



DOCKET NO: H-05	BOARD MEETING: June 2, 2015	PROJECT NO: 15-005	PROJECT COST: Original: \$3,153,640 Modified \$2,898,522
FACILITY NAME: Presence Lakeshore Gastroenterology		CITY: Des Plaines	
TYPE OF PROJECT: Substantive			HSA: VII

PROJECT DESCRIPTION: The applicants (Presence Lakeshore Gastroenterology, LLC, Presence Holy Family Medical Center and Presence Health) are proposing to establish a limited specialty ambulatory surgical treatment facility in leased space at a cost of \$2,898,522. The anticipated project completion date is December 31, 2015.

Board Staff notes the State Board deferred project #15-005 from the April 21, 2015 meeting, due to a need for additional information regarding the project. The applicants have supplied the requested information, and request the following modifications to the previously submitted application. See Transcripts at the conclusion of this report.

The applicants submitted the following documents modifying the project. This modification is considered a Type B Modification:

- o Modified Project Costs and Sources of Funds, showing a **decrease** in the overall project cost 8%, from \$3,153,640, to \$2,898,522
- o Modified Charge Commitment page, identifying the surgical procedures performed at the hospital, with their current associated charges.
- o Modified Narrative Description, reflective of decreased project costs.
- o Modified Availability of Funds Page, showing the adjusted project costs
- o Modified Cost Space Requirements Page, reflective of the decreased cost per GSF.
- o Attestation of the Medicaid payor mix for Dr. Mahdavian's practice
- o Modified Lease statement for the proposed ASTC.

In addition the State Board asked that the State Board Staff to provide a Table of all ASTC's that provide Gastroenterology and their payor mix (patients). See **Table Nine** at the end of this report. There are 20 ASTC's that provide Gastroenterology. The average payor mix of these 20 ASTC's is as follows: Medicare 25.44%, Medicaid 2.69%, Other Public .67%, Private Insurance 65.85%, Private Pay 4.69% and Charity .67%. **Per the applicants Dr. Mahdavian's** patients are 5% Medicaid recipients, 36% Medicare and .5% Tricare.

Only **ONE** criterion is affected by this modification request (see below), resulting in a positive finding for this criterion. All other criteria remain unchanged from the Original State Board Staff Report. At the conclusion of this report are modification information and the April State Board Transcripts. The affected criterion is:

- 77 IAC 1120.140 (c) – Reasonableness of Project Costs

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- **The applicants** (Presence Lakeshore Gastroenterology, LLC, Presence Holy Family Medical Center, and Presence Health) are proposing to establish a limited specialty ambulatory surgical treatment facility at a cost of \$2,898,522 located in the Medical Office Building adjacent to Presence Holy Family Medical Center. Currently, Presence Holy Family Medical Center has 2 dedicated endoscopy procedure rooms, and should the proposed project be approved these 2 procedure rooms will no longer be used for endoscopy procedures. The intended use for the space to be vacated is ophthalmology procedure rooms.
- The proposed ASTC will be a limited specialty ASTC with two procedure rooms dedicated solely to performing endoscopy procedures. Presence Holy Family Medical Center will operate the ASTC as a joint venture with 51 % ownership, and the remaining 49% ownership will be held by Lakeshore Gastroenterology and Liver Disease Institute, S.C. The ASTC will be operated in leased space and the total cost of the project is \$2,898,522.

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- This project is before the State Board because the project establishes a health care facility (ASTC) as defined by the Illinois Health Facilities Planning Act. (20 ILCS 3960/3)

PURPOSE OF THE PROJECT:

- The applicants stated the following regarding the purpose of the project. *“The project will provide better access to endoscopy procedures in the community. Access to care and transportation are primary issues in the community served by Presence Holy Family Medical Center. The location of the proposed endoscopy center will provide easy access. It is on the PACE bus line, one mile from Metra and Presence Holy Family Medical Center offers a low cost Care A Van service to the location. One in five people in the community live below 200% of the federal poverty level, and 13% of those who responded to the Presence Holy Family Medical Center community health needs assessment reported they did not follow up with specialists because of cost. A free standing endoscopy center will provide a more affordable option to those serves. Colon cancer is the third most common cancer and the second leading cause of cancer-related deaths in the United States. Cancer is a leading age-adjusted cause of mortality in the service area. GI screenings, through endoscopy, are a valuable tool to identify and treat colon cancer in the early stages, saving lives. The bulk of patients served will reside within a 10 mile radius of the proposed facility.”*

PUBLIC HEARING/COMMENT:

- A public hearing was offered in regard to the proposed project, but none was requested. No letters of support were received and three letters of opposition were received from the following.
 - Anthony Grande, MD
 - David Yoon, MD

- Michelle Lipman, MD
- **One impact letter was received from Damon N. Havill Vice President, Business Development Advocate Lutheran General Hospital. Mr Havill stated Advocate Lutheran General Hospital “operates a high volume GI lab at our hospital spanning a continuum ranging from screening colonoscopies to ERCP and advanced therapeutic procedures. Our GI lab is located 2.9 miles and less than a ten minute drive from Presence Holy Family Medical Center. There is some overlap across the medical staffs of Presence Health and Advocate Lutheran General Hospital. Seven GI physicians on staff at Presence Health with offices within ten miles of Holy Family were also on staff and clinically active at ALGH. These seven physicians performed 4,497 procedures within our GI lab in 2014. Your letter dated January 14 did not contain details we would need to determine the impact of the project to ALGH First, an explanation of the rationale to discontinue and re-establish the two-room ASTC- e.g., change of address, change of ownership, etc. would provide helpful insight on the intent of the project. Second, a projection of case volumes by physician in the new center would provide us with assurance this is a replacement project and would not shift volume from other facilities within the service area.”**

NEED FOR PROJECT:

- To establish an ASTC an applicant must document that the proposed facility will improve access, will not result in unnecessary duplication of service, cause a mal-distribution of service (surplus of facilities) or have a negative impact on other ASTC facilities within the 45 minute geographic service area (“GSA”). There are a number of hospitals and ASTCs within this 45 minute GSA that provides gastroenterology services and there is unused capacity at these facilities. See Tables at the end of this report. This is a joint venture with a hospital and the hospital is discontinuing the gastroenterology service. Existing hospital financial aid policies will be in the affect at the new ASTC. However referrals to the joint venture are dependent upon the physicians’ referrals and historically ASTC’s are reluctant to accept Medicaid or charity care or self pay patients.
- There are 52 ambulatory surgical treatment rooms within 45 minutes (adjusted) of the proposed facility (See Table Seven). Of those 52 facilities 5 of the facilities are not yet operational. Of these 47 facilities 20 currently provide gastroenterology services (see Table Nine). Of these 20 facilities 15 currently have capacity to accommodate the workload proposed by this facility. In addition 12 of the ASTCs that currently do not provide gastroenterology service can add this service at any time without State Board approval until January 1, 2018. There are 27 hospitals within 45 minutes (adjusted) that provide gastroenterology service (See Table Eight). Of the five hospitals in which the applicants propose to remove cases to support the workload at the proposed facility, three of the hospitals will be negatively affected West Suburban Medical Center, Northwest Community Hospital, and Advocate Lutheran General Hospital (see Table Four below).
- The applicants **have attested** that Presence Holy Family will not, without first obtaining a CON permit, provide outpatient gastroenterology services as long as the proposed surgery center is in operation on the Presence Holy Family campus. However, it will provide gastroenterology services to an inpatient when medically necessary. In addition, if a patient is referred to Presence Holy Family for gastroenterology procedures because

the patient is not medically cleared to have such services performed in an outpatient setting, it will provide such services.

FINANCIAL AND ECONOMIC FEASIBILITY:

- The applicants are financially viable as evidenced by their balance sheet and the project is economically feasible as the applicants have sufficient cash to fund the project.

CONCLUSIONS:

- The applicants addressed a total of 22 criteria and have not met the following:

State Board Standards Not Met	
Criteria	Reasons for Non-Compliance
Criterion 1110.1540 (g) – Service Accessibility	There are existing facilities (ASTC and hospitals in the proposed GSA that are underutilized. Historical utilization at Holy Family does not justify the number of procedure rooms being requested.
Criterion 1110.1540 (h) – Unnecessary Duplication/Maldistribution	There are 52 ambulatory surgical treatment rooms within 45 minutes (adjusted) of the proposed facility. Of those 52 facilities 5 of the facilities are not yet operational. Of these 47 facilities 20 currently provide gastroenterology services. Of these 20 facilities 15 currently have capacity to accommodate the workload proposed by this facility. In addition 12 of the ASTCs that currently do not provide gastroenterology service can add this service at any time without State Board approval until January 1, 2018. There are 27 hospitals within 45 minutes (adjusted) that provide gastroenterology service and have capacity to accommodate the proposed workload. (see Tables at the conclusion of this report)

STATE BOARD STAFF REPORT
Project #15-005
Presence Lakeshore Gastroenterology

APPLICATION SUMMARY/CHRONOLOGY	
Applicants(s)	Presence Lakeshore Gastroenterology, LLC Presence Holy Family Medical Center, and Presence Health
Facility Name	Presence Lakeshore Gastroenterology
Location	150 N. River Road, Des Plaines, Illinois
Permit Holder	Presence Lakeshore Gastroenterology, LLC
Operating Entity/Licensee	Presence Lakeshore Gastroenterology, LLC
Owner of Site	Presence Healthcare Services
Application Received	February 3, 2015
Application Deemed Complete	February 4, 2015
Anticipated Completion Date	December 31, 2015
Review Period Ends	June 4, 2015
Review Period Extended by the State Board Staff?	No
Can the applicants request a deferral?	Yes

I. Project Description

The applicants (Presence Lakeshore Gastroenterology, LLC, Presence Holy Family Medical Center, and Presence Health) are proposing to establish a limited specialty ambulatory surgical treatment facility in leased space at a cost of \$2,898,522. The anticipated project completion date is December 31, 2015.

II. Summary of Findings

- A. The State Board Staff finds the proposed project does **not** appear to be in conformance with the provisions of Part 1110.
- B. The State Board Staff finds the proposed project appears to be in conformance with the provisions of Part 1120.

III. General Information

The applicants are Presence Lakeshore Gastroenterology, LLC, Presence Holy Family Medical Center and Presence Health. Presence Lakeshore Gastroenterology, LLC is owned 51% by Presence Holy Family Medical Center and Lakeshore Gastroenterology and Liver Disease Institute, S.C.

Presence Holy Family Medical Center is an Illinois not for profit corporation and operates as a 188 bed **long term acute care hospital** at 100 North River Road, Des Plaines, Illinois. Long-term care hospitals (LTCHs) are certified as acute-care hospitals, but long term care hospitals focus on patients who, on average, stay more than 25 days. Many of the patients in long term care hospitals are transferred there from an intensive or critical care unit. Long term care hospitals specialize in treating patients who may have

more than one serious condition, but who may improve with time and care, and return home. Long term care hospitals typically give services like comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. This is different than long term care. Long-term care usually refers to care that's basically custodial, like help with feeding or dressing, even if there's some health care given. Medicare doesn't cover this kind of care, which can be given in your own home or in various kinds of facilities, like assisted living facilities. LTCHs are hospitals that give inpatient services to people who need a much longer stay to get well.

Presence Health is an Illinois not for profit corporation and is the largest Catholic healthcare network in the State of Illinois, comprising 11 hospitals, 29 long-term care and senior residential facilities, more than 50 primary and specialty care clinics, and 6 home health agencies. Presence Lakeshore Gastroenterology, LLC is an Illinois limited liability company 51% owned by Presence Holy Family Medical Center and 49% owned by Lakeshore Gastroenterology and Liver Disease Institute, S.C. Lakeshore Gastroenterology and Liver Disease Institute, S.C. is a medical group located in Oak Park, Illinois. The proposed project is located in the HSA VII health service area and Hospital Health Planning Area A-07. There are four additional hospitals in this planning area: Advocate Lutheran General, Park Ridge (313 beds), Alexian Brothers Medical Center, Elk Grove Village, (241 beds), Northwest Community Hospital, Arlington Heights (336 beds), and St. Alexius Medical Center, Hoffman Estates (212 beds). This is a substantive project subject to both an 1110 and 1120 review. Project obligation will occur after permit issuance.

The applicants were not required to provide a letter attesting to the project's compliance with the requirements of Illinois Executive Order #2006-5, Construction Activities in Special Flood Hazard Areas, because this is a modernization of an existing structure. In addition the applicants were not required to comply with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.) because the project is a modernization of an existing building.

IV. Project Description

The applicants are proposing to establish a limited specialty ambulatory surgical treatment facility at a cost of \$2,898,522 located in leased space the Medical Office Building adjacent to Presence Holy Family Medical Center. Currently, Presence Holy Family Medical Center has 2 dedicated endoscopy procedure rooms, and should the proposed project be approved these 2 procedure rooms will no longer be used for endoscopy procedures. The intended use for the space to be vacated is ophthalmology procedure rooms. The proposed ASTC will be a limited specialty ASTC with two procedure rooms dedicated solely to performing endoscopy procedures. Presence Holy Family Medical Center will operate the ASTC as a joint venture with 51 % ownership, and the remaining 49% ownership will be held by Lakeshore Gastroenterology and Liver Disease Institute, S.C. The total cost of the project is \$2,898,522 and the anticipated completion date is December 31, 2015.

V. Project Costs

The applicants are funding this project with cash of \$986,209 and the fair market value of leased space of \$1,912,313. The anticipated start-up costs and estimated deficit is \$192,402.

TABLE ONE			
Project Costs and Sources of Funds			
Use of Funds	Clinical	Nonclinical	Total
Modernization Contracts	\$549,000	\$152,625	\$701,625
Movable or Other Equipment	\$828,929	\$381,729	\$1,210,658
Fair Market Value of Leased Space	\$690,367	\$295,871	\$986,239
Total Uses of Funds	\$2,068,296	\$830,225	\$2,898,522
Source of Funds	Clinical	Nonclinical	Total
Cash and Securities	\$690,367	\$295,841	\$986,209
Leases (fair market value)	\$1,377,929	\$534,384	\$1,912,313
Total Sources of Funds	\$2,068,296	\$830,225	\$2,898,522

VI. Section 1110.230 –Purpose of the Project, Safety Net Impact, Alternatives

The applicants are required to provide responses to these criteria; the State Board Staff reaches no conclusion regarding these criteria.

A) Criterion 1110.230 (a) - Purpose of the Project

The applicants stated the following:

“The project will provide better access to endoscopy procedures in the community. The endoscopy center will be patient centered with navigators to ease the patient through steps of education, diagnosis and treatment of disease. An Advanced Practice Nurse will provide an opportunity to have an office visit and procedure in the same visit. The project will result in strong physician alignment between Presence Holy Family Medical Center (“PHFMC”) and the physicians on staff to focus on a common Mission and aligned vision. The proposed endoscopy center will focus on a workflow with the patient and employee in mind. Access to care and transportation are primary issues in the community served by PHFMC. The location of the proposed endoscopy center will provide easy access. It is on the PACE bus line, one mile from Metra and Presence PHFMC offers a low cost Care A Van service to the location. One in five people in the community live below 200% of the federal poverty level, and 13% of those who responded to the PH FMC community health needs assessment reported they did not follow up with specialists because of cost. A free standing endoscopy center will provide a more affordable option to those PHFMC serves. Colon cancer is the third most common cancer and the second leading cause of cancer-related deaths in the United States. Cancer is a leading age-adjusted cause of mortality in the PHFMC service area. GI screenings, through

endoscopy, are a valuable tool to identify and treat colon cancer in the early stages, saving lives. The bulk of patients served will reside within a 10 mile radius of the PHFMC catchment area. In determining the market area the Applicants reviewed the patient demographics by zip code of the physicians practice and those patients who were referred for surgery by it. The zip codes of the proposed market area are attached, along with population by zip code for the general PHFMC market area. The total population of the area is approximately 2,916,057 (2012 US Census Estimates). However, the proposed ASC will only draw from portions of these zip codes, and the primary service area is reflected on the attached map (30 minutes.) The project will allow for user friendly access to an outpatient service (endoscopy) that is currently provided in an inpatient hospital setting. This setting is more costly and less user friendly. It also will allow alignment between the physician specialists and PH FMC, such that the results and follow-up care can be better monitored between the physician practice and PHFMC, which will improve outcomes and patient communication. The project will follow the Navigator model, which calls for a patient advocate to be present to help the patient through the process of receiving IV sedation, being transferred to the procedure room, and “recovering” to the point of readiness. It also will provide information pre-testing regarding the prep for colonoscopy and will address patient's need in transportation home after the test itself, and any other issues the patient may have upon discharge. There are no quantifiable and measureable objectives, other than lower cost care and more effective management of a fairly straight forward outpatient surgical procedure, which is becoming more and more common giving the aging of the "baby boomer" population, which is recommended to have testing beginning at age 50 - 60 based on risk factors. This population is expected to grow by approximately 10-15% between 2010 to 2020.”

B) Criterion 1110.234 (b) - Safety Net Impact

To the applicants knowledge the impact on safety net services will be positive in that this project will maintain them. The applicants do not have knowledge regarding cross subsidization of services.

TABLE TWO Safety Net Impact			
	2011	2012	2013
Net Patient Revenue	\$79,158,057	\$76,738,700	\$69,546,648
Charity Care Number of Patients			
Inpatient	27	8	11
Outpatient	93	53	27
Total	120	61	38
Charity Care Cost in Dollars			
Inpatient	\$1,181,322	\$52,177	\$706,227
Outpatient	\$25,844	\$13,044	\$140,607

Total	\$1,207,166	\$65,221	\$846,834
% of Net Patient Revenue	1.52%	.08%	1.21%
Medicaid Number of Patients			
Inpatient	92	59	39
Outpatient	6314	6687	6499
Total	6,406	6,746	6,538
Medicaid Revenue			
Inpatient	\$13,755,693	\$6,282,958	\$4,258,943
Outpatient	\$514,112	\$1,014,323	\$419,195
Total	\$14,269,805	\$7,297,281	\$4,678,138
% of Net Patient Revenue	18.02%	9.5%	6.72%

C) Criterion 1110.234 (c) –Alternatives to Project

The applicants stated the following: *“The alternatives to the project were few. The only real alternative is one the HFSRB does not consider, which is "doing nothing" and continuing to provide endoscopy as a hospital based service. The cost of this alternative was zero, but it was not seriously considered given the ultimate goals and objectives of the project. Another alternative was to establish a joint venture to obtain a surgery center license, but have PHFMC be the minority owner versus the majority owner. The cost of this alternative would have been the same, but the return on PHFMC investment would have been less. Given the fact that PHFMC is a NFP, this was not a viable alternative. Another alternative was to locate the ASC off PHFMC campus. This alternative would cost approximately the same as the chosen alternative assuming similar space could be obtained. It was rejected because the location on PHFMC's campus is much more accessible to the community served and convenient for both patients and Medical staff members. The chosen alternative does include pursuing a joint venture. The option of having other health care providers serve the population to be served is currently in place. However, this option is more costly (hospital based outpatient surgery is more costly then ASC based as per attached charge comparison), less convenient for patients and does not achieve the same physician-hospital based alignment as the proposed joint venture. The chosen alternative was considered a positive one for patient centered care, which is why PHFMC chose to pursue same.”*

VII. Section 1110.234 - Project Scope and Size, Utilization and Unfinished/Shell Space

A) Criterion 1110.234 (a) - Size of Project

The applicant shall document that the physical space proposed for the project is necessary and appropriate.

The applicants are proposing 2,196 DGSF for the 2 procedure rooms and the 6 recovery stations. The State Board Standard for procedure rooms is 1,660-2,200 DGSF per

Treatment Room and the recovery stations is 180-400 GSF per station or a total of 6,800 GSF. The applicants have met this requirement.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT TO BE IN CONFORMANCE WITH CRITERION SIZE OF PROJECT (77 IAC 1110.234 (a))

B) Criterion 1110.234 (b) - Project Services Utilization

The applicant shall document that, by the end of the second year of operation, the annual utilization of the clinical service areas or equipment shall meet or exceed the utilization standards specified in Appendix B.

The applicants are projecting 2,728 hours by the second year after project completion. If the hours materialize the applicants can justify the two procedure rooms.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT TO BE IN CONFORMANCE WITH CRITERION PROJECTED SERVICES UTILIZATION (77 IAC 1110.234(b))

C) Criterion 1110.234 (e) - Assurances

The applicants must attest that they will reach target utilization within 24 months of operation and maintain that utilization.

The administrator Pamela Bell attested that the proposed ASTC will meet the occupancy standards required of it within 24 months of its operation. That conclusion was based on Lakeshore Gastroenterology historical practice referrals and utilization. See page 96 of the application for permit.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT TO BE IN CONFORMANCE WITH CRITERION ASSURANCES (77 IAC 1110.234(e))

VIII. Section 1110.1540 –Ambulatory Surgical Treatment Center

A) Criterion 1110.1540 (b) - Background of the Applicant

An applicant shall document the *qualifications, background, character and financial resources to adequately provide a proper service for the community and also demonstrate that the project promotes the orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of facilities or service.* [20 ILCS 3960/2]

The applicants provided a notarized letter from Jeannie Frey Chief Legal Officer and Counsel Presence Health that the ASTC is a newly formed entity and does not own, operate or manage any other ambulatory surgical treatment centers or any other health care facilities or provider entities. Presence Health and Presence Holy Family Medical Center own and operate acute care hospitals. Presence Health has attested that no adverse action has been taken against any health care facility owned or operated by Presence Health during the three years prior to filing this application for permit. In

addition the applicants authorized the Illinois Health Facilities and Services Review Board and the Illinois Department of Public Health to access any and all information to verify information submitted in this application for permit.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH THE CRITERION BACKGROUND OF THE APPLICANT (77 IAC 1110.1540 (b))

B) Criterion 1110.1540 (c) (2) - Geographic Service Area Need

The applicant shall document that the ASTC services and the number of surgical/treatment rooms to be established, added or expanded are necessary to serve the planning area's population.

The applicants have defined their market area as 30 minutes in all direction and have provided zip code information for Presence Holy Family Medical Center market area. In addition the applicants have provided the patient origin zip codes of the patients of the physicians involved in this joint venture. The total population of this 30 minute area is approximately 2,916,057.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH THE CRITERION GEOGRAPHIC SERVICE AREA NEED (77 IAC 1110.1540 (c) (2))

C) Criterion 1110.1540 (d) - Service Demand – Establishment of an ASTC Facility

The applicant shall document that the proposed project is necessary to accommodate the service demand experienced annually by the applicant, over the latest two-year period, as evidenced by historical and projected referrals.

The applicants have provided a referral letter from Lakeshore Gastroenterology and Liver Disease Institute, S.C. that they plan to refer approximately 2,730 cases to the proposed ASTC. The applicants provided patient origin by zip code for the past 12 months and it appears that the residents reside in the proposed GSA. The number of referrals does not exceed the physician's experienced caseload and the applicants have attested that the referrals have not been used to justify any other certificate of need permit application.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH THE CRITERION SERVICE DEMAND (77 IAC 1110.1540 (d))

D) Criterion 1110.1540 (f) - Treatment Room Need Assessment

The applicant shall document that the proposed number of surgical/treatment rooms for each ASTC service is necessary to service the projected patient volume. The number of rooms shall be justified based upon an annual minimum utilization of 1,500 hours of use per room, as established in 77 Ill. Adm. Code 1100.

The applicants are proposing two procedure rooms. The applicants are estimating 1 hour for the endoscopy procedure. Based upon the State Board standard of 1,500 hours per procedure room, the applicants can justify the two procedure rooms being proposed. (2,731 x 1 hour = 2,731 hours/1,500 hours per procedure room = 1.82 rooms or 2 rooms)

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH THE CRITERION TREATMENT ROOM NEED ASSESSMENT (77 IAC 1110.1540 (f))

E) Criterion 1110.1540 (g) - Service Accessibility

The proposed ASTC services being established or added are necessary to improve access for residents of the GSA. The applicant shall document that at least one of the following conditions exists in the GSA:

- 1) There are no other IDPH-licensed ASTCs within the identified GSA of the proposed project;
- 2) The other IDPH-licensed ASTC and hospital surgical/treatment rooms used for those ASTC services proposed by the project within the identified GSA are utilized at or above the utilization level specified in 77 Ill. Adm. Code 1100;
- 3) The ASTC services or specific types of procedures or operations that are components of an ASTC service are not currently available in the GSA or that existing underutilized services in the GSA have restrictive admission policies;
- 4) The proposed project is a cooperative venture sponsored by two or more persons, at least one of which operates an existing hospital. Documentation shall provide evidence that:
 - A) The existing hospital is currently providing outpatient services to the population of the subject GSA;
 - B) The existing hospital has sufficient historical workload to justify the number of surgical/treatment rooms at the existing hospital and at the proposed ASTC, based upon the treatment room utilization standard specified in 77 Ill. Adm. Code 1100;
 - C) The existing hospital agrees not to increase its surgical/treatment room capacity until the proposed project's surgical/treatment rooms are operating at or above the utilization rate specified in 77 Ill. Adm. Code 1100 for a period of at least 12 consecutive months; and
 - D) The proposed charges for comparable procedures at the ASTC will be lower than those of the existing hospital.

The proposed project is a cooperative venture and the existing hospital is currently providing outpatient endoscopy services. Presence Holy Family Medical Center plans to close its two endoscopy procedure rooms and provide this service at the proposed ASTC. Presence Holy Family Medical Center will use the vacated space for ophthalmology procedure rooms. Historical utilization at the hospital will not support the 2 procedure rooms being proposed by this project. 2013 historical utilization of 559 hours will justify one procedure room. The applicants have attested that the charges at the proposed ASTC will be less than the charges at the hospital. The proposed ASTC charges are listed below along with the hospital charges.

TABLE THREE			
Hospital and ASTC's Charges			
Description	Code	Hospital Charge	ASTC Charge
Balloon Dilation> 30mm	43233	\$2,950.00	\$2,250
EGD	43235	\$2,950.00	\$2,150
InjIBotx	43236	\$2,950.00	\$2,250
Biopsy	43239	\$2,950.00	\$2,250
Tube Insert	43241	\$2,950.00	\$2,250
Variceal Sclerosis	43243	\$2,950.00	\$2,250
Band Ligation	43244	\$2,950.00	\$2,250
G Tube Placement	43246	\$2,950.00	\$2,450
Removal of foreign body	43247	\$2,950.00	\$2,650
Balloon Dilation <30mm	43249	\$2,950.00	\$2,200
Hot Biopsy	43250	\$2,950.00	\$2,200
Snare	43251	\$2,950.00	\$2,200
Control Bleeding	43255	\$2,950.00	\$2,200
Ablation	43258		\$2,300
Flexible Sigmoidoscopy	45330	\$2,950.00	\$2,010
Removal of Foreign Body	45331	\$2,950.00	\$2,010
Snare	45332	\$2,950.00	\$2,050
Hot Biopsy	45333	\$2,950.00	\$2,050
Control Bleeding	45334	\$2,950.00	\$2,050
Sigmoidoscopy w submucing	45335	\$2,950.00	\$2,050
Sigmoidoscopy wi removal of tumor	45338	\$2,950.00	\$2,050
Sigmoidoscopy wi balloon dilation	45340	\$2,950.00	\$2,050
Ablation	45339		\$2,550
Colonscopy	45378	\$2,950.00	\$2,450
InjIBotx	45381	\$2,950.00	\$2,550
Biopsy	45380	\$2,950.00	\$2,550
Control Bleeding	45382	\$2,950.00	\$2,550

TABLE THREE Hospital and ASTC's Charges			
Description	Code	Hospital Charge	ASTC Charge
Ablation	45383		\$2,450
Removal of Foreign Body	45379	\$2,950.00	\$2,550
Hot Biopsy	45384	\$2,950.00	\$2,450
Snare	45385	\$2,950.00	\$2,450
Colonoscopy w/dilation	45386	\$2,950.00	\$2,450
Ligation of Hemorrhoid	46221	\$2,950.00	\$2,450
Hemorrhoidectomy Ligation; Single	46945	\$2,950.00	\$2,650
Hemorrhoidectomy Ligation; Qty >2	46946	\$2,950.00	\$2,650
1. Information provided by the applicants			

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT NOT IN CONFORMANCE WITH CRITERION SERVICE ACCESSIBILITY (77 IAC 1110.1540 (g))

F) Criterion 1110.1540 (h) - Unnecessary Duplication/Maldistribution

The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the GSA has an excess supply of facilities and ASTC services. The applicant shall document that, within 24 months after project completion, the proposed project will not lower the utilization of other area providers below the utilization standards specified in 77 Ill. Adm. Code 1100 will not lower, to a further extent, the utilization of other GSA facilities that are currently (during the latest 12-month period) operating below the utilization standards.

There are 52 ambulatory surgical treatment rooms within 45 minutes (adjusted) of the proposed facility (See Table Seven). Of those 52 facilities 5 of the facilities are not yet operational. Of these 47 facilities 20 currently provide gastroenterology services (See Table Nine). Of these 20 facilities 15 currently have capacity to accommodate the workload proposed by this facility. In addition 12 of the ASTCs that currently do not provide gastroenterology service can add this service at any time without State Board approval until January 1, 2018. There are 27 hospitals within 45 minutes (adjusted) that provide gastroenterology service (See Table Eight). Given the number of facilities within the 45 minute (adjusted) GSA it would appear that an unnecessary duplication of service will result with the establishment of this facility. In addition a maldistribution of service or a surplus of ASTC's in this GSA will result.

TABLE FOUR Facilities applicants propose to remove Gastro cases					
	Number of Gastro Rooms ⁽¹⁾	Hours or procedures ⁽¹⁾	Rooms Justified	Hours referred to proposed facility	Rooms justified if project approved
West Suburban Medical Center	4	8,007	6	1089	5
Northwest Community Hospital	9	12,058	9	663	8
Advocate Lutheran General Hospital	8	10,055	7	651	6
Westlake Hospital	2	596	1	13	1
Community First Medical Center	2	2,656	2	12	2
Fullerton Surgery Center	2	1,520	2	5	2
Presence Holy Family Medical Center	2			0	0
Total				2,730	
1. Information on Number of Gastro Rooms and Hours taken from 2013 Hospital and ASTC Profiles					

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS NOT IN CONFORMANCE WITH CRITERION UNNECESSARY DUPLICATION OF SERVICE/MALDISTRIBUTION (77 IAC 1110.1540 (h))

G) Criterion 1110.1540 (i) - Staffing

The proposed facility will be certified for Medicare and Medicaid participation and the State Board relies upon this certification that appropriate staffing will be available for the proposed facility.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH CRITERION STAFFING (77 IAC 1110.1540 (i))

I) Criterion 1110.1540 (j) - Charge Commitment

In order to meet the objectives of the Act, which are *to improve the financial ability of the public to obtain necessary health services; and to establish an orderly and comprehensive health care delivery system that will guarantee the availability of quality health care to the general public; and cost containment and support for safety net services must continue to be central tenets of the Certificate of Need process* [20 ILCS 3960/2], the applicant shall submit the following:

- 1) a statement of all charges, except for any professional fee (physician charge); and

- 2) a commitment that these charges will not be increased, at a minimum, for the first two years of operation unless a permit is first obtained pursuant to 77 Ill. Adm. Code 1130.310(a).

The administrator certified to the following “do hereby commit that the charges listed in the Presence Lakeshore' Gastroenterology CON application. Project number 15-005 will be in place for two (2) years subsequent to the ambulatory surgery center being certified for occupancy.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT TO BE IN CONFORMANCE WITH CRITERION CHARGE COMMITMENT (77 IAC 1110.1540 (j))

K) Criterion 1110.1540(k) - Assurances

1) The applicant shall attest that a peer review program exists or will be implemented that evaluates whether patient outcomes are consistent with quality standards established by professional organizations for the ASTC services, and if outcomes do not meet or exceed those standards, that a quality improvement plan will be initiated.

2) The applicant shall document that, in the second year of operation after the project completion date, the annual utilization of the surgical/treatment rooms will meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100. Documentation shall include, but not be limited to, historical utilization trends, population growth, expansion of professional staff or programs (demonstrated by signed contracts with additional physicians) and the provision of new procedures that would increase utilization.

The applicants have attested that Presence Lakeshore Gastroenterology will maintain a peer review program that evaluates patient outcomes in accordance the quality standards of the Joint Commission as applicable to ambulatory surgery center services and do hereby attest that the proposed ambulatory surgery center will reach target utilization of 1500 hours per surgery/procedure room within two years after beginning operations.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT TO BE IN CONFORMANCE WITH CRITERION ASSURANCES (77 IAC 1110.1540 (k))

IX. Section 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources.

The applicants are funding this project with cash of \$986,209 and lease with a fair market value of \$1,912,313. Based upon the audited financial statements Presence Health has sufficient cash to fund this project.

TABLE FIVE			
Financial Information			
	Presence Health Audited Financial In thousands (000)		Presence Holy Family Medical Center
	2013	2012	2013
Cash	\$192,672	\$192,066	\$7
Current Assets	\$3,277,698	\$3,307,771	\$41,232
Current Liabilities	\$626,881	\$653,609	\$55,740
LTD	\$1,094,741	\$1,129,500	\$0
Total Revenue	\$2,451,328	\$2,490,884	\$70,908
Net Patient Revenue	\$2,700,075	\$2,708,573	\$69,544
Expenses	\$2,761,742	\$2,660,952	\$74,312
Income	\$125,150	\$99,641	-\$3,297

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH CRITERION AVAILABILITY OF FUNDS (77 IAC 1120.120)

X. Section 1120.130 - Financial Viability

The transaction will be funded from internal funds; therefore the applicants have qualified for the financial viability waiver

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH CRITERION FINANCIAL VIABILITY (77 IAC 1120.130)

XI. Section 1120.140 - Economic Feasibility

A) Criterion 1120.140(a) – Reasonableness of Financing Arrangements

B) Criterion 1120.140 (b) - Conditions of Debt Financing

The applicants are funding this project with cash of \$986,209. A modified letter of intent for the lease was provided by the applicants. The lease is between Presence Healthcare Services and Presence Lakeshore Gastroenterology LLC for 3,417 square feet at \$28 per

rentable square foot, for the first five years of the lease. The base rent shall escalate by 2% annually in years 6 -10. Presence Healthcare Services (Services), a not-for-profit corporation that encompasses the following operating divisions: Presence Resurrection Properties, Presence Pharmacies, Presence Ambulatory Services, and Presence Medical Group - RHC; and the Presence Home Medical Equipment.

TABLE SIX Lease Payments		
Year	Monthly Rent	Total Yearly
1	\$7,973.00	\$95,676.00
2	\$7,973.00	\$95,676.00
3	\$7,973.00	\$95,676.00
4	\$7,973.00	\$95,676.00
5	\$7,973.00	\$95,676.00
6	\$8,132.46	\$97,589.52
7	\$8,295.11	\$99,541.31
8	\$8,461.01	\$101,532.14
9	\$8,630.23	\$103,562.78
10	\$8,802.84	\$105,634.04

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH CRITERION REASONABLENESS OF FINANCING ARRANGEMENTS AND CONDITIONS OF DEBT FINANCING (77 IAC 1120.140 (a)(b))

C) Criterion 1120.140 (c) - Reasonableness of Project and Related Costs
The applicant shall document that the estimated project costs are reasonable

Modernization Costs are \$549,000 or \$250 per GSF ($\$549,000/2,196 = \250). This appears reasonable when compared to the State Board Standard of \$264.87.

Initial State Board Standard	\$203
Number of Years to Inflate	7
Inflation Rate	3%
State Board Standard	\$264.87

Movable or Other Equipment Costs are \$828,929 or \$414,465 per procedure room ($\$828,929/2 = \$414,464.50$). This appears reasonable when compared to the State Board Standard of \$461,631. The costs include the following:

Fair Market Value of Leased Space Costs are \$690,368. The State Board does not have a standard for this cost.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH CRITERION REASONABLENESS OF PROJECT AND RELATED COSTS (77 IAC 1120.140 (c))

D) Criterion 1120.140 (d) - Projected Operating Costs

The projected operating cost per case is \$1,339 per case. This appears reasonable compared to previously approved projects.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH CRITERION PROJECTED OPERATING COSTS (77 IAC 1120.140 (d))

E) Criterion 1120.140 (e) - Total Effect of the Project on Capital Costs

The applicants' state there will be no effect on capital costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH CRITERION TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS (77 IAC 1120.140 (e))

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TABLE SEVEN ⁽⁶⁾
Ambulatory Surgical Treatment Centers within 45 minutes of proposed facility

Name	City	Type	Operating Rooms	Hours	Currently Provides Gastro Service	Adjusted Minutes	Rooms Justified
Foot and Ankle Surgery Center	Des Plaines	Multi	3	1,248.25	No	4.6	1
Golf Surgical Center	Des Plaines	Multi	5	4,165.34	No	10.35	3
Northwest Community Day Surgery	Arlington Heights	Multi	10	9,315.00	No	16.1	7
The Glen Endoscopy Center	Glenview	Limited	3	3,535.00	Gastro	16.1	3
Illinois Sports Medicine & Orthopedic Surgery Ctr.	Morton Grove	Multi	4	3,735.00	Gastro	16.1	3
Illinois Hand & Upper Extremity Center	Arlington Heights	Limited	1	1,068.00	No	17.25	1
Northwest Surgicare	Arlington Heights	Multi	4	1,593.50	No	18.4	2
Ravine Way Surgery Center	Glenview	Limited	3	2,909.00	No	19.55	2
North Shore Endoscopy Center	Lake Bluff	Limited	2	2,587.50	Gastro	28.75	2
Vernon Square Surgicenter	Vernon Hills	Multi	2	1,847.25	No	28.75	2
Albany Medical Surgery Ctr.	Chicago	Limited	2	2,915.00	No	30	2
Oak Brook Surgical Center	Oakbrook	Multi	4	4,096.25	Gastro	31.05	3
Children's Memorial Specialty ASTC	Westchester	Multi	3	2,162.97	Gastro	31.05	2
Advantage Health Care Ltd.	Wood Dale	Limited	2	1,069.75	No	31.05	1
Six Corners Same Day Surgery	Chicago	Multi	4	304.75	No	31.25	1
Elmhurst Outpatient Surgery Center	Elmhurst	Multi	4	2,471.50	Gastro	32.2	2
Hinsdale Surgical Center	Hinsdale	Multi	4	5,284.31	No	32.2	3
The Hoffman Estates Surgery Center	Hoffman Estates	Multi	3	2,917.75	Gastro	32.2	2
Alden Center for Day Surgery	Addison	Multi	4	1,082.25	Gastro	33.35	1
Eye Surgery Center of Hinsdale	Hinsdale	Limited	2	972.50	No	33.35	1
North Shore Same Day Surgery Center	Lincolnwood	Multi	3	2,667.16	Gastro	34.5	2
Resurrection Health Care Surgery Ctr.	Chicago	Multi	4	1,822.25	Gastro	35	2

TABLE SEVEN ⁽⁶⁾
Ambulatory Surgical Treatment Centers within 45 minutes of proposed facility

Name	City	Type	Operating Rooms	Hours	Currently Provides Gastro Service	Adjusted Minutes	Rooms Justified
Midwest Center for Day Surgery	Downers Grove	Multi	5	3,485.25	Gastro	35.65	3
Elmhurst Medical and Surgical Center	Elmhurst	Limited	1	192.00	No	35.65	1
Lake Forest Endoscopy Center	Grayslake	Limited	2	1,933.00	Gastro	35.65	2
Grayslake Outpatient Center	Grayslake	Multi	4	1,148.25	No	35.65	1
Loyola Ambulatory Surgery Center	Oakbrook Terrace	Multi	3	2,736.26	No	35.65	2
Ambul Surgicenter of Downers Grove	Downers Grove	Limited	3	993.60	No	36.8	1
Elmwood Park Same Day Surgery Center	Elmwood Park	Multi	3	198.25	No	36.8	1
Salt Creek Surgery Center	Westmont	Multi	4	3,573.50	No	36.8	3
Chicago Prostrate Cancer Center	Westmont	Limited	2	848.00	No	36.8	1
Western Diversey Surgical Center	Chicago	Limited	2	1,545.00	No	37.5	2
Novamed Surgery Center of Chicago	Chicago	Limited	1	1,520.50	No	37.5	2
DuPage Medical Group Surgery Center	Lombard	Multi	5	10,159.00	Gastro	37.95	7
Loyola University Ambulatory Surgery Ctr.	Maywood	Multi	8	9,419.14	Gastro	37.95	7
CMP Surgicenter	Chicago	Multi	2	1,520.15	Gastro	38.75	2
United Therapy-LaGrange	LaGrange	Limited	1	3,128.00	No	39.1	3
Novamed Surgery Center of River Forest	River Forest	Multi	2	920.50	No	39.1	1
Advanced Ambulatory Surgical Center	Chicago	Multi	3	965.90	Gastro	40	1
Hispanic-American Endoscopy Center	Chicago	Limited	1	474.00	Gastro	40	1
Peterson Surgery Center	Chicago	Limited	2	78.25	Gastro	41.25	1
Hart Road Pain and Spine Institute	Barrington	Limited	2	533.33	No	41.4	1
Naperville Fertility Center	Naperville	Limited	1	401.00	No	41.4	1
Lakeshore Surgery Center	Chicago	Multi	2	1,018.75	Gastro	42.5	1
The Center for Surgery	Naperville	Multi	8	5,002.00	Gastro	43.7	4

TABLE SEVEN ⁽⁶⁾
Ambulatory Surgical Treatment Centers within 45 minutes of proposed facility

Name	City	Type	Operating Rooms	Hours	Currently Provides Gastro Service	Adjusted Minutes	Rooms Justified
Victory Ambulatory Surgery Center	Lindenhurst	Multi	4	1,723.00	Gastro	44.85	2
DuPage Orthopedic Group Surgery Center	Warrenville	Limited	4	5,511.90	No	44.85	4
Apollo Health Center (1)	Des Plaines		Not Available			16.1	0
Chicago Surgical Clinic, Ltd. (2)	Arlington Heights		Not Available			17.25	0
Hawthorne Surgery Center (3)	Vernon Hills		Not Available			28.75	0
Ashton Center for Day Surgery	Schaumburg		Not Available			33.35	0
Lisle Center for Pain Management (4)	Lisle		Not Available			42.55	0
1. Completed May 2014 no data available							
2. Approved as Permit #12-076							
3. Approved as Permit #12-041							
4. Approved as Permit #11-121							
5. Time and Distance determined by MapQuest adjusted per 1100.510 (d)							
6. Hours from 2013 Annual ASTC Questionnaire							

TABLE EIGHT ⁽¹⁾
Hospitals within 45 minutes of proposed facility

Name	City	Adjusted Time ⁽¹⁾	Operating Rooms	Hours	Gastro Procedure Rooms	Hours ⁽²⁾
Presence Holy Family Hospital	Des Plaines	0	5	1,986	2	559
Glenbrook Hospital	Glenview	10.35	9	12,234	6	16,068
Advocate Lutheran General Hospital	Park Ridge	12.65	24	44,677	8	10,055
Northwest Community Hospital	Arlington Heights	16.1	14	21,867	9	12,058
Skokie Hospital	Skokie	21.85	10	11,439	5	9,398
Highland Park Hospital	Highland Park	28.75	11	13,408	6	12,868
Presence Resurrection Medical Center	Chicago	28.75	9	4,215	2	2,656
Alexian Brothers Medical Center	Elk Grove Villa	29.9	15	21,222	7	14,568
St. Alexius Medical Center	Hoffman Estates	32.2	11	23,096	5	10,242
Elmhurst Memorial Hospital	Elmhurst	33.35	15	24,252	5	24,252
Evanston Hospital	Evanston	33.35	16	23,603	7	15,368
Northwestern Lake Forest Hospital	Lake Forest	33.35	8	11,793	5	1,820
Advocate Condell Medical Center	Libertyville	33.35	12	15,598	4	2,912
Adventist Hinsdale Hospital	Hinsdale	34.5	12	20,001	4	4,487
Gottlieb Memorial Hospital	Melrose Park	34.5	9	8,639	2	3,184
VHS Westlake Hospital	Melrose Park	35.65	6	3,064	5	296
Advocate Good Samaritan Hospital	Downers Grove	36.8	14	26,367	6	4,545
Presence St. Francis Hospital	Evanston	36.8	16	23,603	7	15,368
Adventist LaGrange Memorial Hospital	LaGrange	36.8	11	12,628	3	3,546
Loyola University Medical Center	Maywood	36.8	27	58,154	6	12,347
Rush Oak Park Hospital	Oak Park	36.8	9	7,853	3	1,687
Community First Medical Center	Chicago	37.5	9	4,215	2	2,656
Adventist Glen Oaks Medical Center	Glendale Heights	40.25	5	3,526	1	1,034

TABLE EIGHT ⁽¹⁾
Hospitals within 45 minutes of proposed facility

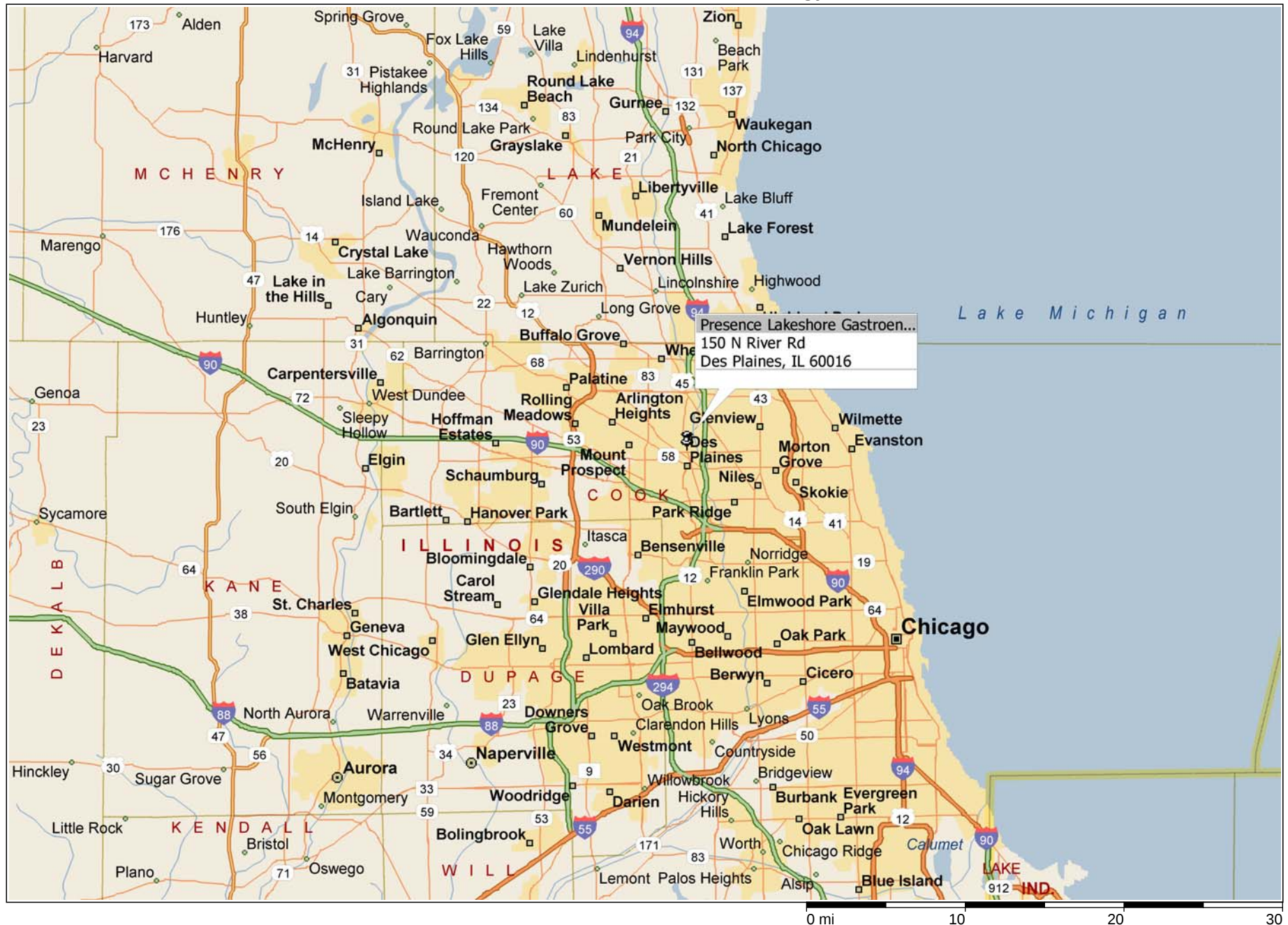
Name	City	Adjusted Time ⁽¹⁾	Operating Rooms	Hours	Gastro Procedure Rooms	Hours ⁽²⁾
Swedish Covenant Hospital	Chicago	41.25	10	13,936	3	4,347
Advocate Good Shepherd Hospital	Barrington	41.4	11	19,670	5	5,515
Sherman Hospital	Elgin	41.4	16	19,208	2	2,248
VHS West Suburban Medical Center	Oak Park	44.85	8	9,941	4	8,807

1. Time determined by MapQuest and adjusted per 1100.510 (d)
2. Hours taken from Hospital 2013 Annual Questionnaire

Table Nine								
Ambulatory Surgical Treatment Centers within 45 minutes providing Gastroenterology Services								
Payor Mix								
Patients								
			Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity
Name	City	Type ASTC	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
The Glen Endoscopy Center	Glenview	Limited	30.37%	0.33%	0.00%	68.47%	0.83%	0.00%
North Shore Endoscopy Center	Lake Bluff	Limited	38.72%	0.16%	0.00%	56.32%	4.80%	0.00%
Oak Brook Surgical Center	Oakbrook	Multi	16.16%	0.18%	0.00%	71.38%	12.28%	0.00%
Children's Memorial Specialty ASTC	Westchester	Multi	0.00%	17%	1%	78%	0%	4.37%
Elmhurst Outpatient Surgery Center	Elmhurst	Multi	37.32%	0.00%	0.00%	60.36%	2.32%	0.00%
The Hoffman Estates Surgery Center	Hoffman Est	Multi	45.59%	0.00%	0.00%	53.85%	0.56%	0.00%
Alden Center for Day Surgery	Addison	Multi	21.22%	3.92%	0.00%	71.08%	3.78%	0.00%
North Shore Same Day Surgery Center	Lincolnwood	Multi	38.72%	0.16%	0.00%	56.32%	4.80%	0.00%
Belmont Harlem Surgery Center	Chicago	Multi	46.40%	0.80%	0.00%	51.37%	1.43%	0.00%
Midwest Center for Day Surgery	Downers Gr.	Multi	28.99%	0.00%	0.08%	66.88%	4.05%	0.00%
Lake Forest Endoscopy Center	Grayslake	Limited	22.98%	0.42%	0.07%	76.21%	0.11%	0.21%
DuPage Medical Group Surgery Center	Lombard	Multi	18.23%	0.00%	0.01%	81.53%	0.23%	0.00%
Loyola University Amb. Surgery Ctr.	Maywood	Multi	25.06%	20.93%	0.87%	48.85%	2.18%	2.12%
Fullerton Kimball Surgicenter	Chicago	Multi	46.49%	0.00%	4.79%	44.68%	3.06%	0.97%
Advanced Ambulatory Surgical Center	Chicago	Multi	0.23%	0.00%	0.00%	87.33%	11.20%	1.24%
Chicago Endoscopy Center	Chicago	Limited	27.55%	2.25%	3.24%	54.80%	11.37%	0.78%
Peterson Surgery Center	Chicago	Limited	0.00%	0.00%	0.00%	91.08%	8.28%	0.64%
Lakeshore Surgery Center	Chicago	Multi	0.00%	0.00%	0.00%	85.74%	13.78%	0.48%

Table Nine								
Ambulatory Surgical Treatment Centers within 45 minutes providing Gastroenterology Services								
Payor Mix								
Patients								
			Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity
The Center for Surgery	Naperville	Multi	29.76%	1.31%	3.08%	58.48%	4.87%	2.50%
Victory Ambulatory Surgery Center	Lindenhurst	Multi	34.93%	6.58%	0.52%	54.30%	3.67%	0.00%
Average			25.44%	2.69%	0.67%	65.85%	4.69%	0.67%

15-005 Presence Lakeshore Gastroenterology - Des Plaines



<u>Ownership, Management and General Information</u>				<u>Patients by Race</u>		<u>Patients by Ethnicity</u>	
ADMINISTRATOR NAME:	John D Baird			White	61.6%	Hispanic or Latino:	6.5%
ADMINSTRATOR PHONE	773-792-5153			Black	4.5%	Not Hispanic or Latino:	83.8%
OWNERSHIP:	Presence Holy Family Medical Center			American Indian	0.3%	Unknown:	9.7%
OPERATOR:	Presence Holy Family Medical Center			Asian	2.7%		
MANAGEMENT:	Church-Related			Hawaiian/ Pacific	0.3%	IDPH Number:	1008
CERTIFICATION:	Long-Term Acute Care Hospital (LTACH)			Unknown	30.6%	HPA	A-07
FACILITY DESIGNATION:	(Not Answered)					HSA	7
ADDRESS	100 North River Road	CITY: Des Plaines	COUNTY: Suburban Cook County				

<u>Facility Utilization Data by Category of Service</u>										
<u>Clinical Service</u>	Authorized CON Beds 12/31/2013	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
Medical/Surgical	59	23	13	597	2,259	0	3.8	6.2	10.5	26.9
0-14 Years				0	0					
15-44 Years				337	1,189					
45-64 Years				240	945					
65-74 Years				17	69					
75 Years +				3	56					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Direct Admission				0	0					
Transfers				0	0					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				0	0					
Clean Gynecology				0	0					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds			0	0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	129	105	99	823	30729	0	37.3	84.2	65.3	80.2
Dedicated Observation	0					0				
Facility Utilization	188			1,420	32,988	0	23.2	90.4	48.1	

(Includes ICU Direct Admissions Only)

<u>Inpatients and Outpatients Served by Payor Source</u>							
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	44.4%	2.7%	0.0%	50.2%	1.8%	0.8%	
	631	39	0	713	26	11	1,420
Outpatients	23.2%	19.0%	0.0%	51.7%	6.1%	0.1%	
	7913	6499	6	17662	2074	27	34,181
<u>Financial Year Reported:</u>	1/1/2013 to	12/31/2013	<u>Inpatient and Outpatient Net Revenue by Payor Source</u>				
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient Revenue (\$)	74.8%	8.3%	0.0%	13.1%	3.8%	100.0%	
	38,546,472	4,258,943	0	6,751,181	1,955,563	51,512,159	706,227
Outpatient Revenue (\$)	15.5%	2.3%	0.0%	80.5%	1.6%	100.0%	
	2,803,667	419,195	0	14,511,828	296,769	18,031,459	140,607
							Total Charity Care Expense 846,834
							Total Charity Care as % of Net Revenue 1.2%

<u>Birth Data</u>			<u>Newborn Nursery Utilization</u>			<u>Organ Transplantation</u>	
Number of Total Births:	0		Level I	Level II	Level II+	Kidney:	0
Number of Live Births:	0		Beds	0	0	Heart:	0
Birthing Rooms:	0		Patient Days	0	0	Lung:	0
Labor Rooms:	0		Total Newborn Patient Days		0	Heart/Lung:	0
Delivery Rooms:	0					Pancreas:	0
Labor-Delivery-Recovery Rooms:	0					Liver:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0		<u>Laboratory Studies</u>			Total:	0
C-Section Rooms:	0		Inpatient Studies		126,197		
CSections Performed:	0		Outpatient Studies		39,378		
			Studies Performed Under Contract		6,358		

Surgery and Operating Room Utilization

<u>Surgical Specialty</u>	<u>Operating Rooms</u>				<u>Surgical Cases</u>		<u>Surgical Hours</u>			<u>Hours per Case</u>	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	0	0	0	0	0	0.0	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	2	2	88	277	88	305	393	1.0	1.1
Gastroenterology	0	0	0	0	74	5	59	3	62	0.8	0.6
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	0	8	0	6	6	0.0	0.8
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	2	2	0	662	0	463	463	0.0	0.7
Orthopedic	0	0	0	0	5	20	7	42	49	1.4	2.1
Otolaryngology	0	0	0	0	14	8	14	12	26	1.0	1.5
Plastic Surgery	0	0	0	0	0	252	0	731	731	0.0	2.9
Podiatry	0	0	0	0	6	131	8	236	244	1.3	1.8
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	1	1	3	7	2	10	12	0.7	1.4
Totals	0	0	5	5	190	1370	178	1808	1986	0.9	1.3
<u>SURGICAL RECOVERY STATIONS</u>				Stage 1 Recovery Stations		13	Stage 2 Recovery Stations		21		

Dedicated and Non-Dedicated Procedure Room Utilization

<u>Procedure Type</u>	<u>Procedure Rooms</u>				<u>Surgical Cases</u>		<u>Surgical Hours</u>			<u>Hours per Case</u>	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	2	2	7	793	4	555	559	0.6	0.7
Laser Eye Procedures	0	0	1	1	0	52	0	16	16	0.0	0.3
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	1	1	0	6	0	3	3	0.0	0.5
<u>Multipurpose Non-Dedicated Rooms</u>											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Emergency/Trauma Care

Certified Trauma Center	No
Level of Trauma Service	Level 1 (Not Answered)
Operating Rooms Dedicated for Trauma Care	Level 2 Not Answered
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Stand-By
Number of Emergency Room Stations	0
Persons Treated by Emergency Services:	0
Patients Admitted from Emergency:	0
Total ED Visits (Emergency+Trauma):	0

Free-Standing Emergency Center

Beds in Free-Standing Centers	0
Patient Visits in Free-Standing Centers	0
Hospital Admissions from Free-Standing Center	0

Outpatient Service Data

Total Outpatient Visits	34,181
Outpatient Visits at the Hospital/ Campus:	34,181
Outpatient Visits Offsite/off campus	0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	0
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Lab	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	0
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	0
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	0
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	0
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	0
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	0

Diagnostic/Interventional Equipment

<u>Examinations</u>		<u>Therapeutic Equipment</u>		<u>Therapies/</u>	
<u>Owned</u>	<u>Contract</u>	<u>Owned</u>	<u>Contract</u>	<u>Treatments</u>	

General Radiography/Fluoroscopy	7	0	6,107	3,354	0
Nuclear Medicine	1	0	51	148	0
Mammography	2	0	0	3,438	0
Ultrasound	3	0	821	2,386	0
Angiography	0	0			
Diagnostic Angiography			0	0	0
Interventional Angiography			0	0	0
Positron Emission Tomography (PET)	0	0	0	0	0
Computerized Axial Tomography (CAT)	1	0	1,470	557	0
Magnetic Resonance Imaging	1	0	0	494	0

Lithotripsy	0	0	0
Linear Accelerator	0	0	0
Image Guided Rad Therapy			0
Intensity Modulated Rad Thrp			0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
HEALTH FACILITIES AND SERVICES REVIEW BOARD
OPEN SESSION

REPORT OF PROCEEDINGS

Bolingbrook, Illinois 60490

Tuesday, April 21, 2015

9:13 a.m.

BOARD MEMBERS PRESENT:

KATHY OLSON, Chairperson

JOHN HAYES, Vice Chairman

PHILIP BRADLEY

JAMES J. BURDEN

BRAD BURZYNSKI

DALE GALASSIE

ALAN GREIMAN

RICHARD SEWELL

Job No. 75848A

Pages: 1 - 307

Reported by: Melanie L. Humphrey-Sonntag,

CSR, RDR, CRR, CCP, FAPR

FULL MEETING
CONDUCTED ON TUESDAY, APRIL 21, 2015

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EX OFFICIO MEMBERS PRESENT:

ARVIND K. GOYAL, IHFS

ALSO PRESENT:

JUAN MORADO, JR., General Counsel

JEANNIE MITCHELL, Assistant General Counsel

COURTNEY AVERY, Administrator

NELSON AGBODO, Health Systems Data Manager

CLAIRE BURMAN, Board Staff

CATHERINE CLARKE, Board Staff

MICHAEL CONSTANTINO, IDPH Staff

BILL DART, IDPH Staff

GEORGE ROATE, IDPH Staff

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1 CHAIRMAN OLSON: I'd like to call the
2 meeting back to order.

3 Next, we have Project 15-005, Presence
4 Lakeshore Gastroenterology in Des Plaines.

5 May I have a motion to approve
6 Project 15-005, Lakeshore Gastroenterology, to
7 establish a limited specialty ambulatory surgery
8 center.

9 MEMBER GALASSIE: So moved.

10 MEMBER BRADLEY: Second.

11 CHAIRMAN OLSON: I see the Applicant's at
12 the table.

13 Would you please be sworn in.

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

16 (Four witnesses duly sworn.)

17 THE COURT REPORTER: Thank you.

18 CHAIRMAN OLSON: Mr. Constantino, State
19 Board staff report.

20 MR. CONSTANTINO: Thank you, Madam
21 Chairwoman.

22 The Applicants are proposing to establish a
23 limited-specialty ASTC in leased space at a cost of
24 approximately \$3.2 million.

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1 The anticipated completion date is
2 December 31st, 2015. There was no public hearing. We
3 did have findings related to this project.

4 Thank you, Madam Chairwoman.

5 CHAIRMAN OLSON: Presentation for the Board?

6 DR. MAHDAVIAN: I want to introduce myself,
7 and I want to thank you for --

8 MS. AVERY: You have to use the mic.

9 DR. MAHDAVIAN: I want to thank you for
10 giving us the opportunity to be here. My name is
11 Mani Mahdavian. I'm a gastroenterologist.

12 I practice out of Holy Family, Presence
13 Health, Northwest Community Hospital, Advocate
14 Lutheran General Hospital, and West Suburban Hospital.

15 We're here to ask and seek your approval for
16 the project that we are planning to do in
17 collaboration with the Presence Health System. The
18 plan is to establish a surgical center or surgical
19 ambulatory center, which will provide a patient-
20 centered, easy access, less-cost for the area.

21 As you know, there has been an increased
22 number of procedures related to gastroenterology that
23 are being performed. Colorectal cancer is one of the
24 leading causes of death in the United States. There's

1 been more increased awareness. I'm sure you all have
2 heard about colonoscopies and endoscopies. These are
3 the type of procedures that will be performed in the
4 center is that we are proposing.

5 We want to encourage a center that has easy
6 access for the patient, is less costly, and navigation
7 would be easy, and this is what our proposed plan is.
8 And the area that we are sort of wanting to emphasize
9 on is to make it less stressful, patient centered, and
10 easy to navigate.

11 I've met with a lot of the leaders of the
12 hospitals and the health systems that we currently
13 practice out of, and I've assured them that the number
14 of procedures that we do perform at their centers will
15 not change because of the fact that our practice has
16 been growing in numbers.

17 We have moved from a four-person group to,
18 hopefully, very soon to be a six-man group, and the
19 number of procedures related to gastroenterology have
20 been increasing because of the awareness, because of
21 the fact that there's a lot of referrals related to
22 colonoscopies and endoscopies. So the sheer volume in
23 numbers at the other centers will not change.

24 There are several endoscopy and surgical

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1 centers in the area, but, unfortunately, they do not
2 accept a lot of the insurances, including Medicaid and
3 Medicare, and we are not members of those endoscopy
4 centers.

5 So one of the proposals that we have,
6 wanting to make sure that we are able to refer to this
7 center and have easy access, less cost for our patient
8 population, which includes the insurances that
9 I mentioned.

10 So I wanted to thank you for giving me the
11 opportunity to express myself and letting you know
12 what our plans are and wanted to hand it over to our
13 attorney to talk about any further issues related to
14 the Board.

15 MS. RANALLI: Thank you, Dr. Mahdavian.

16 Again, my name is Clare Ranalli. To my left
17 is Pam Bell, who will be the administrator for this
18 surgical center, and to her left is Shawn Albritton,
19 who is the CON specialist for Presence Health.

20 With respect to the negatives in the State
21 Board report, one related to the cost, and that was
22 our bad, and I apologize for it.

23 The costs that we included in our costs for
24 this project duplicated costs that will relate to

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1 Dr. Mahdavian's practice that will be leased and built
2 out. And it will be right next to the surgery center,
3 which will be excellent so the patients can be seen
4 there.

5 That cost should not have been included in
6 this project. If we included only the leased space
7 for the actual surgery center, the cost would be
8 significantly lower and within your State Board
9 standards. And, again, we apologize for that error.

10 The other negative findings related to the
11 many ORs in the service area. Obviously, Holy Family
12 is located in a very densely populated area. There
13 are a number of hospitals, ORs, and surgery centers
14 within the area.

15 However, the two procedure rooms at Holy
16 Family Medical Center where endoscopy procedures are
17 done are no longer -- and this is in the
18 application -- they will no longer be used for
19 endoscopy procedures. We are closing those two
20 procedure rooms, and they will be, in essence,
21 transferred to the medical office building that is
22 right next to Holy Family, where Dr. Mahdavian and his
23 practice will lease space and the surgery center will
24 be located.

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1 This is a single-specialty surgery center
2 dedicated solely to gastroenterology procedures.
3 There's no opposition. So although there are many ORs
4 and potential capacity, it certainly is not as if
5 there is any opposition to the project. And as
6 Dr. Mahdavian said, he was very proactive and met with
7 a number of leaders at various hospitals where he
8 currently practices, and they were supportive of him
9 and this project.

10 If you have any questions, we would be happy
11 to answer them.

12 Thank you.

13 CHAIRMAN OLSON: Doctor.

14 MEMBER GALASSIE: And -- and -- I'm sorry,
15 Doctor.

16 I -- did you say under and uninsured would
17 have access? Medicaid would have access?

18 DR. MAHDAVIAN: Correct.

19 MEMBER GALASSIE: Thank you.

20 CHAIRMAN OLSON: Doctor.

21 MEMBER GREIMAN: Can you tell --

22 MEMBER BURDEN: Thank you, Madam Chair.

23 I have Table 3 in front of me here on
24 page 13, and I guess I'm slow to pick up on what is

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1 the charges that hospitals charge versus the charge
2 the ASTC charges, which are identical, that -- I don't
3 quite understand what APC -- "wage-adjusted APC"
4 means.

5 MS. BELL: So I'll answer that. Actually,
6 there are some -- you are right; there are some
7 duplications.

8 So if you look at the third column where it
9 says "Charge" and then the last column, those are
10 exactly the same.

11 MEMBER BURDEN: Yes.

12 MS. BELL: It was duplicated and it was an
13 oversight.

14 MEMBER BURDEN: So that's the charge the
15 hospital charges and the same --

16 MS. BELL: That's the charge, not for the
17 center that we're proposing.

18 MEMBER BURDEN: Pardon?

19 MS. BELL: This would be the charge for the
20 ASTC.

21 MEMBER BURDEN: But the same is --
22 essentially the same as the hospital charges, aren't
23 they? They are.

24 MS. BELL: The hospital charge is the EPIC

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1 charge, where it -- and that should have just said --

2 MEMBER BURDEN: What does "E-P-I-C" mean?

3 MS. BELL: That's our electronic health
4 record. EPIC is the EMR system that we utilize.

5 MEMBER BURDEN: So E is the electronic,
6 P is --

7 MS. BELL: No, EPIC is the name of the
8 system.

9 MEMBER BURDEN: Oh. Well, then I -- okay.
10 And that is the charge that the hospital eventually
11 charges; is that it?

12 MS. BELL: That's the base charge for the
13 hospital. So in our electronic medical record, we
14 have a base charge of the 2950.

15 MEMBER BURDEN: Yes.

16 MS. BELL: And then any additional things
17 that are done during the procedure -- if they do a
18 biopsy or anything like that -- that would be
19 additional charges above that.

20 MEMBER BURDEN: I was hopeful that it would
21 show me the reason why we all love to support
22 ambulatory surgical treatment centers, because they
23 should be cheaper --

24 MS. BELL: Right.

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1 MEMBER BURDEN: -- than the expenses one
2 incurs at a hospital.

3 Does this chart demonstrate that? I thought
4 it would.

5 MS. BELL: It does. So if you look at the
6 last column where it says "ASTC Charge" --

7 MEMBER BURDEN: Yes.

8 MS. BELL: -- that's the charge that we
9 would be charging --

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

11 MS. BELL: \$700 cheaper than the base rate
12 that the hospital charged.

13 MEMBER BURDEN: So the adjacent column,
14 where "EPIC" is, is the distinction? That's
15 700 bucks.

16 MS. BELL: Right.

17 MEMBER BURDEN: Right down the line, those
18 numbers -- so that you are charging \$700 less than the
19 hospital charges?

20 MS. BELL: This is correct.

21 MEMBER BURDEN: Okay. Independently, you
22 have self-pay. Now, how does that fit in? What's
23 that --

24 MS. BELL: It should not -- actually, it

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1 probably should not have been presented in this just
2 because it does cause confusion.

3 So those are --

4 MEMBER BURDEN: It's got me confused so --

5 MS. BELL: I know.

6 Those are the rates that we charge for
7 patients who have no insurance, no means of -- no
8 other support. So we provide them with self-pay
9 rates.

10 MEMBER BURDEN: Okay. That's an uninsured
11 patient?

12 MS. BELL: Correct.

13 MEMBER BURDEN: My understanding is that
14 65 percent of the uninsured patients appearing in
15 hospitals now are -- excuse me -- the changes are less
16 than 65 -- excuse me. I'll get this correct if I can
17 understand it.

18 The changes since the advent of the
19 Affordable Care Act, there are at least 65 percent
20 more patients who now have insurance than did have
21 one; hence, hospitals no longer are picking up that
22 large amount of uninsured patients.

23 Are you -- you expect that number to still
24 be where it is for self-pay? I mean, there are -- the

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1 significance would be you have Medicaid patients,
2 apparently --

3 MS. BELL: We are actually starting to see
4 that more and more patients are coming through the
5 hospital with insurance through the Affordable
6 Care Act.

7 MEMBER BURDEN: What would Medicaid pay this
8 patient who has a charge of \$2200? Would they -- do
9 you have any idea?

10 I'm just curious.

11 MS. BELL: No, I don't know what Medicaid
12 would cover --

13 MEMBER BURDEN: Okay.

14 MS. BELL: -- for the ASTC.

15 But Medicaid would certainly be a part of
16 our population. It's a population that
17 Dr. Mahdavian's practice takes care of, and it's the
18 population that Presence Holy Family has always
19 cared for.

20 MEMBER BURDEN: Well, it's important to us
21 to hear that.

22 As a matter of fact, I've had discussions
23 with prior ambulatory surgical treatment proposals --
24 from orthopedists, for example -- and they didn't

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1 accept Medicare or Medicaid.

2 Now, we can't insist we do. I think we're
3 entitled to tell them "Apply for it," and, hopefully,
4 some will use it.

5 But I'm very -- I've had -- you answered the
6 question Mr. Galassie asked already, so you do accept
7 Medicaid, and I'm happy to hear that.

8 I'm sorry to take so much of your time on
9 this one because I couldn't understand this graph, and
10 you helped me a little bit. I'm still having little
11 problems with it but it's better.

12 Okay.

13 CHAIRMAN OLSON: Mr. Bradley.

14 MEMBER BRADLEY: Explain to a layman exactly
15 what you're going to be doing in this procedure.

16 DR. MAHDAVIAN: So, basically, there are two
17 main procedures that are being done related to
18 gastroenterology.

19 And the best way to describe it is an upper
20 endoscopy, which is a tube that has a light at the end
21 and a camera at the other end, and you actually look
22 at the stomach and look at the esophagus. And you
23 mainly look for either problems -- either somebody who
24 has had problems -- long-standing problems and looks

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1 for diseases or conditions that are potentially
2 precancerous or looking in the colon, which is using a
3 colonoscope -- I'm sure, looking in the population
4 here, a lot of us have gone through this. And the
5 concept behind it is -- is a tube that basically goes
6 through the rectum and looks at the entire colon.

7 And the specific reason for that is to
8 screen for colorectal malignancy and polyps, polyps --
9 some of which are precancerous, identifying those.

10 MEMBER BRADLEY: I understand. And what
11 percentage of the procedures that you do will be
12 colonoscopies?

13 DR. MAHDAVIAN: In general, currently we
14 do -- about 60 to 70 percent of our procedures are
15 colonoscopies.

16 MEMBER BRADLEY: Again, I'm a layman but I'm
17 reading that the kind of colonoscopy that you describe
18 is no longer the most recommended, that there's a
19 noninvasive procedure.

20 DR. MAHDAVIAN: Very good question.

21 MEMBER BRADLEY: What are the reasons that
22 colonoscopies of the type you described continue to be
23 provided? Is it because the providers or physicians
24 have a larger investment in this kind of procedure?

1 What's your response to that?

2 DR. MAHDAVIAN: That's a very good question.

3 There are actually probably three different
4 modalities, three different ways of looking in the
5 colon specifically with respect to colorectal
6 malignancy.

7 There are a lot of newer, stool-based
8 studies, DNA-based studies that are coming out.
9 Unfortunately, they're not that reliable yet. They're
10 not state of the art yet, and the sensitivity and
11 specificity are not there yet. I suspect that this is
12 going to change, probably in about 5 to 10 years.

13 With respect to the other modality, which is
14 a X-ray-based, CT-based study, which is called a
15 CT colography, that is also probably not mastered yet.

16 Unfortunately, the term "noninvasive"
17 probably doesn't apply to it as much because there is
18 still some contrast that has to go through the rectum,
19 and there are some potential risks, not as much as
20 colonoscopy.

21 Unfortunately, when it comes to detection
22 rate, it's probably not as good. So still standard of
23 care without question is colonoscopy. Is that going
24 to change 5 to 10 years from now? Maybe.

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1 But given the fact that we are aging, it's
2 an aging population, we understand more and more about
3 the disease and we try to recognize the disease
4 earlier and earlier, colonoscopy is still going to
5 have a significant role.

6 CHAIRMAN OLSON: Yes, Doctor.

7 MEMBER GOYAL: Madam Chair, thank you for
8 allowing me this question.

9 We did an informal survey in downtown
10 Chicago, and we found out that an average Medicaid
11 patient for a screening colonoscopy waits 18 months to
12 be scheduled, whereas, for a non-Medicaid, paying
13 patient, you can get it done the next day.

14 So a year from now or two years from now,
15 can I come back to you and insist that you treat these
16 patients equally and that our patients can get into
17 your center right away?

18 DR. MAHDAVIAN: Thank you for that question.

19 I'm going to hereby tell you that there will
20 be absolutely no difference. Services will be
21 provided by -- for Medicaid patients the same way that
22 they're provided by self-pay patients as well as other
23 insureds. No difference.

24 And that is my standard of practice

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1 currently.

2 MEMBER GOYAL: I'll hold you to it.

3 CHAIRMAN OLSON: Mr. Sewell.

4 MEMBER SEWELL: I need some clarification on
5 things that were said before.

6 First of all, on this 1120 criteria, you're
7 basically saying that you didn't include the correct
8 costs because you used some of the costs from a
9 physician practice instead of from this project; is
10 that right?

11 MS. RANALLI: Right. We used the total
12 dollar cost for gross square footage for the physician
13 office space and the surgery center, and that was the
14 number. And then that number was divided by the gross
15 square footage for the surgery space, so it was
16 inflated, correct.

17 MEMBER SEWELL: So if you had used the
18 correct numbers, would you be within the State Board
19 standard?

20 MS. RANALLI: We would be, to my
21 recollection, \$20 over the State Board standard per
22 gross square foot.

23 MEMBER SEWELL: Okay.

24 MS. RANALLI: Oh, it was under -- Pam is

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1 telling me --

2 MS. BELL: 147.

3 MS. RANALLI: -- 147. So we'd be under.

4 MEMBER SEWELL: You'd be under.

5 MS. BELL: Under.

6 MEMBER SEWELL: Yeah. Let me change "over"
7 to "under."

8 MS. RANALLI: Yes. She knows the numbers.

9 MEMBER SEWELL: Now, this service
10 accessibility criteria, I need for you to repeat what
11 you said that makes the staff report -- that would
12 create a revision, I guess, in the staff report about
13 the procedure rooms.

14 You said you wouldn't be doing endoscopy.

15 What else did you say? I didn't pick
16 that up.

17 MS. RANALLI: Right. At Holy Family -- so
18 the State Board looks at all of the ORs within the
19 service area for the ASC.

20 We are not contributing to the OR excess
21 capacity because we're taking two ORs at Holy Family
22 than are currently dedicated to endoscopy and placing
23 them in the surgery center, and Holy Family will no
24 longer do endoscopy.

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1 So it's sort of a zero sum gain regarding
2 ORs. With respect to the correlating finding of
3 impact or potential impact or duplication of services
4 because there are ORs in the area, obviously, that
5 could be used, the same is true. We're taking two ORs
6 and putting them into a surgery center and taking them
7 out of the hospital setting. The surgery center, as
8 Dr. Mahdavian said, is less costly and more patient
9 friendly.

10 And with respect to duplication of services,
11 Dr. Mahdavian is already doing these procedures at
12 Holy Family. Now he will be doing them at the surgery
13 center, and those procedures that he does at other
14 hospitals -- he spoke to the CEOs at those very
15 hospitals and addressed that issue with them. And, as
16 he said, his practice is growing, so he'll still be
17 referring to those hospitals, so there will be no
18 duplication of services, which I think is why there's
19 no opposition to this project.

20 MEMBER SEWELL: And one last question:
21 I think I heard, Doctor, in your testimony that some
22 of these other providers -- ambulatory surgery
23 treatment center providers -- in the area do not take
24 Medicaid. Do they do any -- do they treat any

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1 uninsured patients? I'm --

2 DR. MAHDAVIAN: I'm not sure.

3 MEMBER SEWELL: Talk to me about that.

4 DR. MAHDAVIAN: I'm not sure about the level
5 of -- first of all, we are not on staff, as I
6 mentioned before, in those ambulatory centers.

7 MEMBER SEWELL: Right.

8 DR. MAHDAVIAN: But a lot of them, when we
9 have approached them in the past, they do not accept
10 the uninsured and definitely not Medicaid. I can tell
11 you that I know of at least two or three of the
12 endoscopy centers within the vicinity that do not
13 accept that.

14 MEMBER SEWELL: Okay. And then I guess
15 I wanted to ask my question. This may not be fair
16 because all these things just came up.

17 But do you have any comment on what the
18 Applicant is saying about the 1120 finding or the --

19 MR. CONSTANTINO: This is the first time
20 I've heard it.

21 MEMBER SEWELL: Okay. And what about the
22 other two findings?

23 MR. CONSTANTINO: Regarding -- it's been our
24 experience ASTCs do not provide Medicaid --

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1 MEMBER SEWELL: Okay.

2 MR. CONSTANTINO: -- and no charity care.

3 That's the same numbers we get year
4 after year, very little Medicaid and no charity care.

5 MS. BELL: Can I insert in there, though,
6 that this is 51 percent owned by Presence Health? And
7 so our charity care and Medicaid policies will apply
8 to this project.

9 MEMBER SEWELL: I'm done.

10 CHAIRMAN OLSON: Other questions or
11 comments?

12 VICE CHAIRMAN HAYES: Madam Chairman.

13 CHAIRMAN OLSON: Go ahead.

14 VICE CHAIRMAN HAYES: Thank you.

15 In this case, this is -- Holy Family is a
16 long-term, acute care hospital; is that correct?

17 MS. BELL: Yes.

18 VICE CHAIRMAN HAYES: So the procedures that
19 are done in the hospital itself are limited to those
20 patients; isn't that correct?

21 MS. BELL: No. We also maintain a full
22 outpatient services area. So we have patients who
23 have come in for imaging services or for -- that can
24 have some surgery. We do plastic surgery, some

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1 podiatry surgery.

2 VICE CHAIRMAN HAYES: Okay. But will this
3 center have outside patients? A majority of this
4 center that you're proposing will have outside
5 patients coming in through doctors' practice?

6 MS. BELL: Yes.

7 VICE CHAIRMAN HAYES: Okay. So when you --
8 when you take away these procedure rooms, they're
9 really apples and oranges here. You know, the
10 procedure rooms at Holy Family are probably doing less
11 than what your proposed procedure rooms -- and there's
12 two of them, isn't there, at this ASTC? -- and, thus,
13 that is affecting the supply or, you know, the amount
14 of procedure rooms available in the area.

15 It's not like a -- an apples and oranges --
16 it's an -- apples and oranges and you're not having
17 this substituting two rooms of a hospital for this two
18 rooms at this ASTC.

19 MS. RANALLI: If I'm following your
20 question, just to be clear, it actually is apples to
21 apples.

22 The hospital procedure rooms -- there are
23 two of them -- see patients -- Dr. Mahdavian in his
24 practice; they're also open to any patient that a

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1 physician on staff might refer to those rooms for
2 endoscopy procedures.

3 The surgery center similarly will have two
4 rooms. Now Holy Family will have none. And just like
5 the hospital, it's open to any patients that might be
6 referred to it.

7 So I -- I think it's apples to apples, but
8 if I'm missing your distinction, I apologize if I'm
9 not answering your question thoroughly.

10 VICE CHAIRMAN HAYES: Well, it -- I think
11 that what the doctor was saying is that, you know, he
12 expects his practice to grow and to be able to use
13 that. I understand that.

14 But I think we look at a lot of historical
15 information here, and, you know, he's had a lot of --
16 he's had patients that he's referred to Lutheran
17 General, which is not far from here, and then
18 West Suburban is a little farther but, you know, he's
19 referred patients there.

20 And, you know, so, thus, when you're taking
21 away the Holy Family procedure rooms, you know,
22 I think that he, hopefully, expects to have a --
23 significantly more procedures done at the ASTC in
24 those two rooms.

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1 DR. MAHDAVIAN: I think I can refer to that
2 related to my practice.

3 What happened -- what is happening, what our
4 proposed plan will be is the procedures that are
5 currently being done at the Holy Family Hospital,
6 those procedures will go to the ambulatory center.
7 That will be the proposed plan.

8 Certainly, there will be some changes in
9 terms of the number of procedures that we have had
10 done at West Suburban Hospital, Northwest Community
11 Hospital, as well as Advocate Lutheran, but the
12 number -- the sheer number will not change that much.

13 Historically in the past five years, we've
14 had an increase of about 10 to 15 percent individually
15 in our practice, members of our practice, in terms of
16 the number of procedures that we provide.

17 We are adding two additional physicians in
18 our practice, and with just the projected -- even a
19 very low estimation, the sheer number of procedures
20 that we do will increase significantly.

21 So I understand what your question is. The
22 total number of procedures will increase and has been
23 increasing, and, therefore, the net change, if any, at
24 any of the other hospitals will be minimal,

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1 negligible.

2 Does that answer your question?

3 VICE CHAIRMAN HAYES: Yes. Thank you.

4 MR. CONSTANTINO: Madam Chair --

5 CHAIRMAN OLSON: Dr. Burden.

6 MEMBER BURDEN: I have a question for
7 Mr. Constantino. I want to keep him from falling
8 asleep.

9 Under State Board standards not met --
10 I'm sure I missed this -- the criteria unnecessary
11 duplication and maldistribution, I read this over
12 several times. Perhaps you can explain what's being
13 said in that distinctive column. I can't.

14 There are -- there's data that you have
15 demonstrated currently presenting an issue -- how
16 many -- how many of the services that are being
17 provided are within the area that need to be
18 discussed?

19 MR. CONSTANTINO: Okay.

20 Our rules require a 45-minute time frame,
21 not 30. That's what we consider a GSA or geographic
22 service area, 45 minutes. And we identified for you
23 all the facilities within that 45-minute area.

24 And what I've done here in this summary is

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1 stated or told you that there's 52 ASTCs within
2 45 minutes, and that's adjusted for our rules,
3 adjusted times, travel times.

4 Of those 52 facilities, 5 are not yet
5 operational. Of those 47 facilities -- 52 minus the
6 5, which gave me 47 --

7 MEMBER BURDEN: Right.

8 MR. CONSTANTINO: -- 21 provide gastro
9 services.

10 Of those 21 facilities, 16 have capacity to
11 accommodate this workload that's being proposed.

12 CHAIRMAN OLSON: But of those 16, how many
13 take Medicaid? Do we know that?

14 MR. CONSTANTINO: Like I said -- no, I don't
15 know each individual facility. But the data we get --

16 CHAIRMAN OLSON: But they're all ASTCs in --

17 MR. CONSTANTINO: Yeah.

18 The data we get year after year, very little
19 provide Medicaid or no charity care.

20 CHAIRMAN OLSON: Right.

21 MS. BELL: And we didn't have opposition
22 from any of those sites.

23 CHAIRMAN OLSON: Yeah. I thought that was
24 interesting.

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1 MR. CONSTANTINO: I would like to make --

2 MEMBER GALASSIE: Good point.

3 CHAIRMAN OLSON: Yes, Michael.

4 MR. CONSTANTINO: Okay. The change in the
5 cost for gross square foot, that's a Type B
6 modification. Generally, that's reported to us. It
7 doesn't require a new public hearing or -- or anything
8 like that.

9 CHAIRMAN OLSON: So we can still vote, but
10 they should give you that --

11 MR. CONSTANTINO: Well, that's -- it's
12 however you want to handle it. If you want to defer
13 it or you want to --

14 MEMBER GALASSIE: Contingent upon?

15 MR. CONSTANTINO: Yeah. I -- this is the
16 first I'm hearing of the change in the cost.

17 MEMBER GALASSIE: I see.

18 MR. CONSTANTINO: But that's generally
19 considered a Type B modification.

20 MR. MORADO: Mike, where are we at in terms
21 of the time period of this requiring consideration?

22 MR. CONSTANTINO: This is the first time
23 they've -- they still can defer it.

24 MS. RANALLI: We would be happy to submit an

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1 additional statement indicating the revised gross
2 square footage so that it's in your record and, you
3 know, attested to, similarly with the application,
4 although we would prefer not to defer and have to come
5 back and redo this on what is a pretty straightforward
6 point -- although, again, our sincere apologies for
7 not catching this.

8 In fact, when we were -- when we were
9 reading the State Board report, the question came up.
10 It's like, "Why is this so costly?" and that's when we
11 dug into it and found out what happened.

12 MR. MORADO: And if this is approved today,
13 this would -- this change would be considered an
14 alteration?

15 MR. CONSTANTINO: No. It's a modification.

16 MR. MORADO: A modification?

17 MR. CONSTANTINO: Yeah.

18 MR. MORADO: They vote on the application
19 as is.

20 MR. CONSTANTINO: As is? Well, there would
21 be no change.

22 CHAIRMAN OLSON: You lost me there.

23 MEMBER GALASSIE: I'm -- just a comment if
24 I may. I'm inclined to vote in favor of this project

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1 because of increasing the access to the un- and
2 underinsured.

3 But I'm concerned about this last comment,
4 feeling that the --

5 CHAIRMAN OLSON: So let me just clarify.

6 We -- if we vote on the project and the
7 project's approved, then they supply you the numbers
8 and the numbers pan out the way they say they're going
9 to, nothing changes?

10 If we vote and approve it and they give you
11 the numbers and the numbers don't pan out -- actually,
12 all it's going to do is take away that one -- what
13 would happen is it would take away one of the negative
14 findings.

15 So we either go ahead and vote on it with
16 the three negative findings or -- they're asking
17 not -- they prefer not to defer. I'm inclined to say
18 we should go ahead and vote.

19 I mean, they can still get an intent to deny
20 if it doesn't pass and then come back with the
21 corrected numbers; right?

22 MR. CONSTANTINO: Yes. That's -- however
23 you want to handle it, yes. But I wanted you to be
24 aware that is a modification to the project.

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1 MEMBER SEWELL: Madam Chair.

2 CHAIRMAN OLSON: Yes, Richard.

3 MEMBER SEWELL: I have a slightly different
4 remedy than Mr. Galassie.

5 I will be inclined to vote against this
6 project and allow the Applicant to -- they've had a
7 counter to all three of the negative findings. So
8 they can enter into the record, when they come back
9 the second time, corrections on the 1120 finding,
10 clarification on the division of labor between them
11 and Holy Cross, and they might not have any findings
12 as a result of that.

13 So that's just a twist on -- Dale -- on the
14 way I view it.

15 MEMBER GALASSIE: I would tend to agree with
16 Richard. Well said.

17 CHAIRMAN OLSON: Well, I guess it's up to --
18 I mean, do you guys want to take your chances or --

19 MS. RANALLI: Given the concern and
20 understanding -- again, our apology for not catching
21 that cost information -- what we would like to do --
22 because I think it would address everyone's issues --
23 is defer the project, submit the revised cost
24 information. As Mr. Sewell said, we can address the

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1 issues concerning duplication, et cetera.

2 I don't know that those findings will go
3 away because technically I think they have to be, you
4 know, reported -- the excess ORs in the area -- but we
5 can justify them in writing as opposed to before you.

6 We can support what we submitted in the
7 application as well as the fact that we will be
8 serving Medicaid, et cetera. The charity care policy
9 and financial assistance policy for Presence is in the
10 application already, but we can refer back to that, as
11 well.

12 CHAIRMAN OLSON: Do you think it would be
13 possible to find out how many of those 16 other
14 facilities accept Medicaid?

15 MR. CONSTANTINO: Yes. We can do that.

16 CHAIRMAN OLSON: You just pick out
17 16 patients --

18 MR. CONSTANTINO: We can do that.

19 MEMBER GALASSIE: And if so, to what extent.

20 MR. CONSTANTINO: Yeah, we can do that.

21 CHAIRMAN OLSON: If they've taken one, that
22 doesn't mean --

23 MS. RANALLI: Right. Right. We can look at
24 that information as reported to the State. That's

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1 something that we could do.

2 MEMBER SEWELL: Good.

3 MEMBER GALASSIE: I'd like to see that.

4 CHAIRMAN OLSON: I'm going to suggest that
5 we do a Board deferral because I believe that would --
6 that benefits you.

7 MS. RANALLI: That will.

8 CHAIRMAN OLSON: So we do have a motion on
9 the floor.

10 Who made the motion and who seconded it?

11 VICE CHAIRMAN HAYES: But I have --

12 MR. ROATE: Motion made by Mr. Galassie;
13 seconded by Justice Greiman.

14 CHAIRMAN OLSON: Okay.

15 MEMBER GALASSIE: Do you want me to withdraw
16 the motion?

17 MEMBER SEWELL: Mr. Hayes has a comment.

18 CHAIRMAN OLSON: Mr. Hayes has a comment.

19 VICE CHAIRMAN HAYES: Yeah.

20 I also wanted to -- what is the situation
21 with their procedure rooms at Holy Family? What would
22 happen if, essentially, they didn't close them for
23 gastroenterology?

24 You know, do they have a -- when we vote on

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1 this project, are they required to close those
2 procedure rooms?

3 CHAIRMAN OLSON: No, I don't believe they're
4 required.

5 MR. CONSTANTINO: They're converting them to
6 ophthalmology. And what I've been told is that they
7 will provide gastro services on an as-needed basis in
8 their surgery rooms.

9 CHAIRMAN OLSON: For the long-term care
10 residents.

11 MR. CONSTANTINO: Yes. That's my
12 understanding.

13 CHAIRMAN OLSON: Yes.

14 MR. CONSTANTINO: Is that correct?

15 Is that correct?

16 CHAIRMAN OLSON: So you're not going to --

17 MS. RANALLI: Yes.

18 MS. BELL: I was going to say -- yes, that's
19 correct.

20 So for the inpatients who cannot be served
21 in the surgical center, we'll still be able to take
22 care of the inpatients because we'll have the
23 equipment in the OR, which is separate from the area
24 where they go now.

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1 MR. CONSTANTINO: We wouldn't expect to see
2 outpatients there, though.

3 MS. BELL: No.

4 MS. RANALLI: No.

5 CHAIRMAN OLSON: But you -- did
6 I misunderstand?

7 Did you make a comment that they were also
8 doing like plastics and some other procedures in those
9 two rooms? Or is that in the hospital?

10 MS. BELL: We -- no. What I was saying
11 is we were a full -- a full-service, short-term
12 acute care hospital before we converted to an LTAC
13 10 years ago, and so we still maintain our OR suites
14 and have other services there.

15 CHAIRMAN OLSON: I understand.

16 All right. So we do have a -- you are
17 willing to rescind your motion?

18 MEMBER GALASSIE: I will withdraw that
19 motion.

20 CHAIRMAN OLSON: Okay. Other questions or
21 comments?

22 (No response.)

23 CHAIRMAN OLSON: Okay. So that will go down
24 as a Board deferral so as not to penalize the

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1 Applicant, and we'll see you next time.

2 MS. RANALLI: Great. And we appreciate the
3 opportunity to respond to these questions. Thank you.

4 DR. MAHDAVIAN: Thank you.

5 MS. BELL: Thank you.

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