -- I used to be with DaVita, and that's a -- you know, they provide the same thing but it's more commercialized than personal.

With DCC it's more personal care. And with things being personal, you know, you get the medication, but the compassion, the care, and concern is also a help therapy for healing.

And I just want to thank this Board on this morning. Thank you.

MS. GUILD: Thank you.

The next project is Physicians Surgical Center in O'Fallon. There's one person who was planning on speaking, Amy Ballance.

MS. BALLANCE: Good morning. Can you hear me?

My name is Amy Ballance. I'm the vice president of business development for the southern Illinois division of Hospital Sisters Health System.

I'm here on behalf of HSHS St. Elizabeth's

Hospital to voice our opposition for the proposed plan submitted by Dr. Ahmed to discontinue the single-specialty ASTC in Belleville and to relocate it to O'Fallon.

Currently this area has two existing offering -- facilities offering surgery services. They are Memorial Hospital East in Shiloh and HSHS St. Elizabeth's Hospital in O'Fallon. The current surgical bed designation for these facilities combined is 14.

In 2017 the reported number of OR hours for both facilities was 13,730. This is below the State standard, leaving 35 percent capacity across these facilities. The establishment of this center would negatively impact both of these facilities.

In 2015 HSHS St. Elizabeth's came before the Board to gain approval to move the hospital to O'Fallon. A significant component of this move included our commitment to retaining outpatient services in the Belleville area.

St. Elizabeth's has been faithful to this commitment and has maintained lab, imaging, physical therapy, and physician services at that

location. These services continue to be utilized, which supports our belief that access to these services is needed in the area.

Recently we chose not to oppose Dr. Ahmed's proposal to purchase the existing ambulatory surgery center in Belleville due to the fact that it would be retained in Belleville and access to services would remain there.

On behalf of HSHS St. Elizabeth's Hospital, I urge the Review Board to deny Dr. Ahmed's proposal due to the potential of creating an oversaturation in the existing O'Fallon/Shiloh market and that removing this health care option in Belleville will create a lack of access for those residents.

Thank you for your time.

MS. GUILD: Thank you.

The next project is Anderson Rehabilitation Hospital in Edwardsville.

Jill Tomich, Amy Ballance -- you can come back -- Jason Zachariah, Rodney Greeling, and Sue Campbell.

MS. TOMICH: Test, test.

Hi. Good morning. My name is Jill Tomich.

I'm the system manager of strategy for Hospital Sisters Health System.

I'm here on behalf of HSHS St. Elizabeth's Hospital to voice our support for the proposed plans presented by Anderson Hospital, which will add 14 acute rehab beds to their current acute rehab unit.

Recently HSHS St. Elizabeth's underwent an analysis of the availability of acute rehab beds in the region to determine if a redesignation of our current bed capacities was warranted.

Results of this analysis found that there were two projects being proposed that would increase the total number of acute rehab beds in the region to 74 with 54 of these being new.

The existence of these 54 additional beds in such close proximity to St. Elizabeth's will lead to a decline in the utilization of beds in our current unit; however, this will allow St. Elizabeth's to redesignate our current acute rehab beds at our facility and transition them for use in areas that are in higher demand.

Before making the decision to transition our acute rehab unit, we wanted to confirm that

patients in need of these services would have appropriate access to the care they need. We support the proposal by Anderson Hospital, as we believe it will ensure that patients will continue to have an excellent, local choice for their acute rehab needs. With the addition of services that Anderson has also outlined in the proposal, these patients will benefit from advanced care that was previously unavailable in the region.

Again, HSHS St. Elizabeth's supports this proposal by Anderson Hospital, and we encourage the committee to approve this project.

Thank you for your consideration.

DR. GREELING: Good morning.

I'm Rod Greeling, an internal medicine physician at Anderson Hospital and medical director of the Anderson Medical Group. I am speaking on of behalf of the proposed 34-bed rehab unit at Anderson Hospital.

Our current rehab unit's limiting factor is its undersized location, and all 20 beds are in double-occupancy rooms. An inadequate space for support functions such as physical therapy and occupational therapy in the antiquated space

limits our ability to upgrade services such as enhanced care through our complex neurologic and brain injury patients. We need a dedicated brain unit, which is part of our proposal.

A 76-year-old patient of mine recently was rear-ended by a large truck at a stop sign in Madison County. At the scene she was found to have extensive trauma and was unconscious. There was a prolonged extraction time of over 20 minutes, and she was intubated at the scene. She was transported to a trauma center and had massive facial and head injuries, traumatic brain injury, and multiple traumas.

After her 14-day stay, neurosurgery, and treatment of all of her conditions, she was ready for rehab. She was sent to another rehab facility because a traumatic -- our trauma hospital felt at that time she needed a higher level of neurosurgical care than we provided. After two weeks the family requested she be sent to Anderson to be closer to her home.

We at Anderson are growing. We are taking major steps to enhance our neurologic and neurosurgical services. Our rehabilitation

facilities are the greatest obstacle to achieving the necessary improvement needed.

I, for one, am concerned about the exodus of jobs and residents leaving Illinois and moving to adjacent states. I'm even more concerned when patients who reside in Illinois feel the need to leave the state for health care that could be locally provided.

On behalf of my patients, please approve this project.

MS. CAMPBELL: Good morning. I am Sue Campbell, CEO of Community Hospital of Staunton. I'm here to speak on behalf of the Anderson Rehabilitation Hospital.

Community Hospital of Staunton is a 25-bed critical-access hospital in Macoupin County, about 23 miles north of Anderson Hospital. Three years ago we were pleased to become a member of Anderson Healthcare. This affiliation has strengthened our operational capability and financial capacity to continue to provide needed services in Staunton and surrounding rural communities to our service area.

Community Hospital of Staunton does not

offer inpatient rehabilitation. Our physicians refer patients to Anderson Hospital for their rehab care. This project is especially needed following the closure of two other rehabilitation services in Madison County during the past two years, at Gateway Regional Medical Center in Granite City and OSF St. Anthony Hospital in Alton.

Replacing the limited, 20-bed rehabilitation unit at Anderson Hospital with a modern, 34-bed rehabilitation hospital will provide enhanced services to residents of our service area and beyond.

Thank you for listening to my statement. Please approve this important project.

MR. ZACHARIAH: Good morning, Board members.

I'm Jason Zachariah, president of Kindred Rehabilitation Services. Kindred Healthcare is a Co-Applicant with Anderson Hospital on the proposal to establish the Anderson Rehabilitation Hospital in Edwardsville.

My statement has two purposes: First, to provide a summary of the Anderson Rehabilitation

Hospital project so you have this information in advance of your deliberations about the BJC/ Encompass project, which is the other proposed rehabilitation hospital in HSA 11 before you today. Second, to describe our relationship with Anderson Hospital's rehabilitation program.

Anderson Hospital in Maryville operates a 20-bed comprehensive rehabilitation unit along with its medical/surgical, intensive care, and obstetric services.

Anderson and Kindred Healthcare are coming together in a joint venture to establish a 34-bed freestanding rehabilitation hospital just 5 miles from Anderson Hospital. The rehabilitation unit at Anderson Hospital will be closed upon the opening of the rehabilitation hospital.

The Edwardsville site is on a property owned by Anderson and is adjacent to the Anderson Surgery Center site that this Board approved in December and is now under construction. Madison County's the primary service area of the project, with secondary service areas extending north into Jersey, Macoupin, Montgomery, and Bond Counties.

One of the main purposes of the

freestanding hospital project is to establish a modern, state-of-the-art inpatient rehabilitation facility that will serve many of the residents of HSA 11 with too many going to St. Louis for rehabilitation care.

Kindred Healthcare has partnered with Anderson Hospital in the operation of its rehab unit since it was opened in 2004. Kindred operates 22 joint venture rehabilitation hospitals throughout the US with premier hospital systems and manages 99 hospital-based rehabilitation units, including 8 of these in the state of Illinois.

Growing a 20-bed unit into the freestanding rehabilitation hospital is the natural evolution of the service at Anderson and the relationship that Anderson and Kindred have built together to provide access to comprehensive physical rehabilitation at the highest level of quality possible.

We look forward to our presentation this afternoon --

MR. ROATE: Two minutes.

MR. ZACHARIAH: -- and discussion of

Anderson Rehabilitation Hospital with the Board this afternoon.

Thank you.

MS. GUILD: Thank you.

That's the end of the public participation item on our agenda.

- - -

CHAIRMAN SEWELL: There are no items approved by the Chair, so we move to items for State Board action, permit renewal requests.

A-01, Project No. 17-047, Vascular Access Centers of Illinois.

May I have a motion to approve an eight-month permit renewal for this project in Chicago.

MEMBER DEMUZIO: Motion.

CHAIRMAN SEWELL: Is there a second?

MEMBER SLATER: Second.

MEMBER SAVAGE: Second.

THE COURT REPORTER: Excuse me just one second.

Would you raise your right hands, please.

(Two witnesses sworn.)

THE COURT REPORTER: Thank you. And please print your names.

CHAIRMAN SEWELL: Mr. Constantino, do you have a statement for the Board?

MR. CONSTANTINO: Thank you, sir.

In January of 2018 the State Board approved Permit No. 17-047 that authorized the establishment of a single-specialty ASTC in

Chicago.

This permit is financially committed and the current project completion date is September 30th, 2019. The total project cost is $1.2 million.

The permit holders are asking the Board for a nine-month permit renewal, from September 2019 to June 30th, 2020. The reason for the renewal is the Department of Public Health has requested the correction of some deficiencies at the ASTC. This is the fourth permit renewal for this project.

Thank you, sir.

CHAIRMAN SEWELL: Any comments for the Board?

MR. SILBERMAN: If we may, briefly.

And we want to address this issue head-on because it's not normal that you get to a fourth permit renewal, so we'd like to address exactly how and why we got here.

We want to assure the Board this is a project that is, in fact, progressing. Oftentimes you'll see challenges getting financing or getting moving. That is not the case here at all.

If you'll note, we were approved in January of 2018 and the first permit renewal was actually in February of 2018. The permit just took longer to get through the process than was expected, and so we had to seek a renewal right away just to keep the permit valid.

When we came back in October of 2018, we had completed the IDPH review, and the determination was that the location of a sink needed to be on the other side of the hallway for us to comply with the IDPH standards, so we agreed to make that repair.

What happened between October and April of 2019 -- and this is an unfortunate, you know, comedy of errors, if you will -- is once we relocated the sink, we realized it was going to require relocating a pipe, which we undertook and did. That has all been done and Public Health has come in and completed its final evaluation -- so we thought.

And what happened is, once we located the pipe and the sink and refinished the wall, we lost our 8-foot clearance, and we are now just a couple of inches shy of the 8-foot clearance for

licensing.

We've had great communication with Public Health. Because the entirety of the procedures that we perform are done under twilight, there's the potential -- they've actually offered us the ability for a waiver so that we might not have to do the construction and could then be up and licensed shortly.

But what we are trying to do out of our responsibility to this Board is just take the time to look down the road and say, "Is there any chance there are procedures that would require general anesthesia?" Because if there are, we'd rather do the construction now, get that done, and make sure this can be fully licensed as a surgery center.

So with that we'll answer any questions. I think the biggest mistake that has been made, if any, is we've gotten short deferrals just to get done what needed to get done without realizing that unexpected things could occur.

CHAIRMAN SEWELL: Any questions by Board members?

(No response.)

CHAIRMAN SEWELL: Can we have a roll call vote?

MR. ROATE: Thank you, sir.

Motion made by Senator Demuzio; seconded by Mr. Slater.

Senator Demuzio.

MEMBER DEMUZIO: I vote yes based upon the testimony I just heard.

So good luck with everything.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: I vote yes based on the staff report and the testimony heard today.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: I vote yes based on the staff report and the testimony that was given.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: I vote yes based on the staff report and the testimony heard today.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: I vote yes based on the

staff report.

MR. ROATE: Thank you.

Mr. Chairperson.

CHAIRMAN SEWELL: I vote yes based on the report.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

MR. SILBERMAN: Thank you. We hope not to be back.

CHAIRMAN SEWELL: Thank you.

- - -

CHAIRMAN SEWELL: Next is A-02, Project No. 18-027.

Is that -- Aghapy? Is that the proper pronunciation?

MR. LAWLER: Aghapy.

CHAIRMAN SEWELL: Aghapy? Okay.

-- Surgical Center.

MR. LAWLER: Yes, sir.

CHAIRMAN SEWELL: So may I have a motion to approve a 12-month permit renewal for this project in Barrington.

MEMBER SAVAGE: So moved.

CHAIRMAN SEWELL: Is there a second?

MEMBER DEMUZIO: Second.

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

(Two witnesses sworn.)

THE COURT REPORTER: Thank you. Please print your names.

CHAIRMAN SEWELL: I'm sorry.

Mr. Constantino.

MR. CONSTANTINO: Thank you, Mr. Sewell.

In December of 2018 the State Board approved Permit No. 18-27. The permit authorized

the establishment of a single-specialty ASTC in Barrington to perform endoscopic procedures.

The permit is not financially committed, and the current project completion date is December 31st, 2019. The approved permit amount is 3.9 million.

The permit holders are requesting a 12-month permit renewal, from December 2019 to December 2020. The reason for the request is IDPH has identified some deficiencies at the facility that need to be corrected.

This is the first permit renewal for this project.

Thank you, sir.

CHAIRMAN SEWELL: Any comments for the Board?

MS. FALICO: Hello. My name is Amber Falico. I am the director of clinical operations for the Applicant. With me today is Dan Lawler, our CON counsel.

We greatly appreciate the staff's expedited review of our request that allowed us to be here on today's agenda meeting.

We are asking for both a permit extension

and alteration today to address items raised by IDPH after its site review. IDPH requested modifications to plumbing, electrical, HVAC, and a few other items listed with the staff report. We need additional time to make those corrections, and it will require changes in the approved square footage and cost of the project. Both the cost increase and square footage increases are within the limits allowed by the Board's rules.

I'm happy to answer any additional questions you may have.

Thank you.

CHAIRMAN SEWELL: Any questions for the Applicant?

(No response.)

CHAIRMAN SEWELL: Roll call.

MR. ROATE: Thank you, sir.

Motion made by Ms. Savage; seconded by Senator Demuzio.

Senator Demuzio.

MEMBER DEMUZIO: I vote yes based upon the testimony and the staff report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: I vote yes based on the State Board staff report.

CHAIRMAN SEWELL: Thank you.

Dr. Murray.

MEMBER MURRAY: I vote yes based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: I vote yes based on the staff report.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: I vote yes based on the testimony.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: I vote yes based on the State agency report.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

CHAIRMAN SEWELL: Thank you.

MS. FALICO: Thank you.

MR. LAWLER: Thank you.

- - -

CHAIRMAN SEWELL: There are no extension requests. We move to exemption requests.

MS. AVERY: Did you have a question, Dan?

MR. LAWLER: We'll be back for the alteration request.

MS. AVERY: Oh.

THE COURT REPORTER: If you can leave your remarks, please.

- - -

CHAIRMAN SEWELL: So we move to exemption requests.

This is C-01, Project No. E-024-19, MetroSouth Medical Center in Blue Island.

I want to entertain a motion by the Board to defer this project based upon information that we took 20 minutes to read that we just received yesterday earlier on the agenda.

Is there a motion to defer?

MEMBER MURRAY: So moved.

CHAIRMAN SEWELL: Is there a second?

MEMBER SAVAGE: Second.

CHAIRMAN SEWELL: Any discussion on the motion to defer?

(No response.)

CHAIRMAN SEWELL: The background that I would give during discussion is that yesterday at approximately 4:20 to 4:30 p.m., we became aware of and actually received a lawsuit. The plaintiff is People's Choice Hospital, LLC, a Delaware limited liability corporation; the defendant is Quorum Health Corporation, a Delaware corporation.

And among other things, Board members were

given some time to read this since we just received it yesterday in the p.m., along with some other information relevant to the project.

The complaint and the demand is for the attempt to close MetroSouth Medical Center under alleged false pretenses. So we need time to determine whether this impacts or does not impact the project, so that was the reason for the motion to defer.

MR. LAWLER: Mr. Sewell?

CHAIRMAN SEWELL: Yes.

MR. LAWLER: I represent the Applicants, MetroSouth. Will we have an opportunity to address the Board on that issue?

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

CHAIRMAN SEWELL: Hold up. Just a second.

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

CHAIRMAN SEWELL: I'm sorry to leave you standing there.

MR. LAWLER: No problem.

CHAIRMAN SEWELL: He needs to be sworn in.

MS. AVERY: He was already sworn. Name on the record.

THE COURT REPORTER: Just state your name

for the record.

MR. LAWLER: My name is Dan Lawler, L-a-w-l-e-r. I'm with the law firm of Barnes & Thornburg in Chicago. I am CON counsel to the Applicant.

And may I also have our CEO sit with me?

CHAIRMAN SEWELL: Certainly.

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

MR. WALSH: My name is John Walsh. I'm the CEO of MetroSouth Medical Center.

MR. SMITH: Marty Smith, chief operating officer for Quorum Health.

MR. KING: Ken King, senior vice president for Quorum.

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

(Three witnesses sworn.)

THE COURT REPORTER: Thank you. And please print your names on those sheets.

CHAIRMAN SEWELL: What -- if you're speaking, we want you to speak to what the Board is considering right now, and that is a motion to defer the project.

MR. LAWLER: Yes, sir.

This is a factual and legal situation that is nearly identical to a situation that was before this Board in April where there was a pending lawsuit on a hospital closure.

The difference, of course, is that the lawsuit here does not involve the Board, does not ask any relief against the Board, does not ask that the vote today be stopped by the Courts or anyone else.

In addition, this Board had determined that under the statute, the Planning Act, and the regulations in effect at that time and that also apply to this project. Senate Bill 1739 institutes new processes for hospital closures, but that's not applicable to this project.

And what was determined on that project is that the Planning Act requires exemptions to be acted on within a set period of time, and it doesn't say that the Board shall approve a project that complies with the information requirements unless a lawsuit is filed, so the Planning Act requires action by this Board today.

Now, the Board does have a rule -- does have a rule -- that says that if there is a

pending action in which the subject matter of the lawsuit is at issue, that the Board will defer.

Now, what happened is between that -- the difference between what the Planning Act says and what the Board rule says, it was determined by this Board that the statute trumped the regulation and the Board had to act on the project notwithstanding the lawsuit.

That interpretation is essentially affirmed by Senate Bill 1739 because for applications to discontinue after the effective date of that Act, July 15, the statute gives the Board the authority to defer a closure application permit pending litigation that affects the permit.

Now, the fact that the legislature had to give, expressly, this Board the power to defer is a strong indication that this Board did not have that power to do that previously. Otherwise, it would not have had to have been added.

And so the prior interpretation of the Planning Act and the Board's regulations prior to Senate Bill 1739 is that the Board does not have the authority to defer; the Planning Act requires action on this application.

So we would present to the Board that, one, it does not have authority to defer, and, two, the rule doesn't apply here anyway because that lawsuit does not involve the Board, does not involve this application, and does not ask any relief from the Court against the Board.

So how could it possibly be a suit that is the subject matter? The subject matter of the lawsuit is -- as you heard the People's Choice people say today -- they want the Court to force us to sell the hospital to them. That's what the subject matter of the lawsuit is about. It's not changing what the Board is doing today.

So we would object to a motion to defer on the grounds that, one, the Board has no authority to defer under the law that's applicable to this project and, two, that the rule that's being invoked to defer is not applicable here, either.

Thank you.

CHAIRMAN SEWELL: Do Board members have any questions of counsel or the Applicant?

MEMBER MURRAY: Our counsel, you mean?

CHAIRMAN SEWELL: Yeah. This gentleman right here.

MEMBER MURRAY: Okay.

MS. AVERY: Our temporary counsel.

MEMBER MURRAY: Our temporary counsel.

So -- maybe this is for staff. I'm not sure which.

So -- I'm not a lawyer so I can't really judge what this gentleman just said.

But if there's questions about facts in the application, is that a reason to defer?

MR. AFEEF: The applicable rule that you're looking at says that if an individual or entity has failed to comply with the Act or the HFSRB rules and has been notified by HFSRB about an allegation of noncompliance, this shall provide a basis for HFSRB to defer consideration of any and all applications, rulings, or advisory opinions filed before HFSRB until the noncompliant matter is resolved.

The issue that -- for you -- is does this lawsuit create, in your -- for you -- an allegation of noncompliance.

That's your answer.

CHAIRMAN SEWELL: I have another question of counsel.

Part of the presentation was that we had to act today. Not just that we had to act on the application but we had to act today.

Do you or staff support that idea?

MS. AVERY: Are you -- for clarification, you're asking if we need to act on the request for the exemption --

CHAIRMAN SEWELL: Yes.

MS. AVERY: -- correct?

MEMBER MURRAY: Today.

MS. AVERY: Today.

CHAIRMAN SEWELL: Today.

I would add "today." I think that's an important part of the statement that the Applicant made.

MS. AVERY: In the law -- in the Planning Act -- and, again, this is prior to 1739 -- we have "If there is a pending lawsuit that challenges an application to discontinue a health care facility that either names the Board as a party or alleges fraud in the filing of the application, the Board may defer action on the application for up to six months after the date of the initial deferral of the application."

I have spoken with State regulators, and there was no evidence that the Applicant had proceeded to shut down the hospital.

Also, in our rule -- which is very clear -- it says HFSRB will defer consideration of the application for exemption when the application is the subject of litigation until all litigation related to the application has been completed.

So even though we're not named in the lawsuit, there are accusations of some things that weren't true.

And for the record, on public act -- the 99th General Assembly approved -- which this application falls under -- a different set of standards for which you can consider the discontinuation. The Applicant did meet all of those.

CHAIRMAN SEWELL: Uh-huh.

Were you going to --

MR. LAWLER: Sir, just two more points: One is the Planning Act provides -- the Planning Act -- provides, with respect to exemptions, that reviews shall not exceed 60 days from the date the application is declared to be complete.

We were declared complete June 11th. We were initially scheduled for the August Board meeting. We should have been approved already.

There was a request for a public hearing, there was an accommodation made, and we were rescheduled to this meeting.

So we're beyond the time --

MS. AVERY: May I interrupt?

MR. LAWLER: Yes, sir -- yes, ma'am.

MS. AVERY: He's right in some instances, but the public hearing also triggers dates where we have to post.

And that is why it was moved from that meeting to this one, because we have criteria in which we have to post and allow for the transcripts to come back and get to the Board.

MR. LAWLER: Right. And that -- and let me say that that additional time allowed Quorum and the City of Blue Island, through Mayor Vargas and its own CON counsel at Benesch, to work out the agreement that the mayor presented to you today that he said -- and we agree -- would assure access to health care going forward, and the parties would be working together to achieve that.

That agreement would be jeopardized if there's no act on this today.

And the failure of the Board to act today could also result in the irreparable harm that you heard today from the seven other CEOs of Quorum hospitals.

And if I may, I would just like the opportunity -- because it relates to your motion to defer and the direct, severe, negative adverse impact that's going to have not only on the Quorum -- it's going to have an impact on 7 other hospitals in the state, 26 other hospitals in the country. And if I may, I'd like to have Mr. Smith briefly address that.

MR. SMITH: Sure. Thank you, Dan, and thank you to the Board for this time.

While I'm not sharing all my testimony that was previously prepared, Dan asked me specifically to relate you to the issues with Quorum, the overall financial position of the company. You've heard some of that testimony earlier today about that.

Quorum, if you will, was formed in May of 2016 as a corporate spin-off of a larger health

care company. Many of our facilities that you've heard are rural, nonurban communities, safety net hospitals, sole community providers, critical-access hospitals.

Through our spin, Quorum inherited a debt structure -- again, "inherited," key word -- associated with -- and various associated debt covenants binding all of our Illinois hospitals and our hospitals across the country.

Our current debt at the end of the second quarter of 2019 was approximately $1.2 billion at a blended rate of 10 percent, so $120 million in interest expense on an annualized basis.

We believe, as a company, that by early 2020 we will be in a much better position to restructure our debt, but we have to get there first.

As it has been stated, we have various debt covenants that govern our debt structure. At the end of the second quarter we reported -- and it's public information -- that, in large part due to the losses -- the increase of losses at MetroSouth -- that Quorum has basically 3 percent or the equivalent of $6 million from tripping our

debt covenants. We had 3 percent room and about $6 million from tripping our debt covenants.

I can share additional details with the Board on what happens if we trip our debt covenants if you have questions, but just let me simply say it puts 3,000 jobs in your state at risk and more than 10,000 across the country.

If we had additional time to give -- we have been asked about giving additional time -- we would give that additional time. We have no additional time to give as an organization without risking violating these debt covenants.

And the way our covenants essentially work is the losses associated with MetroSouth -- which is roughly about $7 million year to date -- they would be credited back, which basically would more than double the room that we have under our current debt structure.

So while we're very disappointed and discouraged about the situation at MetroSouth, we understand we have to also think more broadly about the rest of the state and our company going forward.

CHAIRMAN SEWELL: Any other questions by

Board members?

MEMBER SLATER: How much is the loss per day?

MR. SMITH: The loss per day?

MEMBER SLATER: At MetroSouth.

MR. SMITH: The loss per month is running roughly a little -- in the neighborhood -- last month our losses on a pretax, predepreciation, preinterest basis were $1.5 million for the month of August projected.

MS. AVERY: And for clarification for the Board members, the date projected to close the hospital is?

MR. LAWLER: September 30.

MS. AVERY: Okay.

MR. LAWLER: And one other item: Given that this is all being generated through an accusation of fraud on the basis that we supposedly discontinued services without State approval, Ms. Avery already stated -- she confirmed that that's not the case.

John Walsh, the CEO of the hospital, and myself have been in continued contact with this Board's staff as well as Karen Singer at IDPH as

to the status of services at the hospital.

We temporarily suspended cardiac cath because we don't have the clinical people to operate the service, and we did that pursuant to notice to this Board and to IDPH.

I do believe that Karen Singer has confirmed to the staff that we are in compliance. We did have a site survey from IDPH following the discontinuation -- the suspension, I'm sorry -- of the cardiac cath unit.

So these allegations are concocted. They're disputed and refuted by the Illinois Department of Public Health.

CHAIRMAN SEWELL: Any other comments or questions by members of the Board?

Staff?

MEMBER MARTELL: Yes.

CHAIRMAN SEWELL: Oh, I'm sorry. Go ahead.

MEMBER MARTELL: The other allegation had to -- the other part of the allegation was related to the buyer and knowledge of a potential buyer.

So could counsel respond to that?

MR. LAWLER: Yes, we can. I'd like to have Mr. Ken King address that.

MR. KING: Yes. Thank you.

My name is Ken King. I'm senior VP of acquisitions for Quorum, and I've also been responsible for our divestitures. And I have been trying to divest Quorum -- Metro -- for the past 2 1/2 years, and we've had two different brokerage firms involved.

We had a group called Ponder & Company, a gentleman based here in Chicago, that tried to help me sell the hospital from April 2017 until April 2018, and he was unsuccessful -- we were unsuccessful. In January we hired another group called MTS Partners. They've been trying to sell Metro for me, and to date they've been unsuccessful.

We have literally gone around to all of the large reputable health systems that surround Metro and made the offer to essentially give them the hospital, to give them the land, the building, the equipment, the operations, the records, licenses -- free of any encumbrances -- and no one took us up on that offer.

Think about that. All of the large health systems surrounding Metro, and none of them took

us up on that offer.

So we were down to sort of the last bottom-of-the-barrel option -- okay? -- a group called People's Choice Hospital. All right? We made them the very same offer -- okay? -- because we need to get out of the hospital, "We will give you the hospital."

People's Choice insisted upon purchasing the net working capital -- in other words, the accounts receivable. We tried to discourage them from that and tried to encourage them to get their own line of credit to fund net working capital but they rejected that. They had to buy the net work -- they had to buy the A/R because that's what they would use as collateral to get a loan.

So on the purchase price we did come to an agreement: "We will give you the hospital, the property, the land, the building, and the equipment, and you will buy the accounts receivable at a 20 percent discount." That's the only thing we reached agreement on.

All of the other major terms and conditions of the purchase agreement we could not reach an agreement on.

There were three turns of the purchase agreement. There was our initial draft to them on July 16. People's Choice turned a redline back to us on July 31st. And then we sent them another redline on August the 6th. That was the last turn of the purchase agreement, and that turn sat with People's Choice. And as the lawyers like to say, the pen was with them.

Now, let me go to their purchase agreement that they sent to us on July 31st. They completely rewrote the purchase agreement and built in all kinds of contingencies and caveats and conditions to closing, you know, to make -- so that they could be half in and half out. Okay?

Now, there's -- there was a big issue with one of the terms. They said that all key contracts of the hospital must stay in place. Sounds reasonable. And they told us managed-care contracts are a key contract and these must stay in place. That sounds reasonable.

Well, except for one thing. There's a major insurer called Aetna that is pursuing litigation against People's Choice for what Aetna describes as a fraudulent lab billing scheme.

The Aetna complaint goes on to outline how People's Choice has perpetrated this fraud and abuse, including mail and wire fraud, racketeering, bribes, and kickbacks in order to perpetrate this scheme. And this is based on a little bitty, tiny rural hospital in Oklahoma. Okay?

So I go back to our agreement -- and this isn't, by the way, the first time that they had pursued this lab billing scheme. They'd done it also in the state of Florida.

So I go back to my agreement that I'm negotiating with People's Choice -- okay? And they say "all key contracts must remain in place," and I know that I've got to get the consent of the managed-care payers to assign their contracts to People's Choice.

Now I ask you, is Aetna or Blue Cross going to assign their contract to People's Choice when Aetna has accused the company of fraud, bribery, kickbacks, racketeering, and this has been publicly reported in Becker's Hospital Review and other publications? Okay?

So it's not as simple as what People's

Choice told you. Okay? They misrepresented the facts to you and they misdirected you.

And based on a frivolous lawsuit that they filed yesterday to try and get this very reaction -- you know, here's the consequences: You know, you guys now are trying to make a decision whether to defer this.

So that's all I have to say. I would tell you that, based on what we know now, you know, that we don't believe that they're a viable buyer, and that's all I have to say.

MEMBER MURRAY: Does that mean that Aetna said no?

MR. KING: Come again?

MEMBER MURRAY: Does that mean that Aetna said no?

MR. SMITH: Aetna is involved in a Federal lawsuit. They've filed a Federal lawsuit against People's Choice.

MEMBER MURRAY: Okay. But did they tell you no?

MR. SMITH: They have not told --

MEMBER MURRAY: Did you ask them and they said no?

MR. KING: No. We didn't -- we never signed an agreement with them because -- we went back to them, ma'am, on August the 6th, and we told them that we will not accept that edit. Okay? We're not going to accept a condition to closing that says they've got -- all the managed-care companies have to agree --

MEMBER MURRAY: Okay.

MR. KING: -- because that leaves me at risk.

MR. SMITH: Let me just please reference a very critical point that's in the lawsuit. You read the lawsuit this morning. I want to point this critical point out.

They make this claim that, for some reason, we walked away from the deal because we wanted to liquidate the assets, and they used the term that we're going to capitalize on that by selling the assets for $60-plus million.

You heard the mayor lead off this discussion today and say, "We have come to an agreement with Quorum to transition the assets to them or to a new buyer." There is no effort on our part to liquidate these assets.

We are, at our heart, trying to find a path forward. This is an incredibly difficult situation we find our other hospitals in, we find our company in, we find their community in, but we worked with the City to come up with a plan to go forward so that there can be a transition of care in line with what you heard from the testimony from Sinai earlier today.

They specifically talked about a transition to more of an outpatient environment, and that's the platform that we're trying to leave with the City and with a new provider, all the equipment and the assets associated with launching a new platform for health care services in this community.

So any allegation that we're doing this -- that we're walking away from People's Choice for our own financial benefit -- is clearly put to rest by our efforts and our signature on a piece of paper with the City to do something very different, to give these assets.

And as Dan pointed out just a few seconds ago, if we are not successful today and at the end of this month, we wipe out -- everything is

contingent upon us being able to close.

The City loses its benefit that we've put in place for them, and our employees, who have severance benefits now established through the end of October, will potentially lose all their severance benefits, as well.

So we don't want to see a company who -- if you Google them, you'll go through 10 pages of Google information about fraud, about various allegations of lab billing schemes. This is not a credible company. They don't even operate a hospital today.

I can't in any stronger terms tell you that this is not a reputable organization. There's not one thing -- outside of the fact that they started negotiating with us in March -- in that lawsuit that I read that is factual, and I am on the record as saying it.

CHAIRMAN SEWELL: Board members, additional questions?

(No response.)

CHAIRMAN SEWELL: All right. The motion on the floor is to defer this project.

And the next meeting of this Board is

September 22nd --

MS. AVERY: October.

CHAIRMAN SEWELL: October 22nd. I'm sorry.

Any additional questions on the motion?

(No response.)

CHAIRMAN SEWELL: Roll call.

MR. ROATE: Thank you, Mr. Chairman.

Motion made by Dr. Murray; seconded by Ms. Savage.

Senator Demuzio.

MEMBER DEMUZIO: Yes, I vote to defer and -- based upon the comments I've heard today.

MR. ROATE: Thank you.

Dr. Sandra Martell.

MEMBER MARTELL: I vote to defer based on legal counsel interpretation.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: I vote to defer based on my understanding of the administrative code and our legal obligation.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: I vote to defer based on what we've heard today and the legal counsel.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: I vote no, based on the rules that we have to follow as this Board.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: I vote yes, based upon the requirements that were read earlier.

MR. ROATE: Thank you.

That's 5 votes to defer, 1 to not.

CHAIRMAN SEWELL: Okay. So we will hear this project at the October 22nd meeting of this Board.

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

CHAIRMAN SEWELL: Okay. We're going to take a 45-minute break for lunch.

MR. LAWLER: Mr. Sewell?

CHAIRMAN SEWELL: Yes.

MR. LAWLER: Can I just have our CEO -- we still have an issue where this is pending. And we've already lost the cardiac care clinic -- clinical people. We can't provide that service

anymore. We have a number of other services on the brink. There's an issue of the care that can be -- that can be provided at this point.

And if I could -- just so the Board is aware -- have Mr. Walsh just briefly address that, issues that he's facing as CEO of the hospital.

MR. WALSH: Thank you very much.

We've heard a lot of emotional testimony today about the care that this organization has provided, and they've done a great job with it for many years to this community.

MS. AVERY: Pull your microphone a little closer.

MR. WALSH: And currently, as you know, we've already had to suspend services for the cardiac catheterization because of ability to staff.

If this gets deferred, we will lose more staff in addition to medical staff coverage, and I won't be able to provide services that are critical to operating even an emergency room. I won't have surgery coverage, I won't have other support coverage, and I will eventually have to shut down even the emergency room in order to

provide safe care at the appropriate level.

So any deferral past the end of this month, I'm putting myself, the community, and everybody else at risk if I'm not providing the care that I need to be, and that's the situation I'm in today.

MR. LAWLER: And the deferral gains little. It loses a tremendous amount.

Eventually, the hospital -- when you vote -- when you vote on this, you have to vote to approve the exemption under the law. And what's lost is everything that Mayor Vargas represented to you this morning and -- for what? Somebody gets delayed? But the hospital has got to close eventually.

And it's just a -- Mayor Vargas spoke about the -- he's trying to do what's best for his own community, and this is not going to allow him to do that.

MEMBER SAVAGE: May I still ask questions of the CEO?

CHAIRMAN SEWELL: Sure.

MEMBER SAVAGE: So my question is, based on the support you have from your nurses and staff

and physicians, what leads you to believe that they're all going to leave?

MR. WALSH: Because we have, through this process, been very supportive of our staff. We've had two very successful job fairs where many of our employees have gotten new jobs, and they've only been holding out to get to the end of this month so they could get the severance that was promised to them.

They're going to risk those new jobs if they don't leave now and just leave the severance on the table.

I've also been notified by providers, physicians, that they will no longer be covering our hospital for very specific services like surgery. So I will not be able to take consults out of my ER or my inpatient unit for surgery.

Without surgery, there's nothing else for me to be able to provide except maybe urgent care.

MEMBER SAVAGE: That --

CHAIRMAN SEWELL: I'm going to call off this discussion unless someone on the Board wants us to reconsider the vote we just took. If I don't hear that, then the decision of the Board

is that we defer until the October 22nd meeting.

(No response.)

CHAIRMAN SEWELL: All right. We're taking a 45-minute break for lunch.

(A recess was taken from 12:25 p.m. to 1:23 p.m.)

- - -

CHAIRMAN SEWELL: We're going to get started.

We're still on exemption requests, and next on the agenda is C-02, Project No. E-032-19, Ingalls Memorial Hospital in Harvey.

So may I have a motion to approve this project to discontinue --

MEMBER DEMUZIO: Motion.

CHAIRMAN SEWELL: -- its 17-bed pediatric category of service.

MEMBER DEMUZIO: Motion.

CHAIRMAN SEWELL: Is there a second?

MEMBER SAVAGE: Second.

MEMBER SLATER: Second.

CHAIRMAN SEWELL: All right.

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

(Four witnesses sworn.)

THE COURT REPORTER: Thank you. And please print your names if you haven't yet.

CHAIRMAN SEWELL: May I have the State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

Ingalls Memorial Hospital is requesting

the approval of a discontinuation of a 17-bed pediatric category of service in Harvey, Illinois.

There's a calculated excess of 483 med/surg pediatric beds in the -- in the A-04 hospital planning area.

There was no request for a public hearing, and no letters of support or opposition were received by the State Board.

The Applicants have provided all the information required by the State Board.

Thank you.

CHAIRMAN SEWELL: Thank you.

Any comments for the Board?

MR. SINOTTE: Yes.

Mr. Sewell, members of the Board, I am Brian Sinotte. I'm the president of Ingalls Memorial Hospital.

I'm pleased to have with me here today Dr. Titus Daniels, our chief medical officer; John Beberman, director of capital budget and controls for USMC; and Joe Ourth, our CON counsel.

I'll just provide a brief summary of the project for this group today.

Ingalls Memorial Hospital is a not-for-

profit health care system that has served Harvey and the south suburbs for almost 100 years. We continue to be committed to pediatrics and the communities we serve and will continue to invest in Ingalls Memorial Hospital.

This application is to discontinue our 17-bed pediatric category of service as a distinct inpatient unit. Our plan will be to convert the existing pediatrics unit to med/surg beds for which there's more community need. Our pediatric nursing staff is already cross-trained and will transition to medical/surgical with no staff reductions.

Our pediatrics unit is licensed for 17 beds. In 2018, however, our average daily census averaged only 2.7 patients, less than 16 percent occupancy. Like many other community hospitals, we have experienced a dramatic reduction in pediatric patient days as the regionalization of pediatrics care continues while we, in hospitals throughout Illinois, see that less complex care is being performed on an outpatient basis and patients requiring more complex care often seek the specialization of

dedicated children's hospitals.

As our application details, the number of pediatric hospital patients in metro Chicago have fallen significantly in the last 15 years. It is important to note that this regionalization of pediatrics generally results in higher quality care.

In brief, higher volume results in more experienced clinical staff and better outcomes. Further, most pediatric inpatient care now involves specialists and subspecialties that are not available in community hospitals that see fewer patients. Dr. Titus Daniels, to my left, our CMO, is with me and could better answer any clinical questions should you have any.

But before I conclude, in our planning our foremost priority was to ensure that our patients have access to high-quality care. First, I want to emphasize that we are not discontinuing pediatric care, only our inpatient hospital unit. Importantly, we will continue to our designation as an emergency department approved for pediatrics -- or EDAP -- and will continue to treat pediatric patients that present to our ER.

We will continue to offer outpatient pediatric services, including at family care centers in Calumet City, Flossmoor, and Tinley Park, which are all open 24 hours a day.

Further, we are coordinating with our sister hospital, the University of Chicago, to treat patients at its Comer Children's Hospital. Finally, we also collaborate with Advocate Christ Medical Center, and you will find in our application Advocate has expressed its willingness to receive patients at its Hope Children's Hospital.

Hope Children's Hospital and Comer Children's Hospital are two of the most renowned pediatric hospitals in Illinois and capable of providing advanced tertiary pediatric care. Our patients will have continuing access to high-quality care.

So in closing, as we heard earlier, this project has no opposition, and we are pleased that the State Board report concludes that we have provided all the necessary information.

We ask your approval of our exemption and are here to answer any questions you may have.

CHAIRMAN SEWELL: Thank you.

Do Board members have questions?

(No response.)

CHAIRMAN SEWELL: Can we have the roll call?

MR. ROATE: Thank you, sir.

Motion made by Senator Demuzio; seconded by Ms. Savage.

Senator Demuzio.

MEMBER DEMUZIO: I vote yes, according to the testimony and the State report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: I vote yes based on the staff report and the testimony heard today.

CHAIRMAN SEWELL: Thank you.

Dr. Murray.

MEMBER MURRAY: I vote yes based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

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

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes, based on the staff report.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: Yes, based on the staff report.

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

CHAIRMAN SEWELL: Thank you, sir.

DR. DANIELS: Thank you.

MR. SINOTTE: Thank you.

- - -

CHAIRMAN SEWELL: Next on the agenda is C-04, Project No. E-034-19, McDonough District Hospital in Macomb.

May I have a motion to approve this project to discontinue a 12-bed AMI category of service.

MEMBER SLATER: I move approval.

MEMBER MARTELL: Second.

CHAIRMAN SEWELL: Is there a second?

MEMBER MARTELL: Second.

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

(Three witnesses sworn.)

THE COURT REPORTER: Thank you. Please print your names.

CHAIRMAN SEWELL: Okay. State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

McDonough District Hospital is requesting the approval of the discontinuation of the 12-bed acute mental illness category of service in Macomb, Illinois.

There was no request for a public hearing, and no letters of support or opposition were

received by the State Board. As of August 2019 there's a calculated excess of 33 AMI beds in this AMI planning area.

The Applicants have provided all the information required by the State Board.

Thank you, sir.

CHAIRMAN SEWELL: All right.

Do you have comments for the Board?

MR. DIETZ: Yes, sir.

Mr. Sewell, members of the Board, I am Brian Dietz, the president and the CEO of McDonough District Hospital in Macomb.

I am pleased to have with me today Ms. Wanda Foster, our chief nursing officer; Bill Murdoch, our chief finance officer; and Joe Ourth, our CON counsel.

McDonough County District Hospital is a 60-bed hospital in Macomb and serves residents in west central Illinois. McDonough District Hospital is a publicly owned county hospital founded in 1958.

This application is to discontinue our 12-bed psychiatric category of service. Our psychiatric unit focused only on geriatric

patients.

McDonough County District Hospital has been affiliated with two psychiatrists. Both physicians performing outpatient services; however, only Dr. Sarwar provided inpatient care. When Dr. Sarwar resigned as our medical director, we could no longer comply with Medicare regulations because we would not have a director of inpatient services.

Our hospital was consequently required to stop admitting patients to the psychiatric department effective June 30th, 2019. We then filed a notice of temporary suspension with the Review Board until we could appear before you today.

While we will no longer be able to offer initiative psychiatric care, we will still be able to offer outpatient psychiatric care. Our daily census for our inpatient unit averaged only 5.2 in 2019, so we believe the impact on the community will be minimal, particularly with the 33 additional beds that are available in our region.

And so the project has no opposition, and we are pleased that the State Board felt we are

providing necessary information to you for decision on this.

We ask for your approval for our application and are here to answer any questions you may have.

CHAIRMAN SEWELL: All right.

Any questions by Board members?

Yes.

MEMBER MARTELL: I have a question regarding plans for any of your outpatients that would need inpatient care in the psychiatric practice area.

MS. FOSTER: I think for our outpatient -- for our outpatients that would need psychiatric care, as Brian mentioned, we have 33 -- we have an excess of 33 beds, and so there certainly is capacity at other places in our region.

Also, we would have greater capacity to, hopefully, provide their care as an outpatient before they reach inpatient status.

MEMBER MARTELL: Are there agreements in place with the other out- -- inpatient centers, too?

MS. FOSTER: We do not have agreements in

place at this time. We have a crisis worker who, if it was a crisis situation, would come in and assist with that placement.

CHAIRMAN SEWELL: Other questions?

(No response.)

CHAIRMAN SEWELL: All right. Roll call.

MR. ROATE: Thank you, sir.

Motion made by Ms. Slater; seconded by -- Mr. Slater -- seconded by Dr. Martell.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon testimony and the staff report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Based on lack of utilization and lack of appropriate staff, my vote is yes.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: I vote yes based on the staff report.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

CHAIRMAN SEWELL: Thank you.

MS. FOSTER: Thank you.

- - -

CHAIRMAN SEWELL: Next is C-05, Project No. E-035-19, HSHS St. John's Hospital in Springfield.

May I have a motion to approve this project to discontinue a 32-bed AMI service.

MEMBER MARTELL: I so move.

CHAIRMAN SEWELL: Is there a second?

MEMBER SAVAGE: Second.

THE COURT REPORTER: Would you raise your right hand.

You're already sworn.

(One witness sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN SEWELL: Thank you.

State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

St. John's Hospital is requesting the approval of the discontinuation of a 32-bed acute mental illness category of service in Springfield, Illinois.

In April of -- excuse me.

There was no request for a public hearing, and no letters of support or opposition were received by the State Board. As of August 2019

there is a calculated excess of 74 AMI beds in the HSA 3 AMI planning area.

The Applicants have provided all the information required by the State Board.

Thank you, sir.

CHAIRMAN SEWELL: Do you have comments for the Board?

MS. GOEBEL: Yes.

Hi. Good morning. My name is Julie Goebel. I'm vice president of strategy for -- sorry.

MS. AVERY: Is it on?

MS. GOEBEL: I don't think it's on.

All right. Sorry. We'll try that again.

All right. Good morning. My name is Julie Goebel. I'm vice president of strategy for Hospital Sisters Health System, central Illinois division.

We appreciate the staff's finding that our application to discontinue the acute mental illness category of service at St. John's Hospital in Springfield is in conformance with the Board's criteria for discontinuation, and there is no opposition to this project.

I briefly note that there is an excess of AMI beds in the planning area and a bed excess will remain following the discontinuation of St. John's beds.

We temporarily suspended this service last year pursuant to the Board's rules, so there have been no patients treated in the unit since June 2018.

The Hospital Sisters remain committed to behavioral health services in central Illinois, including at our behavioral health center of excellence at St. Mary's Hospital in Decatur.

I'm happy to answer any questions that you may have. Thank you.

CHAIRMAN SEWELL: Any questions by Board members?

(No response.)

CHAIRMAN SEWELL: Roll call.

MR. ROATE: Thank you, sir.

Motion made by Dr. Martell; seconded by Ms. Savage.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the State report and the testimony.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: I vote yes based on the staff report.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: I vote yes based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes, based on the testimony.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: Yes, based on the State agency report.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

CHAIRMAN SEWELL: All right.

MS. GOEBEL: Thank you.

- - -

CHAIRMAN SEWELL: Next on the agenda is C-06, Project No. E-036-19, HSHS Holy Family Hospital in Greenville.

May I have a motion to approve this project to discontinue its four-bed obstetric service.

MEMBER MURRAY: So moved.

CHAIRMAN SEWELL: Is there a second?

MEMBER DEMUZIO: Second.

CHAIRMAN SEWELL: All right.

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

(Three witnesses sworn.)

THE COURT REPORTER: Thank you. And please print your names.

CHAIRMAN SEWELL: Okay. State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

Holy Family Hospital is requesting the approval of the discontinuation of a four-bed OB category of service in Greenville, Illinois.

There was no request for a public hearing, and no letters of support or opposition were received by the State Board. As of August there

was a calculated excess of 11 OB beds in the F-02 hospital planning area.

The Applicants have provided all the information required by the State Board.

Thank you, Mr. Sewell.

CHAIRMAN SEWELL: Do you have comments for the Board?

MS. BALLANCE: We do, just a few brief remarks. Thank you.

My name is Amy Ballance, and I'm the vice president of business development, planning, and marketing for HSHS' southern Illinois division.

I'm -- here with me today is Ed Parkhurst, our CON consultant; and David Nosacka, our chief financial officer for the southern Illinois division of HSHS.

I would like to thank the Review Board staff for their assistance in developing our COE permit application. Please note our application has not had any opposition, no public hearing was called, and we have met all the Review Board criteria.

Our subject COE permit application proposes to discontinue Holy Family Hospital's

four-bed obstetric category of service. Of importance to our community, patients, and families, as well as the Review Board, is the fact that in anticipation of this change we worked with our local board of directors and our physician partners to redesign the women and infants service line.

This new approach ensures that expectant mothers continue to receive the comprehensive quality care they deserve in a comfortable setting close to home. The redesign allows a majority of a mother's routine prenatal care visits and outpatient testing to be provided in Greenville.

When it's time to deliver, inpatient and postpartum care in the hospital will be available at our sister hospital, HSHS St. Joseph's Hospital in Breese, only 25 miles away. To ease the transition from hospital to home, the new mother and baby will then receive a complimentary visit from our mother/baby home care nurse in their own home.

Our proposed four-bed OB discontinuation and regional women and infants service line is consistent with national, regional, and local

health care delivery trends as the industry transforms. More specifically, nationally there is a declining birth rate and fertility rate, indicating even lower births into the future.

Obstetrics admissions at Holy Family have shown a steady decline from calendar year '16 through calendar year '18. Total deliveries in 2016 were 234, and in 2018 they were 197, which equates to a 16 percent decline over this time period. The obstetrical program's average daily census has not risen above 1.7 in the last six years, with the ADC being only at 1.1 mothers in 2018.

Staffing such a small program on a 24-hour, 7-day-a-week basis is problematic, especially related to adequate physician coverage necessary to provide that quality of care.

Our sister hospital, St. Joseph's-Breese, has adequate capacity to provide the regional delivery and postpartum care requirements to this region. St. Joseph's has six authorized obstetric beds with an average daily census of 3.3 in 2018. Combining this census with that of Holy Family, the census is resulting in 4.4, in an estimated

60 percent utilization, which still meets the Board's review criteria for occupancy.

St. Joseph's Hospital-Breese was also considered due to its close proximity to Greenville and its outstanding record as an award-winning facility, consistently receiving recognition for patient experience, quality, and safety.

The professional staff at St. Joseph's hospital in Breese is also prepared for critical care situations with neonatal nurse practitioners on-site 24/7 and the expertise of SLUCare neonatologists from SSM Cardinal Glennon Hospital through telemedicine technology.

In summary, our permit application proposes to discontinue the four obstetric beds; however, local access to maternity and child care will not be compromised, given our regional approach to the women and service line.

We're happy to answer any questions for you. Thank you.

CHAIRMAN SEWELL: Questions?

MEMBER SAVAGE: I do have a question.

CHAIRMAN SEWELL: Yes.

MEMBER SAVAGE: What is your preparation of your ER in Greenville for any potential moms that are coming in to deliver?

MS. BALLANCE: So they are currently trained to deal with those expectant mothers today. And if the mom would be appropriate to transfer, they would transfer that mother to St. Joseph's-Breese.

If, by chance, they would need to deliver in the emergency room, they would do that like any other hospital that doesn't provide those services.

MEMBER SAVAGE: Will they have the equipment from OB in the ER?

MS. BALLANCE: They will.

CHAIRMAN SEWELL: Other questions?

(No response.)

CHAIRMAN SEWELL: All right. Roll call.

MR. ROATE: Thank you, sir.

Motion made by Dr. Murray; seconded by Senator Demuzio.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the State report and the testimony.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes, based on the State Board staff report and testimony provided.

CHAIRMAN SEWELL: Thank you.

Dr. Murray.

MEMBER MURRAY: I vote yes based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on the staff report and testimony today.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes, based on the staff report.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: Yes, based on the staff report.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

MS. BALLANCE: Thank you.

- - -

CHAIRMAN SEWELL: Next on the agenda is C-07, Project No. E-037-19, Fresenius Medical Care West Metro in Chicago.

May I have a motion to approve this project for a change of ownership transaction.

MEMBER SAVAGE: So moved.

CHAIRMAN SEWELL: Is there a second?

MEMBER MARTELL: Second.

MEMBER SLATER: Second.

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

(One witness sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN SEWELL: State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

The Applicants are asking the Board to approve a change of ownership of a 12-station ESRD facility in Chicago.

The Fresenius Medical Care West Metro facility is a CMS-certified ESRD facility that is owned by WSKC Dialysis Services, Inc., which is a subsidiary of Fresenius Medical Care Holdings, Inc. The assets of the facility will be transferred to Fresenius Medical Care West Metro,

LLC. This is an internal transfer of assets only.

There was no request for a public hearing, and no letters of support or opposition were received by the State Board.

The Applicants provided all the information required by the State Board.

Thank you, sir.

CHAIRMAN SEWELL: Do you have any comments for the Board?

MS. WRIGHT: I'll just be -- is this on?

I'll just be brief. My name is Lori Wright, CON specialist for Fresenius Medical Care.

First, I'd like to thank the Board staff for their assistance and review of this application.

This is simply an internal transfer of assets and meets all of our criteria, and so I'd be happy to answer any questions you might have.

CHAIRMAN SEWELL: Are there questions?

(No response.)

CHAIRMAN SEWELL: Roll call.

MR. ROATE: Thank you, sir.

Motion made by Ms. Savage; seconded by Dr. Martell.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes, based on the State Board staff report.

CHAIRMAN SEWELL: Thank you.

Dr. Murray.

MEMBER MURRAY: I vote yes based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes, based on the staff report.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: Yes, reasons stated.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

CHAIRMAN SEWELL: Thank you.

MS. WRIGHT: Thank you.

- - -

CHAIRMAN SEWELL: Next on the agenda is C-08, Project No. E-039-19, Silver Cross Hospital in New Lenox.

May I have a motion to approve this project to establish a neonatal intensive care unit service at its acute care hospital.

MEMBER MURRAY: Motion.

CHAIRMAN SEWELL: Is there a second?

MEMBER MARTELL: Second.

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

(Two witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN SEWELL: All right. State agency report.

MR. CONSTANTINO: Thank you, sir.

Silver Cross Hospital and Medical Centers in New Lenox is asking the Board to approve the establishment of a 24-bed NICU unit at the hospital. The cost of the project is approximately 12.8 million. The expected completion date is June 30th, 2021.

The State Board does not have a need methodology for NICU services.

There was no request for a public hearing, and no letters of support or opposition were received by the State Board.

The Applicants have provided all the information required by the Board.

Thank you, sir.

CHAIRMAN SEWELL: Thank you.

Do you have comments for the Board?

MS. BAKKEN: Yes. Thank you, Chairman Sewell.

Good afternoon. My name is Mary Bakken. I am the executive vice president and chief operating officer at Silver Cross Hospital.

MS. AVERY: Mary, see if that mic is on, please.

MS. BAKKEN: Better?

MS. AVERY: Yes. Thank you.

MS. BAKKEN: Okay.

Good afternoon. My name is Mary Bakken. I am the executive vice president and chief operating officer at Silver Cross Hospital. I'm joined here today by Ed Green, legal counsel to Silver Cross Hospital from Foley & Lardner.

I'd like to thank the Board for hearing

this much-needed project.

Consistent with our mission and our history of serving the community, we have identified a pressing need that we feel compelled to address, and that is expanding our services for high-risk mothers and babies.

Silver Cross obstetrics volume has continued to grow with women from within our defined service area and beyond desiring to deliver at our hospital.

In fiscal year 2019 we are projecting we will perform 2,900 deliveries, and the 2017 annual hospital questionnaire, AHQ data, reveals that Silver Cross has the 10th largest obstetrical program in the state of Illinois and is the only hospital in the top 10 within the state without a neonatal intensive care unit or NICU.

Silver Cross has identified a community need for a Level III NICU within Will County. With a population of nearly 800,000, Will County does not today have an NICU. The lack of an NICU has forced Silver Cross patients to either travel or be transferred to other hospitals.

Expectant mothers residing in close

proximity to Silver Cross are forced to travel a minimum of 20 miles or 30-plus minutes in order to receive care at a hospital that offers a Level III NICU.

We currently operate a Level IIE special care nursery where 341 babies were taken care of in 2018. Advancing to the next level of care will meet community need and is a logical progression.

Thank you for your consideration. In response to the State agency report, we have met all requirements.

I'd be happy to answer any questions.

CHAIRMAN SEWELL: Are there questions?

MEMBER SAVAGE: Do you happen to know how many transfers out you've had for Level III NICU?

MS. BAKKEN: Yes. We had 19 mothers transfer and 33 babies transfer in fiscal year '18.

CHAIRMAN SEWELL: Other questions?

(No response.)

CHAIRMAN SEWELL: Okay. Roll call.

MR. ROATE: Thank you, sir.

Motion made by Senator Demuzio; seconded by Dr. Martell.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the State report and the testimony.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Based on the staff report and the testimony heard today.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on the staff report and testimony today.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes, based on the testimony.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: Yes, based on the staff report.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

MS. BAKKEN: Thank you.

- - -

CHAIRMAN SEWELL: Next is C-09, Project No. E-041-19, Memorial Hospital Association in Carthage.

May I have a motion to approve this exemption for a change of ownership transaction.

MEMBER SAVAGE: So moved.

CHAIRMAN SEWELL: Is there a second?

MEMBER MURRAY: Second.

CHAIRMAN SEWELL: All right.

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

(Two witnesses sworn.)

THE COURT REPORTER: Thank you. And please print your names.

CHAIRMAN SEWELL: Okay. State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

Memorial Hospital Association in Carthage is asking the Board to approve a change in control of an 18-bed critical-access hospital. There's no cost to this transaction, and the expected completion date is October 1st, 2019.

Iowa Health System, doing business as UnityPoint Health, and Memorial Hospital

Association propose a change of ownership whereby UnityPoint would no longer be the sole corporate member of Memorial Hospital Association. UnityPoint will provide management services to the hospital.

There was no request for a public hearing. No letters of support or opposition were received. The Applicants have provided all the information required by the State Board.

CHAIRMAN SEWELL: Thank you.

All right. Do you have a presentation for the Board?

MR. GREEN: Not really a presentation.

As Mr. Constantino said, the State agency report was a letter perfect State agency report --

THE COURT REPORTER: Use your microphone, please.

MR. GREEN: The State agency -- the State agency report had no deficiencies. It's a certificate of exception, a change of ownership.

Under the change of ownership, UnityPoint will no longer be the sole corporate member of Memorial Hospital Association and, instead, UnityPoint will provide management services.

If there are any other questions, we're happy to answer them.

MEMBER SLATER: A question.

CHAIRMAN SEWELL: Yes.

MEMBER SLATER: This has been a very short marriage, I think. And -- but what's actually going on here?

MS. GEHL: So you're correct. I would say that the full affiliation of the relationship was just entered into between UnityPoint Health and Memorial.

Originally, when we started conversations with Memorial, we were targeting a management services agreement. Through the course of those relationship conversations, there was interest in a full affiliation so, ultimately, we pursued a full affiliation.

After doing so, as a system UnityPoint Health has started to evolve more into an operating company and, through mutual conversations with Memorial and UnityPoint Health, Memorial wanted to retain more autonomy, and so we reverted back to the original intention, which was a management services agreement.

So Memorial will maintain access to IT, to supply chain, access to certain subject matter experts, which was the original intention.

So, yes, a fairly quick transition but one that's been mutually agreeable and supported by the parties.

THE COURT REPORTER: Could you state your name, please, for the record.

MS. GEHL: Sure.

Carey Gehl, executive director of growth for UnityPoint Health.

CHAIRMAN SEWELL: Other questions?

(No response.)

CHAIRMAN SEWELL: Okay. The roll call.

MR. ROATE: Thank you.

Motion made by Ms. Savage; seconded by Dr. Murray.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report and testimony.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes, based on staff report and testimony heard today.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on the staff report and testimony.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes, based on the staff report.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: Yes, for reasons stated.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

MR. GREEN: Thank you.

CHAIRMAN SEWELL: Thank you.

- - -

CHAIRMAN SEWELL: We've completed our exemption requests. Now for alteration requests.

D-01, Project No. 17-011, Carle Staley Road Medical Office Building in Champaign.

May I have a motion to approve an alteration to this project to increase project cost and project space.

MEMBER SLATER: I move approval.

CHAIRMAN SEWELL: Is there a second?

MEMBER MARTELL: Second.

MEMBER DEMUZIO: Second.

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

(One witness sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN SEWELL: State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

In June of 2017 the State Board approved Permit No. 17-11 that established a two-story medical office building in approximately 150,000 gross square feet of space in Champaign at a cost of approximately $66.8 million.

The permit holders are asking the State Board to approve an increase in the cost to

68.5 million or approximately 1.7 million.

The increase in cost was due to the busy construction market, a small supply of contractors in the area, and the increase in the project size of 347 gross square feet is attributable to the opportunity to tie the three buildings on the campus to an emergency power system.

The permit holders have met all the requirements of the State Board.

Thank you, sir.

CHAIRMAN SEWELL: All right. Any comments?

MS. FRIEDMAN: Hi. I'm Kara Friedman -- Kara Friedman -- counsel for the permit holder, Carle Foundation Hospital.

Thank you for your time today. I'm happy to answer questions.

CHAIRMAN SEWELL: Any questions?

(No response.)

CHAIRMAN SEWELL: Okay.

MR. ROATE: Thank you.

CHAIRMAN SEWELL: Call the roll.

MR. ROATE: Motion made by Mr. Slater; seconded by Dr. Martell.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Based on staff report, yes.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: Yes, reasons stated.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

MS. FRIEDMAN: Thank you very much.

- - -

CHAIRMAN SEWELL: Next is D-02, Project No. 17-013, DaVita Geneva Crossing in Carol Stream.

May I have a motion to approve an alteration for this project to increase project costs.

MEMBER SAVAGE: So moved.

CHAIRMAN SEWELL: Is there a second?

MEMBER MARTELL: Second.

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

(One witness sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN SEWELL: Staff report.

MR. CONSTANTINO: Thank you, Mr. Chairman.

In July of 2018 the State Board approved Permit No. 17-13 for the establishment of a 12-station ESRD facility in Carol Stream, Illinois, at a cost of approximately $2.7 million.

The permit holders are asking the Board to increase the cost of the project by about $150,000 or 5.5 percent.

The permit holders have met all of the requirements of the State Board.

Thank you, sir.

CHAIRMAN SEWELL: Thank you.

Any comments for the Board?

MS. COOPER: Yes. My name is Anne Cooper. I'm counsel for DaVita.

We'd just like to thank the staff for the fully positive Board report, and we're here to answer any questions that you have.

CHAIRMAN SEWELL: Are there questions?

(No response.)

CHAIRMAN SEWELL: All right. Roll call.

MR. ROATE: Thank you.

Motion made by Ms. Savage; seconded by Dr. Martell.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes, based on the staff report.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: Yes, based on the staff

report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes, based on the staff report.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: Yes, based on the staff report.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

MS. COOPER: Thank you very much.

- - -

CHAIRMAN SEWELL: Next on the agenda is D-03, Project No. 18-027, Aghapy Surgical Center in Barrington.

May I have a motion to approve an alteration for this project to increase project cost and project size.

MEMBER MURRAY: So moved.

CHAIRMAN SEWELL: Is there a second?

MEMBER SLATER: Second.

THE COURT REPORTER: Have you both been sworn?

MR. LAWLER: We have.

THE COURT REPORTER: They've been sworn.

CHAIRMAN SEWELL: Okay. Yes.

State agency report.

MR. CONSTANTINO: Thank you, sir.

In December of 2018 the State Board approved Permit No. 18-27 to establish an ambulatory surgical treatment center in approximately 4800 gross square feet of space in Barrington, Illinois.

The permit holders are requesting to increase the cost of the project from 3.9 million to approximately $4 million or $184,000. This is

about a 5 percent increase in the total cost. They're also asking to approve the increase in the gross square footage of 145 gross square feet or 3 percent.

The permit holders have met all the requirements of the State Board.

Thank you, sir.

CHAIRMAN SEWELL: Thank you.

Do you have comments for the Board?

MS. FALICO: Hello again. My name is Amber Falico. I am the director of clinical operations for the Applicant.

This is our alteration request to address items raised by IDPH after its site review. IDPH requested modifications to plumbing, electrical, HVAC, and a few other items listed in the staff report.

This will require changes in the approved square footage and cost of the project. Both the cost increase and square footage increase are within the limits allowed by the Board's rules.

I'm happy to answer any questions you may have. Thank you.

CHAIRMAN SEWELL: Okay. Questions?

(No response.)

CHAIRMAN SEWELL: Roll call.

MR. ROATE: Thank you.

Motion made by Dr. Murray; seconded by Mr. Slater.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes, based on the staff report and testimony.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on staff report and testimony.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Based on the staff report and testimony, yes.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: Yes, for reasons stated.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

MR. LAWLER: Thank you.

- - -

CHAIRMAN SEWELL: We move to declaratory rulings and other business.

Next is E-01, AMITA Health Presence Saint Joseph's Hospital, Chicago.

May I have a motion to correct utilization data for AMITA Health Presence Saint Joseph's Hospital.

MEMBER MARTELL: I so move.

CHAIRMAN SEWELL: Is there a second?

MEMBER SLATER: Second.

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

You're fine; you were previously sworn -- would you both raise your right hands.

(Two witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRMAN SEWELL: State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

State Board staff is asking the State Board to approve a change in Saint Joseph's Hospital in Chicago's 2017 annual hospital questionnaire.

The hospital is requesting to adjust the 2017 number of gastrointestinal procedure rooms

and their usage, which was mistakenly omitted from the annual hospital report.

Thank you, sir.

CHAIRMAN SEWELL: All right.

Any comments for the Board?

MR. MARIN: Yes.

Good afternoon. I'm Flavio Marin, CFO for AMITA Health Saint Joseph's Chicago.

And we identified the error, corrected the error, and are confident that the data going forward is correct.

CHAIRMAN SEWELL: Can you give us a sense of how the -- how and why the error occurred?

MR. MARIN: Sure.

In 2015 we opened a new facility right next door, and the individual collecting the data -- it was just an oversight because it was a new location. And the location just was not picked up in the report, but we have rectified that going forward.

CHAIRMAN SEWELL: Okay.

Questions?

(No response.)

CHAIRMAN SEWELL: Okay. Roll call.

MR. ROATE: Thank you.

Motion made by Dr. Martell; seconded by Mr. Slater.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the staff report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes, based on staff and testimony provided.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: Yes, based on testimony provided.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on staff report and testimony.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes, based on staff report.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: Yes, for reasons stated.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

MR. AXEL: Thank you.

MR. MARIN: Thank you.

- - -

CHAIRMAN SEWELL: There are no Health Care Worker Self-Referral Act issues.

There's no status report on conditional or contingent permits.

- - -

CHAIRMAN SEWELL: We move to applications subsequent to initial review.

It's H-01, Project No. 19-014, MIRA Neuro Behavioral Health Center for Children & Adolescents.

May I have a motion to approve this project to establish a 30-bed AMI hospital in Tinley Park.

MEMBER SAVAGE: So moved.

CHAIRMAN SEWELL: Is there a second?

MEMBER MARTELL: Second.

CHAIRMAN SEWELL: All right.

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

(Three witnesses sworn.)

THE COURT REPORTER: Thank you. And please print your names.

DR. HIGGINS: Mr. Chairman and members --

CHAIRMAN SEWELL: Excuse me just one second. We're coming back to you.

(Laughter.)

CHAIRMAN SEWELL: State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

MIRA Behavioral Health Center is asking

the State Board to approve the establishment of a 30-bed acute mental illness hospital in Tinley Park, Illinois, dedicated solely to the care of children and adolescents.

The cost of the project is approximately 5.6 million, and the expected completion date is August 1st, 2021.

This project was modified on August 15th, 2019, increasing the cost of the project by about $493,000 and increasing the gross square footage by 12,318 gross square feet or approximately 33 percent.

The State Board has received several support letters for this project. One letter of opposition was received.

I will point out to the Board we did receive two comments on the Board staff report that were emailed to you last week and have been placed in front of you today.

No public hearing was requested. The Applicants have not met all the Board's requirements.

Thank you, sir.

CHAIRMAN SEWELL: Thank you.

Go ahead.

DR. HIGGINS: Thank you.

Mr. Chairman, members of the Board, I am Dr. Christopher Higgins, president of MIRA Neuro Behavioral Health Care. I'm pleased to have with me today Drs. Johnson and Mikulecky and Joe Ourth, our CON counsel.

I can't tell you how excited I am to be able to present a real solution to a problem that we have had in our community for a long, long time.

Over a decade ago I tried to hospitalize an adolescent at Christ Hospital. I was informed that they had closed their unit. This was a surprise to me, having worked in the then-EHS, now-Advocate system, that they had decided to leave the child or adolescent psychiatric business.

In investigating further I found out a number of things. One, in order to receive services, we had to leave our area and go a long way, as you have heard from one of our presenters, Joe Bullington, today, who experienced this himself; and, two, that the local hospitals in our

HSA were not interested in building a child and adolescent unit.

Having worked on the psychiatric units, it finally became clear to me, as we would be going in and doing our work, there would be people with construction hats walking around in our unit. And when we asked who they were, they were people through cardiac or oncology or other hospital services that were looking for more space.

Basically, the big hospitals -- you know, it's cost prohibitive to increase psychiatric, especially child and adolescent, because they are not physically ill. They are not interested in doing this.

I went and talked to a number of people in our community; I went and talked to a number of CEOs at hospitals, leaders, and decided that, you know, we could do this.

You know, I went out and looked at a number of examples of this throughout the country and found that it was a very successful and important part of the community, separating child and adolescent psychiatry from both big box hospital medical/surgical centers and adult

psychiatry services that are revamping a unit to try to attend to adolescents.

The highlights of our program are our building is not a hospital campus. It's crucial for kids and family that way. It's not institutional. It's not adult psychiatry being reconfigured. It -- the part that we want to make clear here is that child and adolescent psychiatry and care is different than a lot of other cares.

And two examples of that -- you can do adult care without integrating the family. I don't know if you've been on a hospital unit lately, but there's no family rooms for the adults to be there. There's a visiting room.

However, you can't do child and adolescent without family. We need to integrate them in. I've been on a number of units in the area. Very few of them have spots for the family to be integrated.

The other reason that child and adolescent should be separated from med/surg and psychology is, in our field, medications are all indicated based on research with the adults. You need a child and adolescent psychiatrist in order to move

that down into how to change the doses and change the usage according to children. It's a separate field of what we're doing, that we are proposing to do, and that's the reason that it's a stand-alone hospital.

Another aspect of our project is the building that we're in. Our hospital would be housed -- located in a building that's currently used by community service foundations, a not-for-profit provider, which cares for over 180 individuals.

You heard this morning Mary Pat saying that if we were able to do this, they could move from big box workshops into small community centers, which is really nice. The part that she wasn't able to say that I'm going to say -- this building is perfect for us. It is what -- all the things that cause her trouble are perfect for us.

We've had architects and State officials, everybody go through it and inspect it before we did the application to make sure that we would meet all the codes and we can do this, and our project is going to have incredible areas for our children and adolescents to heal at probably about

$10 million less on the building and facility than we would any like facility in the state or in the nearby states.

Let's move from our project to the need for behavioral health services. You've heard Dr. Chand this morning talk about the 1 in 5 children have a medical mental health issue. 1 in 5, 20 percent.

Suicide, as probably everybody knows since it's in the papers all the time, is the second leading cause of death for children and adolescents.

The third leading cause of death for children and adolescents is homicide. We all know that there's a significant aspect of that that would be criminal homicide. But if you're looking at the shootings, if you're looking at what's happening in our society, mental health, as we cut back services, which we've been doing all over the place -- a great deal of that homicide is of mental illness origin, of which we deal with those children. That's what this program is intended to address.

As an example of that, let's talk about

the need for this service, which is the number one medical service, I believe, facing children and adolescents at this time.

Dr. Johnson's going to give her speech.

DR. JOHNSON: Hi. I'm going to share with you a story that a parent gave me permission to share about her recent experience at a mental health acute system. I've changed the identifying information to protect the privacy.

Her daughter, a 10-year-old, was admitted to a hospital downtown after taking a knife, locking herself in the bathroom, and threatening to kill herself. Due to the lack of services, the parents were unable to follow through on the follow-up intensive care.

It wasn't until the child again threatened to kill herself at school that personnel sent her to our practice for outpatient services. I was hesitant to take on the case. The lack of local acute care facility and the parents' reluctance to consider another hospital admission far outside of their community was concerning.

Once I met with the family and heard their experience within the acute mental health system,

I recognized the family was invested in treatment, the school was supportive, and I could consult with the prescribing provider. Given the trauma that the entire family had endured, they, too, are being treated.

Being able to coordinate her care, work with the family, and be within a reasonable distance for multiple appointments each week has allowed me to feel confident to treat this family; however, given her history of hospitalization and impulsivity, she is at an increased risk of requiring this service again. I need a place that I can trust to send her to.

As my patient's mother reminded me -- and I quote -- "Suicide is on the rise, and we have to go to the north suburbs or Chicago to get help for our children. The south suburbs do not have anything to help us."

Having this type of specialty hospital within our community will provide the safety net that I and all of us professionals struggling with child and adolescent issues needs for appropriate care. Thank you.

DR. HIGGINS: So let's go over the

specifics of this need for a hospital.

There's almost a million people in the HSA that we serve. Only five hospitals in the area provide medical health inpatient services. Four of the five hospitals do not -- only have adult services. One hospital has adult and a small adolescent unit.

As you can see, one of the hospitals that we're talking about, also, MetroSouth, is decreasing services. These hospitals who are caring only for adults all recognize the lack of care for children and have been very supportive of our project.

The only hospital that provides -- in the area -- that provides adolescent inpatient services is outside the Board's 30-minute travel time. It only has 12 beds. Our referral letters take no patients from that hospital area, and the hospital has not opposed our project.

Most of the patients in our area go either to a distant suburb or hospital in Chicago, resulting in considerable travel time. Often patients face a waiting list or long-delayed admissions.

FYI, there are two suburban systems that stand out as resources in the community, Linden Oaks and Alexian Brothers Behavioral Health. Unfortunately, in order get that quality of care, you have to travel way outside of our area.

MIRA is not reinventing the wheel. We are upgrading the services and bringing it into our local community, working with the community.

The founders of MIRA are not an investment company in New York City but, instead, are people who live, work, and practice in the Chicago Southland.

My practice, Palos Behavioral Health Professionals, is a group of clinicians who concentrate on caring for behavioral health issues of children and adolescents and their families.

These are the people behind the project. It's community based, people who have been here for -- I've been working for over 30 years, and my investors are all people who are business leaders in the community who are passionate about this project. We have worked with the schools and social workers in the area, and we recognize that their students have needs for a dedicated

facility. Support is reflected in their letters.

We have worked with the police departments and municipalities that recognize a need for the facility, and they have supported the project.

We have worked with government officials and mayors. You have letters from over 54 different physicians, recognizing the need for the project, pledging to refer almost 1200 patients to the facility. The majority of these medical doctors, mostly pediatricians, have no financial connection with MIRA and provided the letters solely based on recognized need.

I traveled to all of their practices. We didn't have a -- we didn't go to the department of pediatrics at the hospital. I went to their practices. I asked, "Can I talk to you about the program?"

Every single one of them was "Thank you very much. How do we get this done? How do I support it?" Not one refused to write a letter.

We stopped when we met the quota we would need in order to meet 85 percent occupancy, but there are at least 200 other physicians that we didn't get to in our area that I believe would

gladly have sent letters of support, also.

Most impressively -- you have this in our applications -- three of the large hospitals, Advocate Christ Medical Center, Little Company of Mary, and Palos Community Hospital, recognize a need for this service, and we have received a letter of support and referrals from them. We thank them for their cooperation and look forward to providing a service for them and specifically their emergency rooms.

MR. OURTH: Hi. I just want to briefly address some of the negative findings on this. I think that the benefits of this project far outweigh the negative findings but do want to address those.

The first one is, as you'll see in the State Board report, there was a negative finding on planning area need. The basis for that is that the planning area need inventory -- and -- is based on the fact that there is no difference between adult and children. As anybody in the field knows, you cannot mix adult and children in the same units, and so there is no separate methodology for adults and children.

And so that what you find in a population of an HSA of 1 million people, you have 12 adolescent beds and 0 children's beds in there. If there were a separate methodology for child and adolescent, I'd think that any of those methodologies would show a need for that in this area.

Second, there was a question about referral letters in this, that, as Dr. Higgins said, there were referrals from 54 different physicians, totaling almost 1200 referrals.

For those of you not used to seeing hospital projects, this is very much unheard of. What most hospitals do is come up and explain, "Well, referral letters really don't matter." Here, we've got real referral letters that say that people are going to be sending them here.

Now, admittedly, there was a few that -- there were some that staff did not count for two different reasons: One is on some of them the number of referrals exceeded the historical referral number. And the basis for that is that some -- is far different than surgeries.

Everyone knows how many procedures you

perform, but in psych what you'll find is that a number of those patients or -- that -- for which they want to make a referral, the family doesn't want to go a long ways to do that, they don't have that, and they simply don't go too much.

The second thing on the referral letter is some of the referrals -- and anybody who is a doctor would maybe appreciate this -- we know that your rules say that you have to specify the hospital that they go to. Some of the physicians instead said "downtown hospital" instead of the name of the hospital.

Pretty technical kind of thing. We're not disputing staff that that didn't count, but that was still 1200 referrals that get there, and we think that -- we hope that the Board can overlook that technical issue.

The other two things were slightly financial issues. One had to do with there not being a firm commitment letter. What was provided in the application was a very detailed term sheet that -- as to the terms of the loan, as to the loan that would be made as part of this.

As Mike points out, it was not a firm

commitment letter. That's not because the Applicant is unable to get a firm commitment letter. In fact, we had the senior vice president of First Midwest Bank here, who indicated that they -- their interest and readiness to make the loan.

The difference is to have the firm commitment letter right now -- those of you who know the banking process -- it's about a hundred-thousand-dollar commitment to have that before. The bank -- and as I say, that's not a prudent investment, to spend a hundred thousand dollars for a firm commitment letter until you, the Board, give the green light on that, but that's not a reflection on the inability for financing.

And, finally, the last one was a point on debt financing. There are five review criteria for financial viability. The project meets four of them. The fifth one, the State Board report noted that they couldn't verify that because, apparently, we'd left off a line in the pro forma's balance sheet. To the extent we did that, that was inadvertent. We didn't know that.

But we can tell you -- and the banker can

tell you that they've been working with -- that it is an 80 percent/20 percent debt to equity financing on that.

And then, finally, you did hear a little bit of opposition. I want to just point that out.

What you have is you hardly ever see a number of hospitals in the area come together and say, "Yes, I support another hospital in the area." It doesn't really happen. I've been doing this 25 years. You're not going to see this happen very often, but -- because they said, "We have people coming into our emergency room, we can't care for them, we need a place for them to go, and this is a good place for doing that."

The one opposition was not from a hospital but from the investment company that owns part of it that is a competitor, which is a chain hospital, and they're serving people's needs and that's fine. But they also are outside of your planning area, they're not within the 10-minute travel time, and they're not within the HSA.

Also, they're a system that does a hundred-bed hospital, which is a very different experience than a 30-bed child and adolescent.

Finally, without any sense of irony, they say that maybe you shouldn't approve this because it doesn't meet all the review criteria. When their project was here two years ago, did they meet the review criteria for -- your regulations -- for demand for services? No, they didn't. For financial viability? No, they didn't. Or duplication of other services? No, they didn't. So, hopefully, you'll take that with a grain of salt.

And in closing --

DR. MIKULECKY: Hi. I'm Dr. Jessica Mikulecky. I'm a licensed clinic psychologist working at Palos Behavioral Health Professionals.

And a woman who heard about this project recently lost her son and reached out to us to share her story, so, for the sake of time, I'm going to read excerpts from a letter that she asked be shared with you guys.

"My son Eric was kind and caring, athletic and funny, and handsome without ever really knowing it. He was an A student with multiple college scholarships offers. He loved sports, particularly soccer.

"In February of his freshman year of high school, he suffered an evulsion fracture of his right ankle. After six months of recovery and rehab, he went back to soccer but it still wasn't right. The fracture never healed, and he had to have surgery. Eric missed four soccer seasons and lost his spot on the top travel team and starting position on the high school soccer team.

"After his injury, I could tell he was struggling. He was having panic attacks and his demeanor had become angrier. Under his protests I wanted him to see a therapist; however, most therapists either weren't accepting new patients or had a year wait list, and most didn't accept insurance.

"Eric did begin seeing a therapist but his depression deepened. At one point Eric had become distraught and attempted to jump out of a moving vehicle. We had an ambulance take him to the hospital. Eric needed to be admitted to a mental health facility, but we couldn't find a facility with an empty bed.

"During this time the hospital kept Eric heavily sedated in the ER room, mostly ignored.

He was angry and the hospital staff was clearly irritated by him. Finally, 24 hours after being admitted to the ER, we found a vacant bed at a hospital 35 miles from our home.

"A second visit to the ER, Eric was taken by ambulance and I was notified by police. This time I knew better. Upon arriving at the hospital, I began calling mental health facilities looking for available beds. I found one but if I didn't have him there by 10:00 p.m., I would have to wait for the next day, and they couldn't guarantee a spot.

"After four hours in the ER, a nurse came out and said they were releasing Eric. I asked to speak to the doctor. The doctor was not aware of Eric's medications, his diagnosis of bipolar disorder, and mental health history.

"When I went back to see Eric, he became upset and wanted to leave, at which point the hospital staff came into Eric's room and yelled at him 'There are sick people here' and he was just going to have to keep his voice down.

"It was clear there that no one saw my son was ill. He was just a nuisance, that because he

didn't have a physical wound, he wasn't deserving of their compassion or attention. If this was how the medical community was treating my son, how was the world, in general, to support him?

"My son Eric passed away on April 21st. He was 18. I understand that my son's peers had difficulty understanding what my son was going through, but there is no excuse that medical professionals and hospitals are not equipped to help."

DR. HIGGINS: I think we all know that our lives are getting much more complicated, more active. This complication in life is hitting the children and adolescents who are mentally ill very hard, and they're going to need more and more services in the future. Anyone who says that there isn't a demand does not know what's happening out in our communities.

And with your approval, we will provide this service in the HSA that we are in. Thank you very much.

CHAIRMAN SEWELL: I wanted to ask staff, Mike, about -- the Applicant already stated this, but I wanted your take on why all these referrals

were not accepted for purposes of doing the calculation.

MR. CONSTANTINO: As Mr. Ourth explained, they needed to identify the hospitals where the patient was referred, and they didn't do that. That's why I didn't accept quite a few of them. They used the term "other hospital," "downtown hospital," "city hospital."

CHAIRMAN SEWELL: I see. Okay.

And then on the financial piece, it looks like about 20 percent of the cost of the project was going to be -- going to involve debt financing.

DR. HIGGINS: At least.

CHAIRMAN SEWELL: Yeah. So you're saying that a financial institution -- what? -- would not verify that to the State agency?

MR. OURTH: If you mean on the loan commitment letter --

CHAIRMAN SEWELL: Yeah.

MR. OURTH: Yes. And, in fact, you see that on a number of projects. Mike has made this explanation on a number of times. You want to know whether there's going to be financing

available for the hospital.

And I think that what Mike has done over the years is says that he wants to have a letter that says "I, the bank, will make this loan if the CON is approved." And so he wants to know and be able to tell you that the -- that financing is all the way there.

What we did is said, "Here's the terms of the loan; we're not going to get the financial commitment that is a binding commitment" because to get that binding commitment and the loan origination and things like that can cost about a hundred thousand dollars -- over a hundred thousand dollars.

And so what we tried to do instead is to have the senior vice president, who has been working with this for six months, come and say, "We've looked at the business plan; we've looked at the financials; we've looked at this."

We know we needed a commitment letter, and we know what the staff wanted, but we thought it more financially prudent not to do the final commitment until you, the Board, approved that so that there wasn't that expenditure of a hundred

thousand dollars, which would be significant for this project.

CHAIRMAN SEWELL: And then this --

DR. HIGGINS: Can I --

CHAIRMAN SEWELL: Go ahead.

DR. HIGGINS: Just so -- if it sounds like we're making that number up or anything, it is not.

For example, the bank requires you to have full blueprints of your whole remodeling, which our bid for that was $90,000. That's before they do anything. That's our bid for that. We held off on doing that until after this.

So it's kind of a Catch-22 of what we're kind of doing here. So that's basically the cost. We're trying to keep those low.

CHAIRMAN SEWELL: And what was the reason for the inability to calculate all of the required financial ratios?

MR. OURTH: Apparently, when we did the pro forma financial statement, the accountant didn't have a line item on there on the amount of debt.

And so what -- not speaking for staff --

they go through the financials; they try to verify all the ratios that we set. We met four of those.

The fifth one, on debt-to-equity ratio -- because, for some reason, the financial statement didn't have that line item -- they couldn't verify that.

So -- I mean, we're not doubting that. If we would have known it, we would have given it to you, and it would have said it was 80/20 debt to equity. And so we're making that representation.

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

MR. OURTH: And it's represented in the bank's term sheet, the 80/20.

DR. HIGGINS: In the term sheet in the application, it is -- the bank is requiring that minimum, so that's our understanding with them.

CHAIRMAN SEWELL: Questions?

MEMBER SAVAGE: I do have a question.

One of the things I brought up earlier was the Medicaid population calculations that you did.

Are you planning to take all patients that would be coming your way?

DR. HIGGINS: Yes. Yes. There is -- obviously, you can't deny a patient based on

payment, so that's not an issue.

But we have a lot of need for that safety net in there. I think, unlike other projects, I've actually talked to the status workers and the other people who are working in the community who kind of direct those patients. And Dr. Ward from Grand Prairie Services, who is a status worker in our area, one of them, over -- she does over 300 crisis visits a month. She was in support of our project at the announcement and wrote a letter.

We were working with them to provide -- to get -- not only just accept the patients but to have a better solution than we have right now for that problem.

And, also, by the way, I've been on the board of a not-for-profit that works with public support at about the 95th percentile for the last 10-plus years, so I'm very familiar with the challenges and the solutions to that.

Thank you.

MEMBER MARTELL: Would you be doing direct admit rather than referral from providers?

DR. HIGGINS: That's a complicated

question, and I'm not trying to avoid it.

So can someone show up at our door and walk in? They would -- in order -- since we're not part of the hospital -- although the stand-alones, like at your hospitals, want to make sure that you're medically clear before you admit into the hospital. So if we can pull that off -- which we will have the resources to do that the majority of the time -- we will.

An example of this is, you know, you need to make sure someone's not pregnant before you prescribe medications. That lab work is usually a medical issue, so we want to make sure people are medically cleared. Once that is done, we will do direct admits.

MEMBER SAVAGE: What are your plans for your outpatients? Will you be expanding outpatient services out of this health center?

DR. HIGGINS: In the building that we have -- if you want, I'll show you the pictures -- there's a -- the clinical space for not only the unit -- it's beautiful what we can do.

In the same building, there is more than enough space for four different partial

hospitalization programs and IOPs -- and we'll go through that -- and then also what we plan to do in the building is -- in another outpatient center -- is -- and this is kind of part of your answer -- we would have a full diagnostic neuro center, neurodiagnostic and psychology diagnostic, so that people could get the real answers for the problems. And that report will not only provide stuff for an inpatient but also follow through with the entire continuum of care.

You've got to remember this is a -- we already have the continuum of care where the majority of treatment for behavioral mental health is done. We just need this last piece so that our providers, you know, can be secure in treating risky patients, that they're not going to get someone in harm's way.

CHAIRMAN SEWELL: Yes.

MEMBER JENKINS: Yeah. I just wanted to touch on, too -- this morning we heard and also in a letter of opposition of the -- what it said was your financial viability being tied to higher commercial services or people covered by commercial insurance other than Medicaid.

And knowing that a significant portion of the children and adolescents in the state are covered by Medicaid, I just wanted to hear the commitment that I think that you just gave to serve those people covered by the medical assistance programs.

DR. HIGGINS: Not only a commitment but we're already working on it.

MEMBER JENKINS: Okay. Thank you.

CHAIRMAN SEWELL: Yes.

MEMBER QUINTERO: Hi. I have just a couple questions, if I can elaborate a little bit on the programs, especially the somatic expression group and the one of Circle of Courage.

And who will be providing that type of therapy?

DR. HIGGINS: In general -- I'll let them talk about it because they're the experts on it.

But so you know, since we are an outpatient going towards the hospital, we do a lot of therapy that they don't do in the hospital, that a hospital that's developed out of a med/surg, adult psychiatry would never do. And these are some of the exciting programs that we're

going to be able to integrate into in this continuum of care.

DR. MIKULECKY: So the somatic -- I think it's -- there's a typo; it's somatic experiencing -- is a term and it's a trauma-based treatment.

It's kind of a newer treatment, but it's all rooted in the same research, and it's really focused on the nervous system and healing trauma because trauma lives inside the body. So it's focusing on all that research and with an emphasis -- it was designed to treat trauma and addiction.

So Dr. Johnson and myself, we are actually -- we're getting certified in that type of treatment, and that will be done within a month so that's coming up.

And then the other piece that you talked about was another kind of specialty treatment that another provider at the practice uses --

MEMBER QUINTERO: Thank you.

DR. MIKULECKY: -- that will be part of the whole plan and implementation.

MEMBER QUINTERO: Thank you.

CHAIRMAN SEWELL: Oh. Other questions?

Yes.

MEMBER MARTELL: Can the staff provide us any background? Are there any other type of facilities like this in the state?

MR. CONSTANTINO: Not that I'm aware of.

MS. AVERY: Springfield? Isn't there one in Springfield?

MR. CONSTANTINO: It's closed. There's a 97-bed -- 97-bed, yes.

MS. AVERY: Oh.

MR. CONSTANTINO: Not one that -- not one this small, Courtney.

MS. AVERY: I never should have questioned you.

CHAIRMAN SEWELL: Yeah. Don't question Mr. Constantino.

MR. CONSTANTINO: Pardon me?

MS. AVERY: He told me don't question you.

CHAIRMAN SEWELL: I said, "Don't question Mr. Constantino."

Other questions?

(No response.)

CHAIRMAN SEWELL: All right. Roll call.

MR. ROATE: Thank you.

Motion made by Ms. Savage; seconded by Dr. Martell.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon testimony and the staff report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes, based on the testimony and the staff report.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: Yes, based on the testimony and the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on the staff report, the information presented by the Applicants, and the dearth of adolescent and child AMI beds in the HSA and surrounding areas.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes, based on the testimony and the Board's presentation.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: I'm going to vote no because I think that some of these issues could be tightened up in a -- in an intent to deny where you could get the referrals, you could make references to the term sheet to satisfy the financial concerns.

I just think that there's a few holes here that could be tightened up through an intent to deny.

MR. ROATE: Thank you.

That's --

CHAIRMAN SEWELL: But the project's approved anyway.

MR. ROATE: -- 5 votes in the affirmative, 1 in the negative.

CHAIRMAN SEWELL: Thank you.

DR. HIGGINS: Thank you.

DR. JOHNSON: Thank you.

MEMBER SAVAGE: May we see the picture?

DR. HIGGINS: Oh, the picture?

All right. Good thing I was long-winded before.

This is that 18 --

THE COURT REPORTER: Can you use the microphone, please, sir?

MS. AVERY: Off the record.

DR. HIGGINS: Off the record?

CHAIRMAN SEWELL: Yeah, because it's over.

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

- - -

CHAIRMAN SEWELL: Next on the agenda is H-02, Project No. 19-015, Dialysis Care Center of Chicago Heights in Chicago Heights.

May I have a motion to approve this project to establish a 14-station end stage renal disease facility in Chicago Heights.

(No response.)

CHAIRMAN SEWELL: Can I get a motion?

MEMBER SAVAGE: So moved.

CHAIRMAN SEWELL: Is there a second?

MEMBER MURRAY: Second.

CHAIRMAN SEWELL: All right.

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

(Five witnesses sworn.)

THE COURT REPORTER: Thank you. And please print your names.

CHAIRMAN SEWELL: State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

DCC Chicago Heights is asking the State Board to approve a 14-station ESRD facility in Chicago Heights.

The estimated cost of the project is approximately 2.6 million, and the expected

completion date is May 31st, 2021.

There was no request for a public hearing, and no letters of support were received by the State Board. There was one letter of opposition received, and it has been included in your packet of information.

The Applicant has not met all of the criteria of the State Board.

Thank you, sir.

CHAIRMAN SEWELL: Thank you.

Is there a -- are there comments for the Board?

DR. SALAKO: Good afternoon, Chairman Sewell and members of the Board.

I am Dr. Babajide Salako. I am the CEO of Dialysis Care Center. With me today are a couple of my colleagues.

Immediately to my left is Dr. Mohammad Shafi. He's the chief medical director of Dialysis Care Center. Next to Dr. Shafi is Mr. Asim Shazzad. He's the chief operating officer of Dialysis Care Center.

To his left is Ms. Therese O'Donnell. She is the area manager for that territory of our

business. And finally, at the end of the table, is Dr. Tauseef Saragough. He is a medical director at -- one of the physicians at Kidney Care Centers in Olympia Fields.

So I'll let Dr. Saragough start.

DR. SARAGOUGH: Thank you, Dr. Salako.

Hello and good afternoon, distinguished members.

My name is Tauseef Saragough, MD. I'm a board-certified nephrologist and medical director at DCC of Olympia Fields. I'd first like to thank the Board for approving our unit, DCC of Olympia Fields, in January of last year.

You guys heard one of our patients earlier this morning, who was here for the testimony, and he's somebody who I took care of at that unit that you approved, and I'd like to thank you for that. I, here, represent all of those patients or similar patients as the one you heard this morning, and, you know, these are patients who are -- they're our CKD patients or are on dialysis awaiting renal transplants.

Let me also share this opportunity to tell you about another success story that we had at

Chicago Heights.

This is a story that was actually reported by the Chicago Tribune. I'd like to hold it up here for you guys. This is a 23-year-old patient who was one of my patients who I had in Chicago Heights who had this rare kidney condition called atypical hemolytic uremic syndrome.

And she basically had renal failure, was on dialysis, and we took care of her at our home program for a good two months where she was doing peritoneal dialysis with us before she had recovery of renal function and is now doing -- is now doing great. Our practice draws significant numbers of patients like her from the Chicago Heights area.

And DCC of Olympia Fields, which is less than 5 miles from the proposed clinic, which I had just mentioned in my opening remarks, is now at capacity. And it obtained this utilization within a record span of one year since its inception. And due to the rapid growth of ESRD patients that we have seen in our practice, attributable to growing elderly African-American and Hispanic population and ESRD patients in our practice, we

generally look to continue to increase these patients.

So Dialysis Care clinics focuses on individualized care and encourages our patients to choose home therapies, and they have all modality options at our practice. Besides this, you know, our nephrologists work really closely with the nurses of DCC clinics to reduce hospitalizations and improve quality indicators of the dialysis patients.

I request our esteemed Board members here to approve our proposed clinic in Chicago Heights, which will be completed in 2021. It will provide continuity of care to our patients, and our team will have an opportunity to give them the excellent care that they need.

Thank you, Board.

MS. O'DONNELL: Good afternoon.

My name is Therese O'Donnell. I'm the clinical area manager for the home dialysis Olympia Fields office.

At Dialysis Care Centers we are predominantly a home-based dialysis company. We encourage all our new patients as well as our

existing patients to try and transition to home dialysis due to flexibility, convenience, better understanding of their disease process as well as better control of their disease process. We also work with and encourage our patients to become transplanted.

Eventually, over time, though, our home dialysis patients will fail either home PD or home hemo and will need to transition to the in-center. When that happens, we're able to keep our patients in our network and continue to provide continuity of care to them. When our patients stay in our network, they will keep the same -- their same doctors, social workers, dieticians, and nurses.

In the event that our patients have access issues or end up with peritoneal dialysis and need bridge dialysis, we're able to keep our patients in their network and keep the continuity of care. We are also able to transition them back into their home therapy unit faster because our home nurses can visit and follow up with the patient in our own in-centers.

Since we are a home-based dialysis company, we work early on when patients crash into

the in-center dialysis and educate them on home therapy options as well as successfully transition our patients to home dialysis.

Please vote favorably for our Chicago Heights location so we can continue to provide our patients with the continuity of care they need.

Thank you for your time.

DR. SHAFI: Good afternoon, Chairman and esteemed members.

I am Dr. Mohammad Shafi. I'm a board-certified nephrologist. I also serve as the chief medical officer at Dialysis Care Center and would like to bring the attention of the distinguished members of the Board on two core principles we follow in our organization rather vigorously. One is care coordination of the patient and encouraging home dialysis.

Let me explain to you why care coordination has become so much important this day and age. Care coordination is a value-based system focused on caring for the whole patient, improving the efficiency -- improving efficiencies and reducing costs.

We at the Dialysis Care Center have

developed innovative care models based on coordinated patient-centered care, partnering with nephrologists, dialysis nurses, and the patients to oversee and monitor care of the ESRD patients with the focus of reducing ER visits and hospitalization, lessening the financial burden which it poses to Medicare, Medicaid, and patients without compromising the quality of their care.

Let me remind esteemed members, based on the United States renal data alone in 2015, approximately $11 billion was spent on hospitalizations, expenses of dialysis patients.

We at the Dialysis Care Center are empowering patients to be active participants in managing their disease along with their care providers. Our philosophy and approach synergizes completely with a value-based program, such as a QiD, which was introduced by CMS to encourage the dialysis companies and nephrologists taking care of the dialysis patient to improve quality of care of dialysis patients.

Among the wide array of indicators that we were asked to monitor by CMS, special emphasis was placed on reducing hospitalization and patient

satisfaction survey at dialysis centers.

Now I want to briefly inform the members of our home dialysis. It is unfortunate that only 12 percent of the American dialysis patients receive dialysis at home. The executive order issued on July 19, 2019, has set forth the goal of having 80 percent of the new end stage renal dialysis patients by 2035 either receiving dialysis at home or receiving a transplant. And we, as a company, realized that years ago, and we are well positioned to achieve that goal.

We at the Dialysis Care Center have developed innovative programs to educate and empower dialysis patients to choose home therapies as against in-center, recognizing home therapies offer better quality of life and save Medicare/ Medicaid billions of dollars.

It is, therefore, imperative that the patient remains within our Dialysis Care Centers so that our physicians, nurses, and staff can follow these models and follow the patients to reduce the cost, improve outcome, and encourage patient to switch to home therapy.

We at the Dialysis Care Centers in our

clinics treat patients regardless of their financial and insurance background.

You heard, all, the story of one of our patients that we took care of at the Dialysis Care Center in Olympia Fields. His journey started as a home PD patient. He was switched to home hemo, then he was switched to in-center, and eventually he received a transplant and leading a healthy life.

That's what DCC is all about, helping and empowering patients to lead a better life and make better decisions about their health.

As noted earlier, the current DCC clinic in the area has reached their maximum utilization capacity. That is 101 percent, DCC Olympia Fields, in record 1 1/2-year time.

This is -- I want Board members to recognize this unique need of Dialysis Care Center to serve patients in innovative ways to improve their quality of life and to avoid sending these patients into other clinics belonging to large LDOs where the focus and management does not match the preferences and standard set by a small company like us.

Thank you very much.

DR. SALAKO: I'd like to share two posters with the members of the Board, please.

So when Dr. Shafi talks about continuum of care -- can you hear me?

THE COURT REPORTER: Not very well. Sorry.

MS. AVERY: Just bring it up a bit and then you can.

DR. SALAKO: When Dr. Shafi talks about continuum of care, you know, from a care coordination perspective, what we wanted to also show you from a physical client perspective -- these are things that the agency report will not be able to capture.

This is our unit in Olympia Fields. Right? We opened this unit January of 2018.

This is our home dialysis clinic where we're treating, you know, tens of patients. This is the physician office, right in the middle. This is the dialysis clinic, at the end of it.

So we have patients being seen by the nephrologist. If they are home, they go to the left of the door. If they are in-center patients,

they go to the right of the door.

In the -- the kind of seamless care they get here is a model that the LDOs don't have. It's a model that our patient -- it allows us to give really excellent care to our patients.

You know, Dr. Shafi also talked about a model we've been saying for a few years here with the Board, an emphasis on home. The national average is 12 percent of patients on home.

With our organization it's well over 35 percent, and it's because we can do something like this. We can provide patients seamless care, either from home to in-center, in-center back to home, with their physicians being there, next to them, all the time.

That kind of -- this kind of picture, very difficult to see unless you go to one of our facilities, unless you're one of our patients, and you feel totally, totally comfortable in knowing that your caregivers are right there next to you all the time.

Dialysis Care Center has opened three clinics in this HSA in the last 20 months. We opened DCC Oak Lawn. Today we are at over

90 percent utilization. It's an 11-station clinic.

In January 2018 -- DCC Olympia Fields, January 2018. We have over a hundred percent. This particular clinic that's about 5 miles away from where we're asking for this new CON, actually has a fourth shift opened. We have a fourth shift opened MWF; we have a fourth shift opened TTS.

That means the dialysis patient -- because they truly desire to stay in our unit -- are having to dialyze as late as 10:00 p.m. Winter is coming. That's a problem, you know.

We don't -- the patients -- I wouldn't like to get to dialysis at 5:00 p.m. in the evening and then, you know, leave the dialysis clinic at 10:00 at night when it's dark, when it's cold.

This is -- and our last clinic we opened just in March of this year. DCC Beverly is already at 55 percent capacity -- utilization. We expect that this clinic, based on our internal data, will be at about 80 percent capacity before the end of the year.

So there is a need for our own patients to

stay in our own network because they truly believe that they will get the best care when they stay in our network.

Thank you.

CHAIRMAN SEWELL: All right.

Are there any questions of the Applicant?

MEMBER SLATER: Yes.

CHAIRMAN SEWELL: Yes. Go ahead.

MEMBER SLATER: The one thing that you never really addressed is that we've got a whole bunch of beds, apparently, available within the area.

So if that's the case, why do we need this facility?

DR. SHAFI: I'll address that.

And that's part of my testimony -- which I said earlier -- was that every dialysis company is developing their own unique model of this continuum of care, reducing hospitalization, and reducing -- so within our own company that's -- that's a job I'm doing also -- that we identify patients in our network, we try to keep them within our own network so that we can deploy those models, you know, by reducing hospitalization,

improving their quality numbers.

So once they leave our network, we really don't -- we cannot exercise that kind of authority on those patients.

So I think as -- Dr. Saragough also, I think, would like to answer that because he's also part of the DCC organization; he's the medical director.

So I think we like to keep these patients within the DCC network so that all the efficiency models that we are developing we can do better.

DR. SARAGOUGH: I'd like to add to what Dr. Shafi just mentioned.

From personal experience -- I've been practicing in that area for the last four years now. And the transition from PD to hemo or back to PD, if it needs to be done, is just seamless if these patients are part of our network.

It's just easier for me, as a physician, who I know to transfer a patient from PD to hemo with a seamless transition, within hours if it has to be done that way.

If it's a patient that's in a different unit, the transition is not as simple as it would

be if it's somebody who's part of our network. It's just an easier transition.

DR. SALAKO: One other thing.

The gentleman that spoke earlier today, one of our patients, he was a home dialysis patient of ours, and he -- he was a home dialysis patient of ours, and then he needed to go in-center.

And when he went in-center, our clinic hadn't opened at that time, and he went to one of the LDOs, and he had a very torrid time, repeated hospitalizations. He was very unhappy with his experience there.

When he -- when our clinic opened, he did come back to us because he was familiar with the caregivers, he was familiar -- he was familiar with his physicians, and he felt very happy to come back to us. And, of course, we're happy to report today he got a transplant.

So when you start to look at the availability of chairs, there's also choice for the patients. You know, these patients that are dialyzing until 10:00 p.m. at night or -- they could very well go to another dialysis clinic, but

they choose to stay where they are. They choose to stay with this team that's looking after them.

You know, when you're a dialysis patient, you get to a point where it's about trustworthiness. It's about who do I -- who can I entrust my care to? With whom do I feel most comfortable? With whom do I -- who do I believe is really on my side?

And these patients want to stay within our network, and that's why our clinics are always heavily utilized, because those patients want to stay and other patients that they care about want to come into our network.

CHAIRMAN SEWELL: Mike, the Applicant has talked about -- I think they have an estimate of how many pre-ESRD patients there are in the area, and then I guess they have a projection about how many of those will later -- I think it's after two years of completion of the project -- will require care.

That concept and that methodology, that's not the one used by the State agency, is it?

MR. CONSTANTINO: No. We use historic utilization.

CHAIRMAN SEWELL: I see. Okay.

MR. CONSTANTINO: And population.

CHAIRMAN SEWELL: And then, you know, you mentioned that you have these facilities operating at target utilization. But in the State agency report -- your facility at Olympia Fields is at target occupancy but the one -- the others are averaging about 70 percent collectively.

DR. SALAKO: Yeah.

CHAIRMAN SEWELL: And then you've got one -- Hazel Crest -- that's not -- is that not yet operational?

MR. SHAZZAD: It's not certified yet, correct.

CHAIRMAN SEWELL: Oh, it's not certified yet?

MR. SHAZZAD: Right.

CHAIRMAN SEWELL: But it will come online at some point?

MR. SHAZZAD: Yes. But that's a different market area.

CHAIRMAN SEWELL: I see. That's not in this plan?

MR. SHAZZAD: No.

CHAIRMAN SEWELL: Okay.

DR. SHAFI: That 70 percent utilization is not our clinic. That's collectively, other clinics.

CHAIRMAN SEWELL: That's all of them, yes.

DR. SHAFI: Yes.

CHAIRMAN SEWELL: Okay. Other questions by Board members?

MEMBER MURRAY: I have a question for staff.

So there's a lot of demographic changes. When you evaluate need, do you look at the change in the population in this area?

MR. CONSTANTINO: We will be. You will approve that today. We did another -- we do it every two years.

MEMBER MURRAY: Oh, every two years?

MR. CONSTANTINO: Yeah. That -- the number of stations will be approved today by this Board. We have to get your approval.

MEMBER MURRAY: And what is your recommendation going to be?

MS. AVERY: We can't do it.

MEMBER MURRAY: We can't do it ahead of

time? That means you want me to vote without information.

Okay.

MS. AVERY: Well, we were asked -- to be clear, we were asked but we don't -- it wouldn't -- Mike and George wouldn't have had a chance to approve -- analyze the numbers, the new numbers.

MEMBER MURRAY: I understand that. But --

CHAIRMAN SEWELL: Without them being --

MS. AVERY: Yeah.

MEMBER MURRAY: I just want to be clear because this is an area that has seen a big influence, especially of populations that, unfortunately, will use dialysis. So that's why I'm asking about it.

And I understand that you might not be able to use a new recommendation on this application. All right.

DR. SARAGOUGH: Dr. Murray, I can't specifically give you numbers, but just from my personal experience in the last four years, we've seen tremendous increase in the number of CKD patients that we see in our clinic -- you know, in

our outpatient clinics -- which is why -- that center between the two dialysis units that was just mentioned by Dr. Shafi.

So we have personally seen an increase in the number of CKD patients that we've been seeing over the last couple of years.

MEMBER MARTELL: What is the projection in home dialysis? Is that -- considering the office based.

So we know that there's a small percentage using home right now, but how would that impact this?

DR. SALAKO: May I -- we -- our numbers on home dialysis -- our percentage, penetration of home dialysis -- is one of the highest in the United States today. We have 35 percent of our patients on home. Okay?

This number has held steadfast for the last three years. So we are very bullish. We continue to believe that, inasmuch as we are opening in-centers, we are able to bring patients at home because we have those in-centers.

And when patients have to start dialysis at in-center and crash into it -- and Ms. Therese

O'Donnell, she can talk more about it. But patients get into our in-center clinics because they crash into dialysis. Our nurses are extremely proactive. They have a lot of programs in which they still encourage those patients to go home.

DR. SARAGOUGH: And adding to what Dr. Salako just said, we have a dedicated nurse who rounds at our in-center clinics, educating patients on different modality options.

So every patient that goes in-center gets a modality education about their choices and preferences by a dedicated person who rounds on these patients every week.

And I've personally had two patients last week that switched over from hemo to PD because they preferred PD or home options just by talking to a dedicated educator.

DR. SHAFI: I think -- I just would like to add to my answer earlier that, you know, once these patients go to other dialysis clinics, we cannot exercise that influence for them because our staff is not there to change their modality.

So that's the reason it becomes so much

important for us to keep these patients within our network.

So thank you.

CHAIRMAN SEWELL: Other questions?

(No response.)

CHAIRMAN SEWELL: All right. Roll call.

MR. ROATE: Thank you.

Motion made by Ms. Savage; seconded by Dr. Murray.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the testimony I've heard today and the staff report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: No. I have concerns about the capacity issues in the region.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: I'm going to reluctantly have to vote no based on the information we have today.

But let me make a comment that if I'm -- I mentioned this in one of my earlier questions. This is an area that's changing very fast. It's

increasing in African-American population, who, unfortunately, desperately need dialysis.

And so I hope we reconsider this once our new stuff comes out, whatever that is, on our estimates.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: And I have to sadly vote no, as well, based on what was just said.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: I vote no. It appears to me that there's an unnecessary duplication and the result would be an excess supply of facilities.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: Yeah, I vote no. It doesn't meet the criteria in our planning area need.

MR. ROATE: 1 vote in the affirmative, 5 votes in the negative.

MS. AVERY: The motion has failed. You will receive an intent to deny. Thank you.

DR. SARAGOUGH: Thank you.

THE COURT REPORTER: Please leave your remarks for me at the table. Your written remarks, please leave them.

- - -

CHAIRMAN SEWELL: Okay. Next on the agenda is H-03, Project No. 19-021, The Rehabilitation Institute of Southern Illinois in Shiloh.

May I have a motion to approve this project to establish a 40-bed physical rehabilitation hospital in Shiloh.

MEMBER SLATER: I move to approve.

CHAIRMAN SEWELL: Is there a second?

MEMBER MURRAY: Second.

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

CHAIRMAN SEWELL: I'm sorry to have you all at the table. We're going to take a short break.

How long is this break? Five minutes? We always say 5 and it takes 10. This break is seven minutes.

(A recess was taken from 3:09 p.m. to 3:19 p.m.)

CHAIRMAN SEWELL: Okay. We're going to come back to order.

Did we already get a motion and a second on this?

THE COURT REPORTER: Yes, you did.

CHAIRMAN SEWELL: Okay.

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

(Six witnesses sworn.)

THE COURT REPORTER: Thank you. And please print your names.

CHAIRMAN SEWELL: State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

The Applicants are asking the State Board to approve a 40-bed comprehensive physical rehabilitation hospital in Shiloh, Illinois. The cost of the project is approximately $31 million, and the expected completion date is March 31st, 2021.

No public hearing was requested, and we did receive several letters of support. No oppositions have been submitted.

As noted in your report, the Applicants do not meet all of the State Board criteria.

Thank you, sir.

CHAIRMAN SEWELL: All right.

Do you have comments for the Board?

MR. MORADO: We do.

Good morning, members of the Board. My

name is Juan Morado, Jr., from Benesch. I am counsel for this project, and I'm very happy to be here with this team.

The goal of this project is simple: Two world-class health providers, BJC and Encompass, have come together to provide care to Illinois residents -- who are currently leaving the state -- to receive that care in Illinois, and they're going to bring it right back here to Shiloh, Illinois.

As we begin, I'd like to say thank you to the Board staff for their overwhelmingly positive report. I'd like to introduce the folks who are with us here today.

We have Mark Turner, who is the CEO of the Memorial Regional Health System, who is going to discuss the Shiloh community and the partnerships that BJC has established there.

We have Mark Dwyer, who is the CEO of The Rehabilitation Institute of St. Louis, and he's going to be telling you how he's already treating Illinois patients.

We have Dr. Elissa Charbonneau, who's going to be discussing the clinical aspects of

comprehensive rehabilitation care.

Troy DeDecker is with us today, as well, and he's the regional president of Encompass, and he's going to be discussing their model of care.

And Lawrence Whatley is with me, who is the VP of design and construction for Encompass, and he's going to touch on the design of our facility.

Finally, my colleague Mark Silberman is going to be discussing the findings of nonconformance. He's going to provide you with some additional information so that you can address these findings of nonconformance and give you a strong basis to approve this project. He's going to conclude the formal presentation, and then we'll open it up for questions.

This project is a $31 million investment by BJC and Encompass Health to establish a 40-bed rehabilitation hospital in Shiloh, Illinois. It's considered a substantive project, and the establishment of this type of facility requires this Board's approval.

We're very happy to report that the project has successfully addressed 16 of the

19 applicable criteria for this type of project, including all the financial criteria.

Importantly, I'd like to note that your rules actually encourage Applicants to seek out joint venture partners, and the partnership between BJC and Encompass is just that.

This project has received absolutely no opposition during the written comment period. You've already heard about the numerous letters of support that we've received, from stakeholders in the community to elected officials at every level, the mayors, State representatives, and County officials.

At this time I'd like to turn it over to Mark Turner, who's going to tell you a little bit more about the Shiloh community and the work that's going on there.

Mark.

MR. TURNER: Thank you.

Good afternoon. It's my pleasure to be here and thank you for your time.

I am the president of Memorial Regional Health Services and Memorial Hospital East. I have over 30 years of experience in health care

as an executive, primarily had responsibility for most of the types of inpatient and outpatient care that you see in an acute care setting, and I've been with Memorial for over 15 years, moving into the position of president and CEO in 2006.

Memorial has a very rich tradition of expanding services to meet the needs of the communities that we serve.

In 2011 we opened an 85,000-square-foot orthopedic and neurosciences facility in our Belleville campus because what we learned was that our patients in our community -- there was a significant amount of outmigration in orthopedics to St. Louis, to Missouri, for care. Upon opening the facility and recruiting physicians, we've had tremendous success with that program. We've more than doubled the number of orthopedic surgeons in our community providing care.

In 2016, with this Board's approval, we opened Memorial Hospital East, a 94-bed full-service community hospital located in Shiloh, Illinois. We did this in response to our understanding, through our planning process, that many residents of O'Fallon, Shiloh, and Illinois

communities to the east were finding it more convenient to get to St. Louis for their care or to Missouri for their care, and so we responded by opening a facility.

I'm happy to share with you today, now just really in our third full year of service, that this year, in 2019, by the end of the year, we will treat over 4,000 inpatients, over 26,000 visits in the ED; we'll perform over 3,000 surgeries at this facility and care for over 250,000 outpatients.

In 2016 Memorial and BJC came together and completed a strategic affiliation. The -- many objectives but the primary objective of this affiliation was to enhance care and services available in Illinois to Illinois residents.

So -- very excited with the progress we've made in our affiliation with BJC. Some of the things that we've been able to do just since 2016 is to construct two medical office buildings on the campus of Memorial Hospital East. Each of those buildings is approximately 70,000 square feet. The first building is up and fully leased, many physicians and physician specialties there,

some of which we did not have and many of which we did not have enough of to serve our community.

The second medical office building will also have medical office space, but it will also house an Illinois location for Siteman Cancer Center. Siteman Cancer Center is an NIH comprehensive cancer center recognized, and it is a joint venture of BJC HealthCare and Washington University School of Medicine.

So we're very excited about that, and I can tell you that our board, the original board of Memorial, was very, very excited when this was part of the process and part of the project that BJC wanted to bring to our community.

We're continuing to work -- and as you can see Memorial and BJC coming together, BJC and Washington University School of Medicine, and now, with this project, BJC and Encompass, so we have a history -- demonstrated history -- of partnering to work together with other organizations to enhance the care for Illinois residents inside Illinois.

So I thank you for your time, and I pass the microphone on to Mark Dwyer for the next stage

of our presentation.

MR. DWYER: Thank you, Mark.

Good afternoon, members of the Board. My name is Mark Dwyer. I'm the chief executive officer for The Rehabilitation Institute of St. Louis, which is an affiliation between BJC HealthCare and Encompass Health.

I've been a physical therapist since 1987. I'm a Fellow of the American College of Healthcare Executives, and I've held administrative positions in hospitals since 1991. I joined The Rehabilitation Institute of St. Louis in 2017 as their CEO.

The joint venture between BJC HealthCare and Encompass Health is a longstanding one that has been in place since September 8th, 1999. This started out with a unit within Barnes-Jewish Hospital that quickly outgrew its space; hence, the joint venture building in -- or building an 80-bed facility in the central west end just a few blocks away from Barnes-Jewish Hospital.

The community's need eclipsed the original beds, so the fourth floor was built out and an additional 16 beds were added in 2010, bringing

the total bed count to 96.

Due to the number of patients who came from the west side of St. Louis, BJC and Encompass Health partnered once again to build a 35-bed rehabilitation satellite that opened in July 2017 within Barnes-Jewish St. Peter's Hospital.

This joint venture has been successful in that it allows for a top 10 health system in BJC HealthCare to partner with a leading provider of inpatient rehabilitation in the country, Encompass Health.

The outcomes we are generating with our patients at The Rehabilitation Institute this year exceed both Midwest region and national performance measures, meaning we are generating more functional improvement with our patients and we are getting more of our patients home.

Just as Barnes-Jewish Hospital and other BJC hospitals are sought-after destinations for people to receive health care from throughout Missouri and Illinois, The Rehabilitation Institute has also grown to be a destination for rehabilitation health care due to the outcomes that we generate.

The Rehabilitation Institute is accredited by both The Joint Commission and The Commission on Accreditation of Rehabilitation Facilities.

We are recognized for multiple specialties in rehabilitation care by The Joint Commission in the form of five disease-specific certifications: Stroke, brain injury, spinal cord injury, amputee rehabilitation, and wound care.

The Rehabilitation Institute over the past year and a half has had nearly one-quarter of our total patient population come from Illinois. From January 2018 through August 2019, that equates to 918 patients.

Given the opportunity, would these patients and their families prefer to receive their rehabilitation closer to home? Sure, they would.

The average length of stay at The Rehabilitation Institute is 14 days. That, coupled with our goal to get the family involved in the patient's rehabilitation as early as possible and throughout their length of stay for family teaching, is asking a lot of families, especially elderly family members, to drive back

and forth every day from Illinois to St. Louis for two or more weeks. That family teaching is critical, however, to helping us return our patients to home.

Just as we have seen the same strong outcomes in our St. Peter's satellite since it opened a little over two years ago, we have every confidence we will enjoy the same success in Illinois as we have had in St. Louis. With the same partner in BJC and the two Belleville Memorial Hospitals as well as Barnes-Jewish Hospital, we already know how to work together to create the best outcomes for our patients.

In fact, we are already serving these patients, but for those in Illinois we are not doing so in a location that is close to where they live. If they are willing to leave the state to obtain care from us, there is no reason to believe they will not seek the same care from the same providers in a new, state-of-the-art facility closer to their home, especially since our Illinois hospital will offer the same advanced therapies that we currently offer in our two St. Louis hospitals.

We are excited to bring this important level of care to Illinois to meet the needs of the growing population of the Metro East area.

Thank you for your time, and I will now hand it off to Dr. Elissa Charbonneau.

DR. CHARBONNEAU: Good afternoon. Thank you for allowing me to speak with you this afternoon.

My name is Elissa Charbonneau. I am board certified in physical medicine and rehabilitation, and I've been practicing in inpatient rehabilitation hospitals for approximately 27 years. Currently I serve as the chief medical officer for Encompass Health.

I wanted to just give you an idea of the kinds of patients that we treat in our hospitals in case you've not had the opportunity to participate or visit one of our hospitals.

In general, our patients have had some catastrophic injury or illness which has caused them to lose the ability to function at a level that they could return home, so they come to our hospitals after having had a stroke, a spinal cord injury, a brain injury, or other severe illness or

injury.

And when they come to our hospitals, they are able to utilize our state-of-the-art gyms, which are large, sunny, beautiful, high-tech areas where they can learn to walk, take care of themselves, or mobilize with a wheelchair or speak again if need be.

We have the expertise in our dedicated therapists and nurses who have dedicated their careers to taking care of these kinds of patients that need intensive daily inpatient rehabilitation as well as very close physician oversight due to their medical complexity.

We have an electronic medical record throughout all of our 133 hospitals, and we use our electronic medical record to improve our clinical outcomes by providing our clinicians with realtime data so that they can improve the quality of care that they're delivering at the bedside.

We also have been able to use our data to develop a predictive analytical model to reduce the chance of acute care transfers for our patients, and we have other various exciting clinical initiatives ongoing, as well.

I hope that our residents have access to inpatient rehabilitation when they need it and in their community, and they deserve to have that opportunity.

Thank you very much for your attention. And I will now pass it over to Troy DeDecker.

MR. DE DECKER: Thank you.

Good afternoon. My name is Troy DeDecker. I'm the central region president for Encompass Health.

Encompass represents 133 hospitals nationwide. I am responsible for 19 hospitals in the Midwest, including the 2 hospitals in St. Louis that are partnered with BJC HealthCare as well as 1 in Rockford, Illinois, with Mercy Health, so I'm very excited to be here to kind of talk to you about what we do and how we do it.

Dr. Charbonneau discussed a little bit about the types of patients we see, and I wanted to just describe briefly for you where we fit into the health care picture.

Obviously, patients that are being discharged from the acute care hospital are leaving the acute care hospital much more sick

than they ever have before. Oftentimes they're in the hospital for only three or four days and they still need close medical supervision by a physician such as Dr. Charbonneau and they need intensive inpatient rehabilitation services to allow them to gain their function and get back home with their families.

At the end of the day, that's the primary purpose of what we try to do, is allow patients to recover medically and, also, gain the function so they can go back home, but an important part of that -- which Mark Dwyer pointed out -- is family involvement.

And so when we were looking at kind of our planning processes and we were evaluating the patients that were coming to St. Louis, we quickly identified that many of the patients -- about 25 percent of the patients being served in St. Louis -- are from Illinois.

And so we knew that if we evaluated -- with Barnes-Jewish and Memorial -- a hospital in the Shiloh region, that we could cover and care for those patients closer to home where family members could help participate in the rehab

process, which is so important for patients and families.

Additionally, we're very focused on taking care of all patients that need inpatient rehabilitation services. As such, 72 percent of the patients that will be treated in our hospital will be covered either by Medicare or Medicaid.

Currently the three managed Medicaid plans that are in the area of kind of the west metro we are contracted with currently at the St. Louis hospital, and we will plan to contract with any payer in the market as well as provide care to those patients that are either uninsured or underinsured because it is our goal to make sure that we give all patients the best opportunity to return back home with their family.

And with that, I will pass it to Lawrence.

MR. WHATLEY: Thank you, Troy.

I am Lawrence Whatley, vice president of design and construction with Encompass Health. I'm responsible for overseeing the design and construction for our hospitals, including bed additions, renovations, and new hospitals of this type.

I have over 30 years of experience in the construction industry, including 9 years with Encompass Health. We have designed this hospital to meet the needs of our patients and to enhance the patient experience during their stay at our hospitals.

Now, how do we do that? We draw on our experiences from operating over 130 hospitals, including over 20 that have been constructed within the last six years.

We currently have six hospitals under construction now, and as of this month we opened a hospital of similar type in Houston, another one in Indiana, and today received certificate of approval to occupy and move into a new hospital in Pittsburgh, Pennsylvania.

In addition to that, we draw on our experiences from shadowing our nurses and our therapists to get a -- gain a great understanding of how best to design and right-size a hospital of this type. All of this information and knowledge have led us to the design of our hospital today.

Today we are presenting to you a 40-bed hospital that is expandable, is a

single-story hospital that's ADA accessible, that has a large therapy gym, which has been mentioned before, and it has the best-in-class equipment.

In addition to that, it has an activities-for-daily-living environment so when our patients are nearing the end of their stay at our hospitals they're able to go into this area and experience cooking again, making their beds again, taking baths by themselves, and all those things they need to function independently when they move or return home.

And, finally, we have a full-service kitchen and dining room and day space for our patients and wide corridors to provide access to and from the patient rooms.

And with that, I will turn it over to Mark Silberman.

MR. SILBERMAN: Thank you.

Members of the Board, I think, hopefully, you can tell we're very excited about the prospects of this project and bringing this care to Illinois and, most importantly, bringing an aspect of care that Illinois residents shouldn't have to leave Illinois to be able to get.

And while we want to thank the staff again for the overwhelmingly positive report, we thought it would be helpful if we just briefly went through the three criteria with which we weren't in conformance to explain why we believe this project still warrants its approval despite those criteria.

All of the issues related directly to the size of this project. The one issue was with the square footage of the project, and our square footage is above the State's average. And the reason for that is simple: There are aspects of our project that are built out, that are designed based on the experience of these providers to meet the needs of the patient.

And the determination was we could have made modifications, but it wouldn't have allowed for certain things, like the provision of care to bariatric patients or all the necessary equipment and tech that the providers have determined and fed back that is necessary for the care to these patients. And we decided that the most important thing was to focus on meeting patient positive outcomes and meeting patient expectations.

And so we hope the additional size will be acceptable to this Board, especially when you take into consideration we've been able to provide the additional size but still meet the cost requirements identified for the State. So they're getting the benefit of the extra space that's necessary to provide the best care but without increasing the costs.

The other two negatives related to the number of beds, and the 40 beds that are proposed come between the 7 beds of identified need and the standard size of project that the Board's criteria identified, and the reason for that is also very simple.

We agree. We agree that there's a need for these projects, and the historical method -- the historical utilization methodology shows a need for seven beds. We're not asking the Board not to utilize its own criteria, but what we're hoping the Board will do, as it has in other areas, is look to some of the standards that are used around the country in addition to that to see how need is calculated.

And when you look at the need, when you

look at the demographics of the community and of the Medicaid -- excuse me -- Medicare discharge data, it shows a much higher need for these services.

I also think that if you look at the referrals that have been identified for this project from the providers that are already providing care to this patient population, it justifies the 40 beds that we've sought to be at the full utilization identified by the Board's standard.

And when you consider that, we believe this 40-bed facility to be the right-sized facility for this community for this time, able to meet the needs from today and tomorrow.

The last thing we would point out to you is this: That the best two things you can see as evidence of the need for this level of care in this way is -- you heard testimony from what could be a competitor earlier this morning, where what they testified was, if the project's proposal is approved, what they would do with their inpatient rehabilitation services, not in opposition. There was no opposition to this project, but they

identified that if these services were made available, they could better utilize their inpatient rehabilitation space because a dedicated hospital with dedicated staff offers that additional level of care.

But the best evidence of the need for this project is that Illinois residents are currently leaving Illinois to obtain this care. The good news is they're leaving Illinois to obtain this care from the world-class providers that are sitting here at this table, who are ready and prepared to provide this care to Illinois residents in Illinois.

So with that, we're happy to answer any questions the Board members might have, and we appreciate your consideration.

MEMBER SLATER: I'm confused about the request that Anderson Rehabilitation has made. That's the potential competitor of this project; correct?

MR. SILBERMAN: No. That was with regards to -- if I understood correctly, there was testimony from HSHS that talked about the idea of repurposing their beds in the event that these

projects were approved.

MS. AVERY: Yes, that's correct.

What are you saying with Anderson? Not them, yes.

CHAIRMAN SEWELL: So 40 is too many beds and 40 isn't enough beds?

MR. SILBERMAN: Well, we actually think 40 is the exact right number of beds.

CHAIRMAN SEWELL: Well, somebody, in doing planning for Illinois, I think may have been -- and I'm speculating here -- they might have envisioned that comprehensive physical rehabilitation hospitals would be sort of special, strategically located, and of sufficient size to justify some of the things that y'all have been talking about. So that's probably where the -- what seems now -- arbitrary 100-bed standard came from.

I'm troubled by the fact that we have a need for 7, though, and you're coming in with 40. That's troublesome.

MR. DE DECKER: So if I may --

CHAIRMAN SEWELL: Yes, sir.

MR. DE DECKER: So of our 133 hospitals,

only about 10 percent of our hospitals are a hundred beds.

CHAIRMAN SEWELL: Uh-huh.

MR. DE DECKER: Most of our hospitals -- just from an efficiency and access of care -- are 40 beds. But even in this project, we can expand this campus up to 80 beds, and we do it as the demand is needed.

And I suspect that -- if we are able to provide the same level of care that we have provided to Illinois residents in St. Louis, our preliminary review indicates that perhaps by Year 3 we'll be evaluating do we need to add additional beds. But it's really not necessary to build out the full -- to make the full need right out of the gate.

CHAIRMAN SEWELL: No, I'm not suggesting that you should have proposed a hundred. I'm just speculating that in some kind of an ideal, that freestanding comprehensive rehabilitation hospitals would be of sufficient mass that they could support all of the things that are associated with contemporary approaches to substantives.

MR. SILBERMAN: Understood and agreed. And if I could address one aspect.

You talk about the methodology showing the need for seven, and we're not challenging that methodology, and I think the Board's finding is accurate.

But the one thing that, Member Sewell, isn't factored into that is the patients who are leaving Illinois to get that care in St. Louis don't ever get reflected in the Board's need methodology because they're not receiving care in Illinois.

CHAIRMAN SEWELL: Right.

MR. SILBERMAN: And so this project is designed to allow those residents to receive care in Illinois, and there's no speculation because the people they're leaving to receive the care for are the providers here, and the documentation's been provided that those patients will be referred here.

MEMBER MARTELL: Mr. Chairman --

CHAIRMAN SEWELL: Mr. Slater, did you --

MEMBER SLATER: A question for you, Mike: How does the Anderson Edwardsville operation fit

in with this one?

MR. CONSTANTINO: They're both in the same planning area, and they're both proposing rehab hospitals in this planning area.

MEMBER SLATER: So the Edwardsville question is still before us? It will be after this one?

MR. CONSTANTINO: It will be after these folks, yes.

MEMBER SLATER: So is it -- is it --

MEMBER MARTELL: When --

MEMBER SLATER: -- a choice between Shiloh and Edwardsville that this Board needs to make?

MR. CONSTANTINO: That's up to the Board.

MS. AVERY: It's individual, stand-alone applications, and you vote for which one you feel.

CHAIRMAN SEWELL: Yeah.

Dr. Martell.

MEMBER MARTELL: Yeah. I want to go back to the projected utilization because I've kind of heard some varying discussion in the formula that you provided.

So -- but none of those indicate the number of patients you currently know are in

Missouri that would use Illinois services, so that would have been a more realistic kind of assessment versus kind of like a projection.

MR. DE DECKER: Mark, did you want to comment?

I think Mark --

MR. DWYER: For the last year and a half, particularly January 2018 through August 2019, we have serviced 918 patients who live in Illinois who cross the state line and come over and receive their care at The Rehabilitation Institute.

MEMBER MARTELL: And how many days of stay?

MR. DWYER: Average is 14. That's our average length of stay, 14 days.

MR. MORADO: And, Member Martell, those are the same patients that are reflected in the application, in the referral letters that we provided. Part of that process is providing a list of zip codes that all -- in this case -- reside within the HSA 11.

And I guess I would add one more point for Member Slater.

You had some questions about some of the

other things that are up later today. I think it just speaks volumes that there's been no opposition to this project, and I think you can take that for what it's worth.

CHAIRMAN SEWELL: Any other questions?

(No response.)

CHAIRMAN SEWELL: All right. Roll call.

MR. ROATE: Thank you, sir.

Motion made by Mr. Slater; seconded by Dr. Murray.

Senator Demuzio.

MEMBER DEMUZIO: I'm going to go ahead and vote yes, based on some of the testimony that I've heard today.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: I'm going to be a qualified no with the understanding that I have concerns about the projections and capacity.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: I'm going to vote yes based upon the testimony about patients presently cared for.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: I'm going to vote yes based on the testimony and the staff Board report as well as the project utilization I feel is better than the other proposal.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: I vote yes based on the testimony.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: I vote no based on the planning area need criteria.

MR. ROATE: That's 4 votes in the affirmative, 2 votes in the negative.

MS. AVERY: You've received an intent to deny. You'll have the opportunity to submit additional information.

MR. MORADO: Thank you.

MR. DE DECKER: Thank you.

- - -

CHAIRMAN SEWELL: Next on the agenda is H-04, Project No. 19-025, Physicians Surgical Center in O'Fallon.

May I have a motion to approve this project to relocate an existing ambulatory surgery treatment center in O'Fallon.

MEMBER SAVAGE: So moved.

CHAIRMAN SEWELL: Is there a second?

MEMBER SLATER: Second.

CHAIRMAN SEWELL: I just wanted to point out that there were no findings on this. Right?

MR. CONSTANTINO: We did receive an opposition letter that has been made available to you by email.

CHAIRMAN SEWELL: All right.

MR. CONSTANTINO: And we -- and a handout today.

CHAIRMAN SEWELL: All right.

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

(One witness sworn.)

THE COURT REPORTER: Thank you. And please print your name.

CHAIRMAN SEWELL: State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

Physicians Surgical Center is asking the State Board to approve the relocation of a single-specialty ASTC from Belleville, Illinois, to O'Fallon, Illinois, approximately 7 1/2 miles.

The cost of the project is $1.4 million, and the expected completion date is June 30th, 2020.

Service at the Belleville facility has been suspended as the facility addresses deficiencies identified by IDPH. The Department of Public Health is monitoring the needed updates, and the facility will not be reopened until the Department surveys the facility and grants permission.

No public hearing was required -- requested -- and no support or opposition letters were received by the State Board.

The Applicant has met all the requirements of the State Board.

CHAIRMAN SEWELL: Thank you.

MR. CONSTANTINO: Thank you.

CHAIRMAN SEWELL: Do you have a presentation?

MS. FRIEDMAN: Hi. I'm Kara Friedman, CON counsel for the Applicant. With me is Tom Glick, their attorney.

And I just want to comment, with respect to the condition of the current facility, that is why the facility needs to move. There was some private survey work that we were doing in order to assess the facility for going forward, and we reported that to IDPH.

So it's in collaboration with Mr. Afeef and his staff that we are temporarily suspended until we make the corrections that they want and are able to relocate the facility.

And I'll let Mr. Glick provide a few comments.

MR. GLICK: Thank you.

As indicated, my name is Tom Glick, and I work for PSC. I am in-house counsel.

And this is a fairly straightforward project to update the facilities of an ambulatory surgery center, which mostly provides endoscopy services, which are primarily oriented toward the detection of precancerous polyps.

Colonoscopy is the gold standard for

colorectal cancer screening. With these polyps being treated at the same time as they are identified, it leads to extraordinarily less mortality and morbidity and thousands and thousands of dollars in cost savings for payers and employers.

The existing center is now located in a fairly outdated, difficult-to-reach building in Belleville. Many of the problems associated with the location come from the fact that it is directly across the street from a gigantic multiacre vacant lot covered in dirt and mud that used to be St. Elizabeth's Hospital. When the project was -- when the building was in its prime, it was well positioned across the street from St. Elizabeth's Hospital, which, of course, has now moved to just two blocks from where we are proposing moving, as well.

The physical plant issues are made more challenging by the fact that our landlord is none other than St. Elizabeth's Hospital. You can see that there are potentially multiple motivations for St. Elizabeth's objection to our application today, which go well beyond the factors which

could normally be considered by this Board.

To continue to try to operate the facility is not out of the question. We believe, in fact, that we have remedied almost all of the problems we need to be up and running at the current facility -- we still have to be inspected, so take that with a grain of salt -- but it has not been easy or inexpensive.

And the problem is not that we do not believe that we can be up and running at this facility soon and for a long time. The problem is the extreme cost of continuing to do that.

As the facility continues to degrade, the costs go up, and all of the great advantages of lower costs associated with surgery centers as opposed to hospitals are lost because of the high costs of maintaining the building.

I would -- so just to turn briefly to our -- to the Applicant itself, our company, we have a fantastic record for serving safety net -- as a safety net provider, serving the Medicaid population with a full 27 percent of our caseload associated with -- the surgery center a few miles away in Fairview Heights has over 27 percent

Medicaid patients.

Of the 14 endoscopy centers in the state, this is by far the largest proportion of Medicaid patients served by an endoscopy center -- most don't serve Medicaid patients -- and the next highest Medicaid payer mix was 11 percent in Rockford, Illinois.

We are extremely serious about continuing to serve Medicaid patients, so much so that I would suggest to you that part of our business model involves continuing to serve Medicaid patients. It's not something we're doing to be politically correct; it's something to do because that's our business model.

So the problem is that our landlord has left the building in the middle of a sort of wasteland that we spoke of -- that I spoke of earlier at the meeting.

A simple relocation of the endoscopy center is not, to me, a very controversial project. There were no deficiencies cited in our proposal, and your Board staff wrote a fully positive report.

There are other endoscopy centers in

Belleville where we're coming from just a few blocks away, so the relocation will, overall, improve access to the services in this area.

Just briefly, I want to go over sort of the typical benefits of a surgery center.

They are almost universally seen as a substantial savings in cost over the same procedures in hospitals. In most cases, they are able to be completed for about a third of the cost with much, much higher client satisfaction.

And let's not mince words here. A lot of the things the clients are more satisfied about are not medical. Clients like to park right outside the door that they know is the door they're supposed to go into and walk in that door to the reception desk that they know is the reception desk they're supposed to go to without a lot of wandering around a whole bunch first or having to get a card punched or anything else, and that's what surgery centers are.

The hospital's statement in writing -- he went earlier today orally, which were relatively the same -- are somewhat misleading because they only discuss the utilization of the same types of

procedures in the hospital, and we know very well by this time -- now that surgery centers have been around for a substantial period of time -- that utilization of the services at surgery centers is not comparable to hospitals from a consumer standpoint or from the standpoint of private or public payees or the occasional individual pay.

UnitedHealthcare, for example, has led the movement toward insisting that simple elective surgical procedures be performed in a freestanding setting and not a hospital-based one when this is possible. And we are trying to make that as possible as possible in O'Fallon.

Thank you very much for your time.

CHAIRMAN SEWELL: Thank you. All right.

MR. GLICK: Thanks to the staff for their report on it. And I'm glad we got to provide you a little break between rehab hospital discussions.

CHAIRMAN SEWELL: Any questions?

(No response.)

CHAIRMAN SEWELL: Roll call.

MR. ROATE: Thank you, sir.

Motion made by Ms. Savage; seconded by Mr. Slater.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based on the comments I've heard today and staff report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes, based on the staff report and testimony heard today.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on staff report and the testimony today.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes, based on staff report.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: Yes, reasons stated.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

CHAIRMAN SEWELL: Thank you.

MS. FRIEDMAN: Thank you.

MR. GLICK: Thank you.

- - -

CHAIRMAN SEWELL: Next on the agenda is H-05, Project No. 19-026, Anderson Rehabilitation Hospital at Edwardsville.

May I have a motion to approve this project --

MEMBER MURRAY: Excuse me.

CHAIRMAN SEWELL: Go ahead.

MEMBER MURRAY: Didn't we move that other thing about Andersonville --

MS. AVERY: After this one.

MEMBER MURRAY: After this one?

MS. AVERY: Yes.

CHAIRMAN SEWELL: Yeah.

So I want a motion to approve this project to establish a 34-bed physical rehabilitation hospital in Edwardsville.

Is there a motion?

MEMBER MARTELL: So moved.

CHAIRMAN SEWELL: Is there a second?

MEMBER MURRAY: Second.

CHAIRMAN SEWELL: All right.

THE COURT REPORTER: Would you raise your right hands, please, if you have not been sworn.

(Five witnesses sworn.)

THE COURT REPORTER: Thank you. And print your names, please.

CHAIRMAN SEWELL: State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

The Applicants are asking the State Board to approve a 34-bed comprehensive physical rehabilitation hospital in Edwardsville, Illinois. The cost of the project is approximately 26 million, and the expected completion date is October 31st, 2021.

Should you approve this project, Anderson Hospital has submitted Exemption E-033-19 to discontinue their 20-bed comprehensive physical rehab unit at Anderson Hospital in Maryville.

There was no public hearing requested, and several letters of support have been received. No opposition letters have been submitted.

As noted, the Applicants do not meet all of the criteria of the State Board.

Thank you.

CHAIRMAN SEWELL: All right.

Any comments for the Board?

MR. PAGE: Yes, we do.

Good afternoon. I'm Keith Page, president

and CEO of Anderson Hospital in Maryville. I'm pleased to present our project, the establishment of a 34-bed rehabilitation hospital in Edwardsville.

With me today are Jason Zachariah, president of Kindred Rehabilitation Services, a division of Kindred Healthcare, and our joint venture partner; Lisa Klaustermeier, chief nursing officer, Anderson Hospital; Brian Samberg, division vice president, Kindred Healthcare; and Ralph Weber, our CON consultant. Others from Anderson and Kindred are also with us today to answer your questions if we need their input.

The proposed Anderson Rehabilitation Hospital will be dedicated to comprehensive physical rehabilitation on a site owned by Anderson Real Estate. The site is adjacent to the Anderson ASTC now under construction following approval of this Board this past December. The new hospital will replace the existing 20-bed rehabilitation unit in our hospital in Maryville.

The site of the project is about 5 miles from Anderson Hospital in Maryville. The proposed project is a joint venture with Kindred

Healthcare. Kindred has been a partner with us in the operation of our rehabilitation unit for the past 15 years.

I will first provide a little background on Anderson Hospital, then describe our project and the need in the communities we serve. I know it is of interest to the Board to understand how our project compares with the BJC/Encompass project, so I will address that, focusing on the differences and the merits of our project. Following my comments, Mr. Weber will briefly respond to the State report's negative findings and explain the rehabilitation impairment code methodology used in estimating demand.

Southwestern Illinois Health Facilities, Inc., d/b/a Anderson Hospital, is a 154-bed community hospital providing medical/surgical, ICU, obstetrics, and comprehensive physical rehabilitation services.

We are located in HSA 11, the source of 87 percent of our inpatient admissions. We are a significant provider of Medicaid service, with 20 percent of our patients on Medicaid. An additional 52 percent are on Medicare.

Three years ago Southwestern Illinois Health Facilities acquired Staunton hospital, a critical-access hospital located 24 miles to the north, as part of our commitment to the delivery of high-quality health care services extending into the rural areas of southwestern Illinois.

Now to address the need for the project. During the past two years, the only two other hospitals providing comprehensive inpatient rehabilitation care in Madison County closed their units. They are Gateway Regional Medical Center in Granite City, which closed 14 rehab beds, and OSF St. Anthony's Hospital in Alton, which closed 24 beds. In their last year of operation, they provided a combined 3500 days of rehabilitation care.

Over 70 percent of our residents of our planned service area who receive inpatient rehabilitation following hospitalization for medical and surgical care are now hospitalized out of state in St. Louis. 70 percent. This is about 900 patients per year. Our project will provide the facilities and services to keep a portion of these patients near their homes in Illinois.

The leaders of several smaller hospitals in our area have come to us, asking for Anderson Hospital to invest in developing our rehabilitation service so that their patients have access to enhanced rehabilitation care and can remain in Illinois.

Several hospitals have written in support of our permit application, including St. Anthony's, which closed their rehab unit, Carlinville Area Hospital, Jersey Community Hospital, and our affiliated Community Hospital of Staunton. No one has opposed this project. We are especially pleased with the support of our project by St. Elizabeth's Hospital, the only other hospital currently providing rehabilitation services in HSA 11.

Our permit application also documents that there are many residents of our service area who qualify for acute in-hospital rehabilitation but either receive that care in lower intensity nursing homes or do not receive that care at all. That totals an additional 889 patients. The estimate comes from a rigorous analysis using the system of rehabilitation impairment codes

developed by the US Centers for Medicare and Medicaid Services.

These two factors, the outmigration of patients to St. Louis and the unrealized need quantified by the rehabilitation impairment code analysis, document two separate access-to-care issues. These access issues are additive to the State's calculated deficit of seven rehab beds in HSA 11.

Now to compare our application to that submitted by BJC/Encompass. There are several factors that distinguish our projects from one another.

First, our location is in Madison County, is much closer to the populations previously served by the closed rehabilitation services at Gateway Regional Medical Center and St. Anthony's Hospital in Alton. Our site in Edwardsville is 17 miles from Gateway Hospital and 22 miles from St. Anthony's in Alton. The site of the BJC/ Encompass project in Shiloh is farther from these two hospitals, 21 miles and 37 miles, respectively. Our location is centrally located and ideal for serving these patients formerly

cared for in Granite City and Alton.

I would like to utilize a map to clarify some geography related to our project, first point out that HSA 11 includes four counties, Madison County, Clinton County, St. Clair County, and Monroe County. The Mississippi River and the St. Louis locations are also shown.

Second, the BJC/Encompass location is in St. Clair County, to the south of Madison County. St. Clair County is not a part of the service area for Anderson Rehabilitation Hospital. Our location for Anderson Rehabilitation Hospital remains in Madison County.

Madison County is the primary service area, with a population of 272,000. The secondary area to the north includes zip codes in Macoupin, Jersey, Montgomery, and Bond Counties, which have a combined population of 117,500. Consequently, our service area is farther to the north than the area for the BJC/Encompass facility.

Combined, our Madison County primary service area and the zip codes to the north in our secondary service area are projected to be the source of 90 percent of our rehabilitation

patients.

Third, Anderson Hospital has been operating inpatient rehabilitation services in the area. We are not coming from out of state but have been providing these services for 15 years. We are proposing a new hospital that adds 14 beds to our existing 20-bed service.

Finally, Anderson's commitment to providing care for Medicaid patients. As I mentioned, 20 percent of our patients are on Medicaid. We participate in the major Illinois Medicaid contracts, and Anderson Rehabilitation Hospital will continue the practice to take Medicaid patients now in effect at Anderson Hospital.

Before closing, let me talk about our partnership with Kindred. We are so pleased to have them as a partner and benefit from their extensive expertise in rehabilitation care. Kindred Healthcare is a nationally recognized health care services company based in Louisville, Kentucky, with annual revenues of approximately $3.3 billion.

Kindred, through its subsidiaries, has

approximately 35,700 employees providing health care services in about 1800 locations in 45 states, including owning and operating 74 long-term acute care hospitals -- 6 of those in Illinois -- 22 inpatient rehabilitation hospitals, and 11 subacute units. Kindred manages another 99 hospital-based inpatient rehabilitation units. Eight of these are in Illinois.

Kindred provides contract rehabilitation service for almost 1600 skilled nursing/long-term care sites of service. It is ranked as one of Fortune magazine's most admired health care companies for nine years. Kindred's mission is to help patients reach their highest potential for health and healing with intensive medical and rehabilitative care through compassionate patient experiences.

A presentation of Kindred's outstanding quality outcomes for patient rehabilitation within its comparable rehabilitation hospitals across the US is included in the "Purpose of the Project" section of our permit application.

In closing, I thank the staff for their time and technical assistance as we developed our

permit application. I'd point out that there was no opposition to our project, which is unusual in Illinois when there is a proposal to establish a new health care service. It is even more unusual that two competing projects submitted at the same time for the same service have not opposed each other. That is testimony to the access issues at play and the need for additional rehabilitation services in HSA 11 to keep Illinois residents in Illinois for their health care.

Thank you for your time and attention. I now ask Mr. Weber to provide our response to the State report negative findings.

MR. WEBER: Good afternoon. I'm Ralph Weber, CON consultant for Anderson/Kindred.

It has been a long day, so I will try to be brief in covering the three negative findings on the project. But, first, I echo Keith's thanks to the staff for their work with us on technical assistance during the application process.

The State Board cites three negative findings.

First, one negative relates to the State's determination of need and their calculation of the

deficit of seven rehabilitation beds in HSA 11. The proposed 34-bed project adds 14 beds, just 7 more than the State's calculated deficit. Anderson Hospital's 20-bed inpatient rehabilitation unit in Maryville will be closed after the opening of the 34-bed hospital, so the proposed project is a net addition of 14 beds, a relatively small incremental increase.

The State's formula recognizes that there is outmigration and that residents of the HSA are getting care but elsewhere, reducing the bed need within the HSA area. However, for HSA 11, most of this outmigration is to Missouri and St. Louis in particular. Our analysis in the permit application showed that there are about 900 residents of the project's planning area who traveled to Missouri for their rehabilitation care last year. We believe this is a significant volume of patients who would benefit from access to more rehabilitation services in HSA 11.

Our permit application also quantifies a volume of patients who qualify for needed comprehensive physical rehabilitation in a hospital but either do not receive that care or

receive a different level of care in a nursing home. This is independent and separate from the number of patients who receive care in Missouri.

Our calculations use a system called rehabilitation impairment codes developed by the US Centers for Medicare and Medicaid Services. We matched these codes to hospitalizations for medical and surgical care provided, which show that there were over 25,800 patients from the planning area last year who qualified for acute rehabilitation after their hospital medical/surgical stay. Based on a national experience rate that only 8 percent of those who qualified actually convert to care in a rehabilitation hospital, that would mean 21,000 -- I'm sorry -- 2177 from the planning area who should have rehabilitation care.

Subtracting the 1288 patients who received care from our area results in a net of 889 patients who needed hospital rehabilitation but did not receive it. And I hope, Dr. Martell, that's responsive to your question earlier.

This is the same -- I'd like to go back in history a little bit, five years, and maybe --

Senator Demuzio and Mr. Sewell, you may remember this project.

This is the same model that Brian Samberg of Kindred -- that Brian -- and I used five years ago to support establishing a 17-bed rehabilitation service at Northwest Community in Arlington Heights. The Health Facilities and Services Review Board approved that project even considering strong opposition by The Rehabilitation Institute of Chicago, which is now the Shirley Ryan AbilityLab, and Alexian Brothers Medical Center. RIC ran the unit at Alexian Brothers. The opponents claimed that the Northwest Community project would reduce the volume significantly at Alexian Brothers.

In fact, a few months ago I looked back and found that that did not occur. As we report on page 100 of the permit application, over the past five years the volumes at Alexian Brothers did not decline but have remained relatively constant. Meanwhile, Northwest Community's new rehabilitation service grew to capacity, and a year ago last month -- a year ago last month they added 16 beds to their unit under the 20-bed

rule. This history shows that the rehabilitation impairment code analysis is a reliable planning tool for projecting need for hospital beds, rehabilitation beds.

The visual board shows how these components of need relate to the project. Anderson Hospital's existing volume of about 400 admissions a year, plus the 889 patients from the rehabilitation impairment code model, plus retaining not all but two-thirds of the patients from our area who go to Missouri, that shows a collective opportunity for an annual 1889 rehabilitation patients. Anderson/Kindred, our project, forecasts a conservative volume of 816 patients after completion of the project.

The HSA today has only 36 comprehensive physical rehabilitation beds, serving a resident population of 614,000 people, and that 36, by the way, counts the 16 at St. Elizabeth's Hospital, which they testified earlier today they're planning to close their unit if these two projects are approved and convert that to medical/surgical services.

HSA 11 and HSA 8 have the lowest ratios of

beds to population in the state, and that's shown on this chart. Each of the bars -- each of the HSAs shows as one bar on this chart, the 11 HSAs, the 11 bars. The height is the ratio of beds to population. You can see that HSA 11 and HSA 8 in the far northeast corner of the state are the two lowest, only half of the statewide average. This is indicative of an access-to-care issue and helps explain the exodus of patients to rehabilitation hospitals outside the area. More beds and comprehensive rehabilitation services are needed in the area.

So all of these analyzes relate to that seven-bed issue, which we don't take lightly, but we think that, supplemented with this other information, is reason for the Board to say, "Yes, that makes sense; the project makes sense."

Now for the remaining two negative findings -- and I'll be shorter. The project does not meet the hundred-bed minimum size for rehabilitation hospitals. Similar to the BJC project, our project is scaled to meet the needs of Anderson Hospital's existing rehabilitation program plus a portion of the unmet needs of

patients migrating -- and patients migrating to Missouri.

According to the State inventory, there are four freestanding rehabilitation hospitals in Illinois. Only two of the four have a hundred beds or more, Chicago's Shirley Ryan AbilityLab, which is huge, and the Marianjoy Hospital in Wheaton, which has exactly 100. Throughout the US, Kindred owns and operates 22 rehabilitation hospitals. None exceed the hundred beds, yet all 22 provide significant services in their communities and all are viable.

A hundred beds has been a State standard for a long time but is not the norm. It may have been a standard for urban areas when lengths of stay were much longer. Part of the reason for a hundred beds could have been to concentrate a base of sufficient patients to be able to spread fixed administrative costs, such as human resources, planning, and finance. And now, with these functions being centralized in hospital systems, individual hospitals can be smaller and benefit from shared system operational costs. These economies of scale apply to the Anderson/Kindred

project and to the BJC/Encompass projects.

The third negative addresses the physician commitment letters. We provided letters from 48 physicians documenting 190 committed referrals. That's about half of Anderson Hospital's rehabilitation admissions in 2018.

Honestly, it was a difficult process to get physicians -- most of whom are not on the Anderson staff -- to spend their staff time documenting their referrals and the zip codes of their patient residences. We made the best effort we could. And if this is not complete, we believe that the demand analysis using the rehabilitation impairment codes adequately fills the gap on justifying full utilization.

So in summary, this project is the expansion of an existing service at Anderson Hospital in an area with one of the lowest ratios of rehabilitation beds to population in Illinois. I also just noticed that this HSA has 5 percent of the population of the state and 2 percent of the rehabilitation beds.

The project meets 16 other standards and dozens of subcriteria, including not creating

duplication or maldistribution of service or having a negative impact on other area providers. There is no opposition to the project.

Anderson Hospital and Kindred Healthcare have been active in providing this service in southwest Illinois and request your approval to enhance their delivery of rehabilitation care.

Thank you for your attention.

CHAIRMAN SEWELL: I wanted to make a couple of comments about the charts there that you had just before that one.

Could you put that back up?

Yeah, that one.

The first one is about number one. Those -- for our purposes, as the Planning Board, your plans to either discontinue or not discontinue the facility in Maryville is really not relevant because it's in a different planning area.

It's relevant to you as the manager of multiple facilities, but it's not relevant to us in terms of bed capacity and planning area because it's in a different planning area.

MR. WEBER: No -- I'm sorry. Finish.

CHAIRMAN SEWELL: No, go ahead --

MR. WEBER: Well, it's --

CHAIRMAN SEWELL: -- if I'm wrong.

MR. WEBER: It -- yeah.

Maryville, the current location, is in the middle of Madison County, which is in the middle of HSA 11.

CHAIRMAN SEWELL: Oh, okay. Well, I was wrong about that.

MR. WEBER: So it is very much in that area. And Edwardsville is only 5 miles away from Maryville, from Anderson at Maryville. So they're really very close to each other, and both are in Madison County, and both are in HSA 11.

CHAIRMAN SEWELL: Okay. Well, I want the Board to disregard the comments I just made.

Okay. Now, on number two on this chart, your need approach using rehabilitation impairment code analysis, while it may be valid and it may have even been established as relevant because of some things in the past, it's not what the State agency uses to get at the need for these beds.

So, you know, I think sort of offline or in another type of setting you probably need to

help us maybe change our policies with respect to how we project bed need of rehab. But that -- that may be valid, but it's not relevant to what we do because we have a historical utilization approach.

So those are the two things I just wanted to put on the -- no, the one thing. The first thing I put on, I took it back.

MR. WEBER: Well, as to the second thing, you know, when we bring permit applications, if you don't comply exactly to a requirement, we like to bring other information that's relevant.

CHAIRMAN SEWELL: Sure. No, it's helpful.

MR. WEBER: And by bringing something that, you know, the Federal government adapted to be current -- not that they're right all the time, but the Center for Medicare and Medicaid Services have a very good system. And that's why I went into the detail about the project that we worked on five years ago, because that -- it's not hocus-pocus numbers. It's very relevant to planning for rehabilitation care, and it really worked very nicely with that.

So, yeah, it's not the formula the State

uses, but I do think it's very relevant to the Board's consideration today.

CHAIRMAN SEWELL: Sure.

Questions?

(No response.)

CHAIRMAN SEWELL: No questions?

(No response.)

CHAIRMAN SEWELL: All right. Roll call.

MR. ROATE: Thank you.

Motion made by Dr. Martell; seconded by Dr. Murray.

Senator Demuzio.

MEMBER DEMUZIO: Yes. I'm going to go ahead and vote yes based upon getting close to most of the criteria.

You know that there's the need -- okay? -- or the excess, but I am going to go ahead and vote yes based upon your testimony and the Board report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: I'm going to vote a hesitant yes again on this because of the formula; again, taking a look at some of the area that's

going to be uncharted in terms of our State code but understanding that they have documented need.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: I'm going to vote yes based on the testimony.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: I'm going to hesitantly vote yes based on the testimony and the calculations that showed need.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Based on the testimony, yes.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: I vote no because of the planning area need criterion.

MR. ROATE: That's 5 votes in the affirmative, 1 vote in the negative.

CHAIRMAN SEWELL: Thank you.

MR. WEBER: Thank you.

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

MR. CONSTANTINO: Mr. Sewell, we need to hear E-033.

CHAIRMAN SEWELL: I'm sorry?

MR. CONSTANTINO: We need to hear E-033, the exemption.

CHAIRMAN SEWELL: Yes.

It's been approved.

She told me to say that.

- - -

CHAIRMAN SEWELL: Okay. So now we go to C-03, Project E-033-19, Anderson Hospital in Maryville.

So I need a motion to approve this project to discontinue a 20-bed physical rehabilitation category of service.

MEMBER SLATER: I move to approve.

MEMBER DEMUZIO: Second.

CHAIRMAN SEWELL: Okay. They're already sworn in.

Did you want to say anything about the State agency report?

MR. CONSTANTINO: No, sir.

CHAIRMAN SEWELL: Okay. Any presentation on this?

MR. WEBER: Just -- no presentation.

But may I just make one clarification? That the discontinuation, as we requested in the permit application, would take effect upon the opening of the new rehabilitation hospital beds.

CHAIRMAN SEWELL: Okay.

MR. WEBER: Obvious, but I don't want to get caught up in --

CHAIRMAN SEWELL: No, I think that needed

to be said.

MR. WEBER: Okay.

CHAIRMAN SEWELL: Any questions by the Board?

(No response.)

CHAIRMAN SEWELL: Okay. The roll call.

MR. ROATE: Thank you, sir.

Motion made by Mr. Slater; seconded by Senator Demuzio.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the fact that the closure will happen at the time of the opening of the new facility.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on the staff report and testimony.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: I vote yes.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

MR. PAGE: Thank you.

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

CHAIRMAN SEWELL: I'm sorry. I'm going to call the next project in just a second.

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

- - -

CHAIRMAN SEWELL: Please forgive me for the delay.

Okay. Next on the agenda is H-06, Project No. 19-028, Fresenius Medical Care Metropolis in Metropolis.

May I have a motion to approve this project to add two ESRD stations to an existing eight-station ESRD facility in Metropolis.

MEMBER DEMUZIO: Motion.

CHAIRMAN SEWELL: Is there a second?

MEMBER SAVAGE: Second.

CHAIRMAN SEWELL: All right. Already sworn in.

State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

The Applicants are asking the State Board to approve the addition of two stations to an existing eight-station facility in Metropolis at a cost of $53,000. Expected completion date, May 31st, 2020.

No public hearing was requested. No letters of support or opposition were received by the State Board.

I would like to point out to the Board

that the facility is not at target occupancy; however, in these rural areas the Board has historically allowed additional stations even though the facility may not be at target to make access to this service in daylight hours.

Thank you, sir.

CHAIRMAN SEWELL: Thank you.

Do you have a presentation?

MS. WRIGHT: Just briefly. Good afternoon.

I want to thank all of you for your time here today and thank the Board staff for their review of this project.

It did meet all the criteria, so I'd be happy to answer any questions you have.

THE COURT REPORTER: Could you state your name for the record, please.

MS. WRIGHT: Lori Wright.

CHAIRMAN SEWELL: Do we have questions?

(No response.)

CHAIRMAN SEWELL: Seeing none, a roll call vote.

MR. ROATE: Thank you, sir.

Motion made by Senator Demuzio; seconded

by Ms. Savage.

Senator Demuzio.

MEMBER DEMUZIO: I vote yes, based upon the staff report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Pardon me.

Sorry.

MR. ROATE: You --

MEMBER MARTELL: Yes.

MS. AVERY: Sorry.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: I vote yes based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Based on the State staff report, yes.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: Yes, based on the State agency report.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

MS. WRIGHT: Thank you.

CHAIRMAN SEWELL: Approved.

- - -

CHAIRMAN SEWELL: Next on the agenda is H-07, Project No. 19-029, Blessing Hospital Ambulatory Surgery Treatment Center in Quincy.

May I have a motion to approve this project to relocate on an existing multispecialty ASTC in Quincy.

MEMBER SLATER: I move to approve.

CHAIRMAN SEWELL: Is there a second?

MEMBER DEMUZIO: Second.

MEMBER SAVAGE: Second.

CHAIRMAN SEWELL: All right.

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

(Four witnesses sworn.)

THE COURT REPORTER: Thank you. And please print your names.

CHAIRMAN SEWELL: State agency report.

MR. CONSTANTINO: Thank you, Mr. Sewell.

Blessing Hospital is asking the Board to approve the relocation of an existing multispecialty ASTC with three operating rooms and three procedure rooms currently in an existing medical office building in Quincy to the campus of Blessing Hospital and connected to the hospital by

a walkway. The new site is approximately two minutes from the existing site.

Total cost of the project is 21.4 million, and the expected completion date is January 31st, 2022.

A public hearing was conducted on August 19th in Quincy by the State Board. No letters of opposition have been received, and there were several letters of support that have been submitted and are included in your packet of information.

As noted in the report, Blessing Hospital did not meet all the State Board's criteria.

I'd like to take just one minute to comment on the comments that have been made about the application.

Over the years Blessing Hospital has submitted over 45 applications to this certificate of need Board -- that's since 1975 -- as certificate of permits. Not once was Blessing Corporate Services ever an Applicant on those applications. I can't tell you why. I don't know why.

In the case of this project, Blessing

Hospital is the licensee for this ASTC. It owns the property, it owns the building, and is responsible for the debt on the project and is issuing the bonds.

We did not feel it need -- Blessing Health Ser- -- or Blessing Corporate Services needed a Co -- to be a Co-Applicant.

The second thing I'd like to point out is regarding the physician referral letters. Historically on any relocation project we rely upon historical utilization at the facility.

In this case, this ASTC has come before you in the last nine months. We had testimony under oath that stated -- from Quincy Medical Group -- that utilization at this existing ASTC would not change once Quincy Medical Group became operational. That is the reason those weren't requested.

Thank you, Mr. Chairman.

CHAIRMAN SEWELL: Okay. My head is spinning.

MR. CONSTANTINO: So was mine.

CHAIRMAN SEWELL: And this is to you, Mike: What is the significance of the -- who the

Applicant is and whether or not there's a Co-Applicant?

MR. CONSTANTINO: The most important thing for us is the licensee.

CHAIRMAN SEWELL: I see.

MR. CONSTANTINO: That is who IDPH is responsible to and for.

CHAIRMAN SEWELL: Okay.

MR. CONSTANTINO: Okay? We require co-applicants when they guarantee the debt.

CHAIRMAN SEWELL: I see.

MR. CONSTANTINO: I don't know why Blessing Corporate Services was never made a Co-Applicant. I can't tell you why that decision was made.

It was Ray's responsibility and evidently he had information that didn't require them to be a Co-Applicant.

CHAIRMAN SEWELL: Ray -- Ray --

MR. CONSTANTINO: We have other hospitals --

CHAIRMAN SEWELL: -- Ray Passeri?

MR. CONSTANTINO: Yes.

CHAIRMAN SEWELL: Oh. This is a former

administrator of this.

MR. CONSTANTINO: There are other hospitals in the state where their sole corporate parent is not co-applicants on the applications.

I don't know why those decisions were made, but we've continued to follow it.

CHAIRMAN SEWELL: Does the Applicant have any insight into all this?

MS. AVERY: Probably not.

But what we will do is just look at it for future to make sure that we're consistent with it. We'll either change it to say it's not necessary or change it to say it's necessary. That will make it cleaner.

So we'll work on that. But for now it's not --

MR. CONSTANTINO: We never had this issue come up before, Courtney.

MS. AVERY: Right. So now it's not really applicable.

CHAIRMAN SEWELL: Okay.

Whatever presentation you were going to make before this.

MS. KAHN: Okay. Well, good afternoon.

It's good to be here.

My name is Maureen Kahn, and I am the president and CEO of Blessing Hospital. And today I am here with Julie Brink, the chairman of Blessing Hospital's board; Pat Gerveler, the CFO; and Betty Kasparie, who is our compliance officer, and she's responsible for writing all of our certificate of need, and I think she's written all 40 of them.

Thank you for the opportunity to present today and thank you for the Board staff who worked on our application for all their work.

Let me first tell you a little bit about Blessing Hospital, and then I will address the one negative finding that we did receive.

Blessing Hospital is located in Quincy, Illinois. We're about 285 miles southwest of where we are gathered here today. We are a full-service acute care hospital, and, you know, at least when you think about surrounding us, there's not a hospital with a hundred beds in any direction a hundred miles from us.

So we sit in a geographic area with some degree of isolation, and we're surrounded

primarily by critical-access hospitals, and then we go a little bit further before we get into tertiary and quaternary hospitals. Blessing provides a comprehensive list of services for our patients, up and including open-heart surgery, mental health services, trauma services.

In addition to that, we also have a college on our campus where we teach -- we have a nursing school, we have a school of radiology, laboratory, and we also train respiratory therapists and medical record specialists. So we try and make sure that we have a workforce of the future.

We're a 327-bed, not-for-profit, sole community hospital. Our board of trustees consists of community volunteer members and physicians who represent the needs of the region. We are the largest employer in Adams County, and we have served the health care needs of the people of west central Illinois, northeast Missouri, and southeast Iowa for 144 years.

I believe that Blessing Hospital is well-known by your staff and certainly by the residents of our area to be a high-quality

provider of health care services.

The project, as described in the CON Application 19-029, is to relocate the hospital's existing ASTC from leased space at 1118 Hampshire to the hospital's campus. This is simply a relocation and modernization of the three operating and three procedure rooms to the Blessing Hospital campus.

There has been widespread community support for this relocation. We've been very transparent with the medical staff and the greater Quincy community.

I personally conducted three open meetings with the medical staff, sharing with them the plans of the building, asking them for their input, any changes, any suggestion they had, and I also conducted three community meetings with the community, asking them the same thing, sharing with them the plans, asking them what they would like to see in the building. And then I conducted a meeting with the chamber of commerce and all of our business leaders and showed them the plans and asked them for their input, suggestions, anything that they would like to see.

As with all the forums that we conducted, we received positive support, and, also, we received letters and testimony supporting the project.

In addition to that, you will see in our project file support letters from our legislators, Senator Jil Tracy, Randy Frese; our mayor, Kyle Moore; Jerry Kruse, the dean of the SIU School of Medicine; the Adams County Ambulance, the Public Health Department of Adams County, numerous Quincy-area employers, various not-for-profit organizations, the United Way, Quincy-area health organizations, many Quincy physicians, the Blessing-Rieman College of Nursing & Health Sciences, and Quincy University.

We are here today to respectfully ask the Review Board to allow us to relocate our existing three operating rooms and three procedure rooms from 1118 Hampshire to our hospital campus.

The staff report found that Blessing met 22 of the 23 criteria, so I want to take some time to address the 1 negative finding.

We believe the staff report to be very positive. The one negative finding was the number

of recovery stations, 28. It exceeds the standard by 4 stations, so we have 28 instead of 24.

Importantly, I want you to remember the project is fully compliant with the State standards for cost and square footage. But we were able to identify and put into that project an additional four recovery stations, and we did so for three reasons: One, to reflect the localized needs for patient care; the second was considering optimizing patient flow; and the third was to look at the evolving patient care trends.

So when we think about the localized needs for patients, when we designed this unit, we designed our recovery spaces to be prep and recovery rooms. They were not just to be recovery spaces. We wanted them to be multipurpose when we did them. We do have some Phase 1 recovery, but primarily our rooms are to be multipurpose.

We also wanted to recognize the fact that our patients in our area -- if you look at Illinois, 62 percent of Illinois adults are overweight, 25 percent of them being obese, and in the rural areas we have the highest level of obesity. Adams County ranks seventh in obesity.

We designed two of our prep and recovery rooms specifically for bariatric patients, so we made sure that the room design and the bathroom and toilet facilities in those rooms would be specific for bariatric patients.

We also made sure that we had two isolation rooms. Because of the importance today of infection, we wanted to make sure that -- if we had a patient who could be at risk, we wanted to protect other patients from the transmission of infection.

We also wanted to make sure that we had optimal flow, so that we had enough rooms. As Medicare moves more and more patients to the outpatient environment, sometimes recovery times are a little bit longer. We wanted to make sure we had enough room to give patients the time appropriate to recover before we move them out of the center, and we didn't want to block up the operating rooms, which is the most expensive time in the surgery center, and we wanted to make sure we had the space to allow people to recover.

And so that was our reason for adding these four additional spaces, was to give our

surgeons the right amount of time in the operating room, give our patients the right amount of time in the recovery space so we could send them home safely. We believe that our design best meets the needs of our patients, our physicians, our staff, our employers, and our payers.

This project has the support of the greater Quincy community and its civic leaders. I respectfully encourage the Illinois Health Facilities and Review Board to approve this relocation of the Blessing surgery center.

Thank you.

And Julie.

MS. BRINK: Thank you very much.

My name is Julie Brink, and I serve as the president of the Blessing Hospital board of trustees.

Since the inception of the surgery center market in Quincy and continuing until now, there has only been one ASTC in town. That surgery center was first owned by QMG and then sold to Blessing Hospital, which continues to own the center.

Since acquiring this ASTC until now,

Blessing has partnered with QMG, paying rent for the space in their building where the surgery center was located when it was purchased and, also, contracting with QMG to continue its management of the center as a hospital-based department.

Now that QMG has been awarded a permit to build its own, competing ASTC in Quincy, the Blessing Hospital board had to make decisions, decisions that included where the Blessing ASTC should hereafter be located. Decisions -- excuse me.

When Blessing purchased the center in 2006, the location was already determined, as it was in the middle of the QMG medical office building. Continuing to be located in a competitor's building is not a viable option. To use an imperfect analogy, there are no Burger King in McDonald's.

In assessing options it quickly became apparent to the Blessing Hospital board that locating on the hospital campus was the obvious and best choice. Better yet, with a walkway to the hospital and its operating rooms.

The 50/50 ownership that Blessing had previously offered QMG as an alternative to having two ASTCs in Quincy was rejected by QMG. Instead of deepening our preexisting partnership, QMG was committed to competing, and the Review Board ultimately embraced competition through its approval of their application for a second surgery center in Quincy.

QMG argued and the Review Board agreed that competition, rather than collaboration, would be beneficial for the greater Quincy community and its health care. Blessing accepted this determination and turned to the necessary decisions in this new paradigm of competition. We chose not to relitigate but to accept the decision and to move forward.

Approval of this CON will not only allow Blessing to effectively compete in the newly competitive ASTC market in Quincy but also enhance patient care through a more contemporary ASTC, one that reflects standards of today rather than of 20 years ago, when the current surgery center was built out in the QMG medical office building.

This project makes good sense for the

impacted community and its health care needs, and I respectfully urge approval of CON Application 19-029.

Thank you.

MS. KAHN: Thank you for your time. Are there any questions that we may answer for you?

CHAIRMAN SEWELL: Anyone have questions?

(No response.)

CHAIRMAN SEWELL: Roll call.

MR. ROATE: Thank you, sir.

Motion made by Mr. Slater; seconded by Senator Demuzio.

Senator Demuzio.

MEMBER DEMUZIO: I vote yes, based upon the testimony I've heard and the staff report.

MR. ROATE: Thank you.

Dr. Martell.

MEMBER MARTELL: Yes, based on the staff report and testimony.

MR. ROATE: Thank you.

Dr. Murray.

MEMBER MURRAY: Yes, based on the staff report.

MR. ROATE: Thank you.

Ms. Savage.

MEMBER SAVAGE: Yes, based on the staff report and testimony.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Based on the staff report and the testimony, yes.

MR. ROATE: Thank you.

Chairman Sewell.

CHAIRMAN SEWELL: I vote yes in spite of the extra recovery rooms because I think the Applicant gave a good explanation as to why they needed them.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

MS. KAHN: Thank you.

CHAIRMAN SEWELL: The project's approved.

MS. BRINK: Thank you.

THE COURT REPORTER: Please leave your remarks with Mike.

MR. CONSTANTINO: Thank you.

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

- - -

CHAIRMAN SEWELL: I'm getting a request for a Board discussion or clarification on -- I'm trying to find the project.

It's the -- no, it's Anderson --

MEMBER MARTELL: No.

MS. AVERY: The Rehabilitation --

MEMBER MARTELL: The Rehabilitation Institute of Southern Illinois.

CHAIRMAN SEWELL: Really?

Yeah, the Shiloh project, Rehabilitation --

MEMBER SAVAGE: Institute.

CHAIRMAN SEWELL: -- Institute of Southern Illinois, Shiloh.

I'm getting a request for a Board discussion, a brief discussion, about that. And I think we are going to allow that unless the Board members have an objection.

MEMBER MURRAY: What are we --

CHAIRMAN SEWELL: So what are we talking about?

MEMBER MURRAY: What are we doing?

CHAIRMAN SEWELL: Who's got to discuss the issue?

MS. AVERY: I'll discuss it.

CHAIRMAN SEWELL: Okay. Go ahead.

MS. AVERY: Okay.

The counsel for the Applicants have requested that we look at the transcript to see the vote for Dr. Martell and the reason for the vote and make sure that there wasn't any comparative review.

They're saying so based on discrepancies with the 900 figure that was used in both presentations.

CHAIRMAN SEWELL: What's "the 900 figure"?

MS. AVERY: The 900 patients. Sorry.

That they used --

MEMBER MURRAY: The 900 patients from Illinois?

MS. AVERY: That are migrating out to St. Louis.

I think that's clarification but we don't -- so -- Court Reporter, can you go back and look at that for us, please?

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

THE COURT REPORTER: Mr. Roate said "Dr. Martell"; Dr. Martell said, "I'm going to be

a qualified no with the understanding that I have concerns about the projections and capacity."

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

CHAIRMAN SEWELL: Okay. So what of that?

MS. AVERY: And then the other vote was a reluctant yes, using the patient methodology that the Applicant used for Anderson?

MEMBER SAVAGE: That was me.

MS. AVERY: That was you.

CHAIRMAN SEWELL: That was Edwardsville.

MS. AVERY: Can you read those two -- three?

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

THE COURT REPORTER: Ms. Savage on that issue said, "I'm going to vote yes based on the testimony and the staff Board report as well as the project utilization I feel is better than the other proposal."

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

MS. AVERY: Back on the record, please.

MEMBER SLATER: It would seem to me anyone who has voted in the affirmative has the right to re -- make a motion to reconsider.

MS. AVERY: According to Robert's Rules.

MEMBER SLATER: It doesn't have to be the person who made the motion.

MEMBER DEMUZIO: Right.

MS. AVERY: Okay. Is there anyone who made a vote in the affirmative on this application that would like to make a motion to reconsider?

MEMBER MURRAY: On the Andersonville? Is that what you're talking about?

MS. AVERY: The Shiloh.

CHAIRMAN SEWELL: This is Edwardsville.

MS. AVERY: I'm sorry. The Edwardsville -- the question is the vote on The Rehabilitation Institute of Southern Illinois, was -- was there an issue of comparative review.

MR. ROATE: Would you like me to read the vote back, the vote record?

MS. AVERY: Yes.

MR. ROATE: The vote record for Project No. 19-021, Rehabilitation Institute of Southern Illinois, Shiloh, reads as: Senator Demuzio voted yes; Dr. Martell voted no; Dr. Murray voted yes; Ms. Savage voted yes; Mr. Slater voted yes; Chairman Sewell voted no. 4 votes in the affirmative, 2 votes in the negative.

MS. AVERY: Okay.

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

MS. AVERY: Dr. Martell.

MEMBER MARTELL: Yes.

MS. AVERY: So are we okay with your vote? Do you need to reconsider your vote even though it was a no?

Because of the language with the comparative review.

MEMBER MARTELL: I did not make that --

THE COURT REPORTER: I can't hear you. I'm sorry.

MEMBER MARTELL: I did not make that statement. That was made on the second application, on the second --

MS. AVERY: The comparative -- the comparative review language, the second application, for Anderson, was made by Savage, Ms. Savage?

THE COURT REPORTER: I can read it to you if you've like.

MS. AVERY: Okay. Would you again, please. I'm sorry.

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

THE COURT REPORTER: So the roll call for the first one, Shiloh:

"Motion made by Mr. Slater; seconded by Dr. Murray.

"Senator Demuzio.

"MEMBER DEMUZIO: I'm going to go ahead and vote yes, based on some of the testimony that I've heard today.

"MR. ROATE: Thank you.

"Dr. Martell.

"MEMBER MARTELL: I'm going to be a qualified no with the understanding that I have concerns about the projections and capacity.

"MR. ROATE: Thank you.

"Dr. Murray.

"MEMBER MURRAY: I'm going to vote yes based upon the testimony about patients presently cared for.

"MR. ROATE: Thank you.

"Ms. Savage.

"MEMBER SAVAGE: I'm going to vote yes based on the testimony and the staff Board report as well as the project utilization I feel is better than the other proposal.

"MR. ROATE: Thank you.

"Mr. Slater.

"MEMBER SLATER: Yes based on the testimony.

"MR. ROATE: Thank you.

"Chairman Sewell.

"CHAIRMAN SEWELL: I vote no based on the planning area need criteria.

"MR. ROATE: That's 4 votes in the affirmative, 2 votes in the negative."

Do you want me to read the next vote, then?

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

THE COURT REPORTER: This is the next vote:

"MR. ROATE: Motion made by Dr. Martell; seconded by Dr. Murray.

"Senator Demuzio.

"MEMBER DEMUZIO: Yes. I'm going to go ahead and vote yes based on getting close to most of the criteria.

"You know that there's the need -- okay? -- or the excess, but I am going to go ahead and vote yes based on your testimony and the staff

report.

"MR. ROATE: Thank you.

"Dr. Martell.

"MEMBER MARTELL: I'm going to vote a hesitant yes on this based on the formula and looking at some of the territory that's sort of uncharted in terms of our State code but understanding that they do have documented need.

"MR. ROATE: Thank you.

"Dr. Murray.

"MEMBER MURRAY: I'm going to vote yes based on the testimony.

"MR. ROATE: Thank you.

"Ms. Savage.

"MEMBER SAVAGE: I'm going to at this point vote yes based on the testimony and the calculations that showed need.

"MR. ROATE: Thank you.

"Mr. Slater.

"MEMBER SLATER: Based on the testimony, yes.

"MR. ROATE: Thank you.

"Chairman Sewell.

"CHAIRMAN SEWELL: I vote no because of

the planning area need criterion.

"MR. ROATE: That's 5 votes in the affirmative, 1 vote in the negative."

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

MS. AVERY: So both were voted -- when a comparative review was done, it was voted in the positive. So, therefore, the Chair has decided that the vote will stand and there was no problem and won't be a reconsideration of the vote.

But you still have an avenue to review, Administrative Judge review.

MR. SILBERMAN: Would it be appropriate to present one question? And if not, we respect the process.

We just want to make sure that we understand so we provide the right information to this body to understand the issue.

CHAIRMAN SEWELL: Yeah. Sure. Go ahead.

MR. SILBERMAN: And to be clear, this is not -- thank you for this opportunity. This isn't to challenge the decision. We want to come back; we want to provide the information that will allow the Board to comfortably address this issue.

The question was the concern seemed to be

the speculative nature of the 900 patients and the projections --

MS. AVERY: Use the microphone.

MR. SILBERMAN: My apologies.

The concern seemed to be the speculative nature of the 900 patients that we are serving on an annual basis in St. Louis and the impact that had on the projections.

And those 900 patients were based on the testimony presented to you, also relied on by the other Applicant, saying that 893 app- -- you know, people -- are leaving to St. Louis, and those are the patients that we're already serving.

And so it just confused us how it was too speculative for our project but sufficient for theirs -- not to challenge that but then so -- we don't know what information to provide to address that issue.

And that's our only concern, is we want to make sure that we provide the information to address that for the -- absolutely. We respect the process. We will adhere to the process.

But we aren't doing justice to any of you or our clients if we don't bring you the

information that will address those concerns.

MS. AVERY: Okay. So once we -- thank you, Mr. Silberman.

Once we receive the transcripts, go through it -- we'll expedite that portion, those two projects. We'll expedite those. And we'll get them to you and we can have a technical assistance meeting.

Okay?

MR. SILBERMAN: Thank you very much.

MR. MORADO: Thank you.

MS. AVERY: Great. We may bill you for it.

- - -

CHAIRMAN SEWELL: All right. Moving along, there are no applications subsequent to intent to deny.

There's no rules development.

There's no unfinished business, but there is other business, 2019 inventory of health care facilities and need determination and then 2020 meeting dates.

Who's talking?

MS. AVERY: Do you all still have the meeting dates?

CHAIRMAN SEWELL: Who's talking about the inventory?

MS. AVERY: Michael.

MR. CONSTANTINO: Yeah. Mr. Sewell, we need to have the Board approve the -- what we call the inventory updates.

CHAIRMAN SEWELL: Right.

MR. CONSTANTINO: This is a new estimate of need, an excess in the state of Illinois.

So if we can have a roll call vote.

CHAIRMAN SEWELL: Do we have those?

MEMBER MURRAY: They're in the --

MR. CONSTANTINO: Yes. They've been

submitted to you, yeah. They're on your --

MEMBER MURRAY: We have them.

CHAIRMAN SEWELL: Okay.

MR. CONSTANTINO: You've received them.

CHAIRMAN SEWELL: Yeah. They are on the disk.

MR. CONSTANTINO: You've received them. If you vote to approve them, they'll be posted on our website tomorrow.

CHAIRMAN SEWELL: Is there a motion?

MEMBER MURRAY: So moved.

CHAIRMAN SEWELL: Is there a second?

(No response.)

CHAIRMAN SEWELL: Is there a second?

MEMBER MARTELL: Second.

CHAIRMAN SEWELL: Any discussion on the motion?

(No response.)

CHAIRMAN SEWELL: This is voice vote, isn't it?

MS. AVERY: Yes.

CHAIRMAN SEWELL: All right. All in favor, aye.

(Ayes heard.)

CHAIRMAN SEWELL: Opposed?
(No response.)
CHAIRMAN SEWELL: Abstentions?
(No response.)
CHAIRMAN SEWELL: Okay. It is done.
Oh, wait a minute.
Mr. --
MEMBER SLATER: Did you want a roll call?
CHAIRMAN SEWELL: No.
MS. AVERY: We can do an aye vote.
MR. CONSTANTINO: They decided they want a voice vote.
CHAIRMAN SEWELL: You told me voice. I asked but she said voice.
Okay. Now, 2020 meeting dates.
MS. AVERY: Okay. You still have these. And I understand that some people may have a conflict. If you can just email me your conflicts, we'll work those out for 2020. Okay?
You need a motion.
CHAIRMAN SEWELL: On the meeting dates? We already did those.
MS. AVERY: All right. Thank you.
CHAIRMAN SEWELL: Okay. Before we

adjourn, I just want to make an editorial comment.

All of that time we spent on -- I believe it was exemptions -- we wouldn't need to do that here if we had a Chairperson. I am not the Chairperson. I'm just serving in that role on an interim basis.

The Governor's office has not picked a Chairperson. I think what happens is that the Board picks a Vice Chair. Is that right?

MS. AVERY: Correct.

CHAIRMAN SEWELL: And the Governor's office picks a Chairperson.

So, you know, if any of y'all have influence with the Governor's office, you're being inconvenienced by them not selecting a Chair because we spent a significant amount of time on exemptions, and we don't do exemptions here.

MS. AVERY: Well, let me clarify.

CHAIRMAN SEWELL: The Chair does them and then recommends --

MS. AVERY: The Chair has the authority.

The process that we use is that, when an exemption or permit renewal for the first time comes in, we send those to you via email, and we

ask if anyone has any questions about it. If not -- or conditions -- or if they want to refer to it to the full Board, then fine, and we put it on the agenda.

If not, the Chair has the authority to sign off on the exemptions and the first permit renewals.

And the -- you remember 1739 kind of changed it a little bit. But I think it will still be a little bit of status quo. We'll look into it and give you an update in October.

But for first-time permit renewals, yes. But some of those that are after that, they do have to come before the Board -- or unless a member asks to have the entire application presented before the Board. Then we just bring it to the Board.

And that's that one item -- agenda item on the -- one item on the agenda that says "Approval by the Chair." We still list them all, and the Chair does not sign off on them until after the Board meeting.

CHAIRMAN SEWELL: Okay. Any comments on that or questions?

(No response.)

CHAIRMAN SEWELL: All right. Is there a motion to adjourn?

MEMBER MURRAY: So moved.

MEMBER MARTELL: Second.

MEMBER DEMUZIO: Motion.

CHAIRMAN SEWELL: All in favor, aye.

(Ayes heard.)

CHAIRMAN SEWELL: Opposed?

(No response.)

CHAIRMAN SEWELL: Abstentions?

(No response.)

CHAIRMAN SEWELL: Our next meeting is the 22nd of October and it's here.

MS. AVERY: Yes, it is.

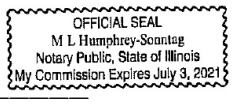
(Off the record at 5:14 p.m.)

CERTIFICATE OF SHORTHAND REPORTER

I, Melanie L. Humphrey-Sonntag, Certified Shorthand Reporter No. 084-004299, CSR, RDR, CRR, CRC, FAPR, and a Notary Public in and for the County of Kane, State of Illinois, the officer before whom the foregoing proceedings were taken, do certify that the foregoing transcript is a true and correct record of the proceedings, that said proceedings were taken by me and thereafter reduced to typewriting under my supervision, and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 16th day of October, 2019.

My commission expires July 3, 2021.



MELANIE L. HUMPHREY-SONNTAG
NOTARY PUBLIC IN AND FOR ILLINOIS

I

P

V

W