

**In the Matter Of:**  
**HAYMARKET DuPAGE LLC**

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**REPORT OF PROCEEDINGS**

*May 05, 2021*

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1 PRESENT VIA REMOTE VIDEOCONFERENCE:

2 MR. BRENDAN DALY, Chairman;

3 MR. FRANK CARELLO, Commissioner;

4 MS. LORI DRUMMOND, Commissioner;

5 MR. JEFFREY HOLMES, Commissioner;

6 MR. ANTHONY RUSSO, Commissioner.

7  
8 ALSO PRESENT VIA VIDEOCONFERENCE:

9 MS. YORDANA WYSOCKI, Village Attorney;

10 MR. MO KHAN, Village Planner;

11 MS. CHRISTINE WILLIAMS, Recording Secretary;

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13 MS. BRIDGET M. O'KEEFE  
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8 Appeared on behalf of 865 West Irving Park  
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16 Appeared on behalf of Itasca Fire Protection  
17 District.

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I N D E X

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1 COMMISSIONER CARELLO: Chairman Daly?

2 CHAIRMAN DALY: Hello, Commissioner Carello.

3 COMMISSIONER CARELLO: Moving forward, are we  
4 allowed to attend, if we choose to, to come to the  
5 village hall?

6 CHAIRMAN DALY: Yes.

7 COMMISSIONER CARELLO: Okay. Thank you.

8 CHAIRMAN DALY: Good evening, everyone.

9 Welcome to this meeting of the May 5th, 2021 Itasca  
10 Plan Commission. I call this meeting to order.

11 Will the secretary please call the  
12 role.

13 MR. KHAN: Commissioner Carello.

14 COMMISSIONER CARELLO: Here.

15 MR. KHAN: Commissioner Drummond.

16 COMMISSIONER DRUMMOND: Here.

17 MR. KHAN: Commissioner Holmes.

18 COMMISSIONER HOLMES: Here.

19 MR. KHAN: Commissioner Ray is absent tonight.  
20 Commissioner Russo.

21 COMMISSIONER RUSSO: Here.

22 MR. KHAN: And Chairman Daly.

23 CHAIRMAN DALY: Here.

24 I declare a quorum present.

1 Good evening, everyone. Today is  
2 Wednesday, May 5th, 2021. The case before the Plan  
3 Commission is PC #19-014 continued from April 28th,  
4 2021.

5 The petitioner and owner is  
6 Haymarket DuPage, LLC, and the location is  
7 860 West Irving Park Road.

8 The procedures for tonight's meeting  
9 moving forward are as follows: This evening we will  
10 begin with Itasca Fire Protection District Chief  
11 Burke followed by Mr. Kevin Wrigley, and with time  
12 permitting, Director of Police O'Connor.

13 The Plan Commission has adopted new  
14 rules of procedure which are now in effect. We are  
15 proceeding remotely due to COVID-19, and the public  
16 may watch the proceeding through the Village's  
17 YouTube channel.

18 Anyone wishing to make public  
19 comment will be able to do so after the presentation  
20 of cases. They will need to sign up on the Village's  
21 website. Anyone wishing to ask questions of the  
22 petitioner, Village staff, or other parties will be  
23 able to do so after the presentation of cases. The  
24 sign-up form is also on the Village's website.

1 Remote Village staff is monitoring  
2 the video streaming. If the video streaming does not  
3 work during the proceedings, we will stop and wait  
4 until the video streaming is fixed or rescheduled for  
5 a later date.

6 I would now like to invite Yordana  
7 Wysocki, our legal counsel, for her opening remarks.

8 THE REPORTER: I'm sorry. I can't hear  
9 anything.

10 MS. WYSOCKI: Can you hear me now?

11 THE REPORTER: Yes. Thank you.

12 MS. WYSOCKI: Okay. I'm sorry. I didn't  
13 realize I had to hit the mic button.

14 My name is Yordana Wysocki, and I'm  
15 the attorney advising the Plan Commission in this  
16 matter.

17 This is a legal proceeding with  
18 legal significance. A court reporter is swearing in  
19 witnesses and will be transcribing the testimony.  
20 This is not a trial, but we are developing a record  
21 of proceedings before the Plan Commission. This is a  
22 legal public hearing on a zoning petition.

23 My job is protect the rights of the  
24 petitioner, any objectors, and the public. The Plan

1 Commission will make findings and recommendations to  
2 the Village Board. Please understand that the Plan  
3 Commission is a recommending body. The Village Board  
4 will make the final decision on the Haymarket zoning  
5 petition.

6 Due to the pandemic and the  
7 Governor's emergency orders, we are unable to meet in  
8 person. A virtual hearing is not the preferred  
9 method for hearing the zoning petition; however, the  
10 business of government must move forward, and the  
11 virtual hearing has been approved by state statute  
12 and is used by local governments across the state.  
13 Everyone is doing the best they can under the  
14 circumstances.

15 The procedures used by the Plan  
16 Commission for large hearings during a pandemic are  
17 available on the Village's website. The website has  
18 a lot of information, including a comprehensive  
19 step-by-step guide about this hearing.

20 The Village will have an opportunity  
21 to ask questions -- excuse me. The public will have  
22 an opportunity to ask questions and to provide  
23 comment to the Plan Commission at the appropriate  
24 time.

1                   Witnesses will be presented by the  
2 petitioner and possibly by other interested parties.  
3 Cross-examination will be allowed only by the  
4 attorneys and anyone who has been legally recognized  
5 by an interested party -- as an interested party by  
6 this Commission.

7                   Finally, this is a slow and  
8 deliberate process that creates a record appropriate  
9 for the Plan Commission hearing. We ask that you  
10 please respect the legal process even if you do not  
11 agree with it.

12                   That's all I have for now,  
13 Mr. Chairman.

14                   CHAIRMAN DALY: Thank you, Ms. Wysocki.

15                   With that, the business before the  
16 Commission this evening is the public hearing on case  
17 PC #19-014. The request is for a petition for a  
18 planned development by special use with exceptions  
19 and Class I Site Plan approval all in order to permit  
20 a mixed-use residential and healthcare facility and  
21 other accessory uses in the B-2 Community Business  
22 District at 860 W. Irving Park Road.

23                   I will now entertain a motion to  
24 open this continued public hearing.

1 COMMISSIONER HOLMES: So moved.

2 COMMISSIONER CARELLO: Second. Commissioner  
3 Carello.

4 CHAIRMAN DALY: There being a motion and a  
5 second, will the secretary please call the vote.

6 MR. KHAN: Commissioner Carello.

7 COMMISSIONER CARELLO: For.

8 MR. KHAN: Commissioner Drummond.

9 COMMISSIONER DRUMMOND: For.

10 MR. KHAN: Commissioner Holmes.

11 COMMISSIONER HOLMES: For.

12 MR. KHAN: Commissioner Russo.

13 COMMISSIONER RUSSO: For.

14 MR. KHAN: Chairman Daly.

15 CHAIRMAN DALY: For.

16 The motion carries. The public  
17 hearing is now open.

18 At this time I would ask the court  
19 reporter to swear in Chief Burke.

20 (Witness sworn.)

21 CHAIRMAN DALY: Thank you. At this time,  
22 Ms. O'Keefe, are you still in cross-examination?

23 MS. O'KEEFE: Yes, Mr. Chairman, I am. I  
24 have a few more questions.

1 CHAIRMAN DALY: Please proceed.

2 MS. O'KEEFE: Okay. Thank you, sir.

3 FRANK F. BURKE, JR.

4 recalled called as a witness herein, having been  
5 first duly sworn, was examined and testified as  
6 follows:

7 CROSS-EXAMINATION

8 BY MS. O'KEEFE:

9 Q. Good evening, Chief Burke.

10 A. Hello, Counsel.

11 Q. Just a few more questions.

12 Since last week's meeting, have you  
13 conducted any further research on this case?

14 A. No, I haven't conducted any research.

15 I did take a look at some of the --  
16 the data that was presented under exhibits -- that  
17 you had presented as exhibits, reviewed some of  
18 those.

19 Q. Have you had any further conversations  
20 with Mr. Moeller?

21 A. Not since our last meeting, no.

22 Q. Were you asked by anyone to review any  
23 additional information?

24 A. No.

1 Q. Have you had any conversations with your  
2 staff about the information that was provided at the  
3 hearing?

4 A. No.

5 Q. Are you aware that the Village of Itasca  
6 can make a condition of the zoning approval the need  
7 to have a contract with a secondary ambulance in  
8 place at all times?

9 A. No, I wasn't aware of that.

10 Q. So when you're doing a planned  
11 development or a special use, it can be common for a  
12 Village to put a condition on the use; and if the --  
13 if the user doesn't comply with that condition, they  
14 can stop the use on the site. So they can halt the  
15 operation.

16 So, for example, if the Village was  
17 to place a condition on the approval of the planned  
18 development saying you have to have a secondary  
19 ambulance in place and we don't, they could shut us  
20 down.

21 So then if -- you're not aware that  
22 Haymarket has agreed to such a condition already?

23 A. Counsel, I haven't seen anything from  
24 Haymarket, as I mentioned last week, other than, you

1 know, having that initial meeting with them. I have  
2 not seen anything officially. You had asked about  
3 the Elite contract. I haven't seen the Elite  
4 contract.

5 And, again, there would have to be,  
6 in my mind, some performance metrics that go along  
7 with that contract that would need to be reviewed as  
8 well.

9 Q. And so that's a little outside the  
10 question that we're talking about right now. We're  
11 talking about just a -- just a condition.

12 But say, for example, we were to  
13 agree to a condition, share with you a contract, sit  
14 down and meet with you and talk about performance  
15 metrics, is that something that would give you more  
16 comfort with the use?

17 MR. DI NOLFO: I'm just going to object. It  
18 calls for speculation and lack of foundation.

19 But go ahead, if he knows.

20 BY THE WITNESS:

21 A. Again, I would say, much like I said last  
22 week, this would be -- this would be up to my Board.  
23 This really is a decision that would have to be  
24 discussed with my Board of Trustees to get their

1 thoughts on this before I would commit to any --  
2 anything you just mentioned.

3 BY MS. O'KEEFE:

4 Q. Well, for the record, you know, our  
5 client has authorized us to make that offer to sit  
6 down at any time. So we hope you will present it to  
7 the board and potentially, you know, agree to a  
8 meeting where we can have some constructive  
9 conversations to address these issues.

10 A few more questions: Have you  
11 discussed the Haymarket project with the mayor?

12 A. No, I have not.

13 Q. So in the last two years since it first  
14 came to be when the initial conversations were in  
15 April of 2019, from April 2019 to now, you've never  
16 discussed this case with the mayor?

17 A. No.

18 Q. Okay. Have you ever discussed this case  
19 with Superintendent Benes?

20 A. No.

21 Q. Okay. Have you ever discussed this case  
22 with Director O'Connor?

23 A. No, I haven't had any conversations  
24 with -- with any of the people you've mentioned.

1 Q. Are you familiar with House Bill 2853  
2 that was introduced by Representative Lewis?

3 A. I am aware of it, yes.

4 Q. Have you discussed that legislation with  
5 any party in -- either the mayor, any commissioners,  
6 trustees, school district?

7 A. The only -- the only person that we've  
8 had any discussion with was legal, that I've had  
9 discussion with.

10 Q. Did your office play a role in drafting  
11 the legislation?

12 A. No.

13 Q. If it was adopted, would it be fair to  
14 say that the district's economic concerns would be  
15 addressed?

16 A. I can't really comment on that,  
17 Counselor. I don't know the extent of how the bill  
18 exactly reads or what's being proposed.

19 MS. O'KEEFE: Okay. Mr. Chairman, I would  
20 like to introduce the -- one last question, and then  
21 I need to -- I realized I failed to introduce the  
22 exhibits into the record last week, so I need to do  
23 that before I close.

24

1 BY MS. O'KEEFE:

2 Q. But one last question: With regards to  
3 the exhibits that you looked over since the last  
4 hearing, did that -- did the data you review in any  
5 way cause you to change your testimony, or is there  
6 any modifications you'd like to make to the testimony  
7 you previously provided?

8 A. No, I mean I think I covered it pretty  
9 much in my testimony there as to what my thoughts  
10 were on that -- on that data that was presented.

11 MS. O'KEEFE: Okay. Well, thank you, sir.

12 And if I could introduce my  
13 exhibits, which -- Exhibits No. 64 through 78 into  
14 the record, Mr. Chairman.

15 CHAIRMAN DALY: We will accept those exhibits  
16 into the record. Thank you.

17 (Petitioner's Exhibit Nos. 64-78  
18 admitted.)

19 MS. O'KEEFE: I have no further questions.  
20 Thank you, Chief Burke.

21 THE WITNESS: Thank you, Counsel.

22 CHAIRMAN DALY: At this time I would ask if  
23 any of the attorneys have any follow-up questions  
24 based on the cross-examination by Ms. O'Keefe?

1 MR. DI NOLFO: Mr. Chairman, Steve DiNolfo  
2 here. I do have a few questions.

3 CHAIRMAN DALY: Okay.

4 MR. DI NOLFO: Thank you.

5 REDIRECT EXAMINATION

6 BY MR. DI NOLFO:

7 Q. Chief, counsel spent a lot of time I  
8 think last week, not so much this week, asking you  
9 about the State Fire Marshal numbers versus what your  
10 data showed for the mutual and auto aid calls.

11 Do you recall that?

12 A. Yes, I do.

13 Q. And I think we talked about Exhibit 67,  
14 which was, I think, a FOIA response that you provided  
15 to Haymarket; is that correct?

16 A. That's correct.

17 Q. And the data contained in that response,  
18 were those totals for auto aid and mutual aid that  
19 occurred for the time frame contained within that  
20 FOIA request?

21 A. Yes, they were.

22 Q. And that data that you provided in the  
23 FOIA, is that a summary of what you provided to  
24 ultimately the state through the NFIRS document you

1 submit?

2 A. Yeah, that's a -- that's a summary query  
3 right out of our in-house reporting system.

4 Q. And the data that's contained in  
5 Exhibit 67, are you -- given that it's your numbers,  
6 your documents, are you confident that they're  
7 accurate?

8 A. Yes.

9 Q. Out of curiosity, counsel last year -- or  
10 last week, I should say, indicated that the Office of  
11 the State Fire Marshal reports weren't available for  
12 2019 to 2020.

13 Were you able to see those when I  
14 showed them to you today?

15 A. Yes, I was.

16 Q. All right. And just real quick, I  
17 understand you don't agree with the numbers or  
18 actually understand --

19 MS. O'KEEFE: I'm going -- I'm going to object  
20 because we haven't been presented with the OSFM  
21 numbers from '19 and '20.

22 MR. DI NOLFO: Just go to the website.  
23 They're on there.

24 MS. O'KEEFE: No, I object. You're

1 questioning on something that's outside the scope of  
2 cross-examination, because we haven't seen those.  
3 They've not presented.

4           You had your opportunity to present  
5 them into the record and present them to us on  
6 Friday, and you failed to do so.

7           MR. DI NOLFO: I'm not introducing them into  
8 the record. I just asked him if he saw them.

9           MS. O'KEEFE: Well, you're cross-examining  
10 based on that information that's not been provided  
11 for review. So we -- we lodge a formal objection.

12           MS. WYSOCKI: Okay. So -- so, Mr. DiNolfo, I  
13 understand your question to be that you asked the  
14 Chief if he had seen these and whether -- I'm sorry,  
15 can you repeat your question, Steve?

16           MR. DI NOLFO: Basically I asked the Chief do  
17 you recall last week counsel said that the reports  
18 weren't available for 2019 and 2020 on the Office of  
19 the State Fire Marshal; was I able to show those to  
20 you today? That was my only question.

21           MS. WYSOCKI: Okay. I'm going to let that  
22 question proceed. Your objection is overruled.

23 BY MR. DI NOLFO:

24           Q. You can answer.

1           A.     So -- so, yes, I did see them.

2           Q.     And with Exhibit 66 that counsel went  
3 through with you, and I understand you and she  
4 disagreed about the numbers, just so I'm clear, is  
5 your concern -- strike that.

6                         What is your main concern when you  
7 talk about concerns involving Haymarket? Is it EMS  
8 or fire or both?

9           A.     Well, it's EMS calls for sure, I think is  
10 what we are talking about.

11          Q.     So I understand that you disagree with  
12 the numbers on Exhibit 66.

13                         When you look at the EMS calls and  
14 that percentage of what you tried to keep the call  
15 volume within so you're not overburdening or your  
16 neighbors aren't overburdening you, when you look at  
17 those, do those numbers, while you don't agree with  
18 them, fall within that range?

19          A.     They do.

20          Q.     Counsel also asked you about the  
21 Carol Stream facilities. I think it was Belmont  
22 Village and you also looked at some villages -- or  
23 some facilities in Bloomingdale.

24                         Why did you look at those

1 facilities?

2 A. The sole purpose there was to take a look  
3 at facilities that we -- ambulance provided service  
4 to and see just exactly what kind of relief they were  
5 giving to local EMS, if any.

6 Q. You weren't looking at those to say they  
7 provided the same service as the Haymarket facility  
8 downtown or what's proposed in Itasca, were you?

9 A. No, they weren't comps.

10 Q. When you looked at the data from  
11 Carol Stream and from Bloomingdale, from  
12 Hoffman Estates, did it do anything to reduce the  
13 concern you have about the impact the proposed  
14 facility would have on the Itasca Fire Protection  
15 District?

16 A. No. The data showed that local EMS was  
17 still responding to these facilities, you know,  
18 hundreds of times annually.

19 Q. And counsel spent some time on cross  
20 asking you about capacity, but does focusing solely  
21 on capacity give a true picture of what the proposed  
22 project impact may be on the Fire Protection  
23 District?

24 A. No, it's impact. Impact -- capacity

1 means nothing without impact.

2 Q. And based upon your review, what impact  
3 do you believe that the proposed facility will have  
4 on the operation of the Itasca Fire Protection  
5 District?

6 A. Well, I think that Mr. Moeller's report  
7 pretty well summed it up. I think we're going to see  
8 a significant increase in calls to that facility in  
9 town that is going to obviously put a demand on our  
10 single resource ambulance in the district and along  
11 with placing an added burden, I believe, on asking  
12 our neighbors to come in and help, you know, respond  
13 to those calls.

14 MR. DI NOLFO: That's all the questions I  
15 have, Chairman Daly. Thank you.

16 CHAIRMAN DALY: Thank you, Mr. DiNolfo.

17 Mr. Ellenbecker, do you have any  
18 questions in redirect?

19 MR. ELLENBECKER: I do not. I have no  
20 additional questions. Thank you.

21 CHAIRMAN DALY: Thank you. Ms. Smith, do you  
22 have any questions of Chief Burke at this time?

23 MS. SMITH: No, no additional questions.  
24 Thank you.

1 CHAIRMAN DALY: Thank you. Ms. O'Keefe, do  
2 you have any other follow-up questions before we turn  
3 it over to the Plan Commission?

4 MS. O'KEEFE: I do. I just have two, but I'm  
5 trying to find the testimony that Chief Burke  
6 provided.

7 CROSS-EXAMINATION

8 BY MS. O'KEEFE:

9 Q. And with regards to the FOIA information,  
10 Chief Burke, that you provided us on the mutual aid  
11 numbers with regards to 2019 and 2020, you reviewed  
12 those -- or you testified to those at the last  
13 hearing. And this was data that you provided. And  
14 if I recall -- and I'm trying to find his  
15 testimony -- those numbers weren't even. There was  
16 far more aid given than received.

17 And I just wanted you -- could you  
18 confirm that again, for the record?

19 MR. DI NOLFO: Could you just say the years  
20 again, Bridget? I'm sorry.

21 MS. O'KEEFE: It's 2019 and 2020, and it's in  
22 here. I'm just trying to find it. So please excuse  
23 me for my delay.

24 You can never find something when

1 you need it, right? A big record here.

2 MR. DI NOLFO: We got the exhibit, Bridget, in  
3 front of us.

4 BY MS. O'KEEFE:

5 Q. So for 2019 there were 360 calls given  
6 and 250 received, isn't that correct, under the data  
7 you gave us under -- in response to the FOIA? That's  
8 in Exhibit 67.

9 MR. DI NOLFO: We're just looking for the  
10 total. If that's the math, Bridget, we'll --

11 BY THE WITNESS:

12 A. Yeah, I don't -- I don't have the total  
13 in front of me, but...

14 BY MS. O'KEEFE:

15 Q. Okay. And then the testimony was also  
16 for 2020, it was 230 given to 155 received. But we  
17 can move on.

18 Secondly, just to -- just to confirm  
19 again for the record, there was a lot of testimony  
20 given regarding the AMITA facility in Hoffman  
21 Estates. There -- you don't know that they have a  
22 contract with Elite, do you?

23 A. No, and I didn't allude to that in my  
24 testimony.

1 Speaking with Chief Fortunato, I was  
2 told that they do have a contract with a private  
3 ambulance. I do not know if it is Elite.

4 Q. Okay.

5 A. But, again, the point there was to try  
6 and see how much burden they took off of local EMS by  
7 having that in place, and --

8 Q. But you never talked to AMITA to confirm  
9 they, indeed, have a contract with a private  
10 ambulance?

11 A. No, but the fire chief confirmed it.

12 Q. Okay. But you have no direct knowledge?

13 A. Other than what the fire chief told me,  
14 no.

15 Q. Okay. But we have confirmed Elite does  
16 not -- does not have a contract with them.

17 MS. O'KEEFE: So I have no further questions.  
18 Thank you, sir.

19 THE WITNESS: You're welcome.

20 CHAIRMAN DALY: Okay. Before we turn it over  
21 to the Plan Commission, do any of the other attorneys  
22 have any final questions?

23 MR. DI NOLFO: Chairman, this is Steve  
24 DiNolfo. I do not.

1 MS. SMITH: Jennifer Smith. No further  
2 questions.

3 MR. ELLENBECKER: Steve Ellenbecker. No  
4 questions.

5 CHAIRMAN DALY: Thank you all. At this time I  
6 would ask if the Plan Commission has any questions  
7 for Chief Burke.

8 COMMISSIONER RUSSO: I have one question. I  
9 believe that, Chief Burke, you said the initial cost  
10 was going to be close to a million dollars, and I  
11 just wanted to make sure I got the numbers correct.

12 And then what would you estimate the  
13 annual cost would be after that?

14 THE WITNESS: So just talking in sort of round  
15 figures, we would need to purchase another fully  
16 equipped paramedic unit. And that, just ballpark  
17 figure, would be roughly \$300,000 for that unit.

18 And then I would need, because  
19 fire -- the firefighter/paramedics work a 24-hour on,  
20 48-hour shift off, so they work every third day, I  
21 would need two additional staff for three of those  
22 days. So two times three is six additional staff  
23 members.

24 When I calculate, you know,

1 everything for, you know, firefighters and everything  
2 that goes along with that, that is roughly about  
3 125,000 annually for each additional staff member.  
4 So when you take those numbers and you add them all  
5 up, you're in the ballpark of a million dollars.

6 COMMISSIONER RUSSO: Okay. Fair enough. I  
7 just wanted to make sure I had those numbers right.

8 And that's not for the police  
9 department, that's only for the fire department;  
10 correct?

11 THE WITNESS: That's just the fire department.

12 And then that annual cost for  
13 staffing would be an ongoing thing. So, you know,  
14 you'd probably be in that 700 to 750,000 range  
15 annually.

16 COMMISSIONER RUSSO: Got you. All right.  
17 Thank you.

18 THE WITNESS: Sure.

19 CHAIRMAN DALY: Are there any other questions  
20 of the Commission?

21 COMMISSIONER CARELLO: Yes, I have one for  
22 Chief Burke.

23 So making an assumption that, let's  
24 say, they maybe do get a private ambulance, and does

1 it ever happen -- and I don't even know how to ask  
2 this question because it's a medical facility. So is  
3 it possible that multiple calls could happen at the  
4 same time for a facility such as this,  
5 Chief Burke?

6 THE WITNESS: Yeah, yeah, absolutely, it does.  
7 In fact --

8 COMMISSIONER CARELLO: So if their ambulance  
9 was in use responding to one call and a second call  
10 came, who would have to respond to that?

11 THE WITNESS: Well, again, I think that would  
12 hinge on who Haymarket would call in on that  
13 second -- you know, that second call.

14 You know, Haymarket's going to have  
15 to make a decision if this is, you know, the way they  
16 go as to who they're going to call, whether it's  
17 Elite or dial 911.

18 You know, some of that would  
19 probably hinge on the availability of the next  
20 closest ambulance. But certainly, you know, we're  
21 the closest of anybody being right up the road.

22 COMMISSIONER CARELLO: Well, but -- so you're  
23 saying if they have a contract with Elite, they can  
24 get multiple ambulances if needed, or they only get

1 one ambulance?

2 THE WITNESS: Well, that -- that I don't know  
3 because, again, I don't know how any of the contract  
4 reads or any of that. You know, that's a question  
5 you'd probably have to ask on their side.

6 COMMISSIONER CARELLO: And I guess that's the  
7 only thing that I'm confused on, because they keep  
8 saying one ambulance. Well, that's great if they --  
9 if Elite has one ambulance, but in the possible  
10 situation of multiple calls to the same location,  
11 they would need two ambulances or Itasca or Wood Dale  
12 or whoever is in our jurisdiction would have to come  
13 in and help.

14 I mean, wouldn't that work that way?

15 THE WITNESS: Yeah, it would, in that case,  
16 for sure.

17 COMMISSIONER CARELLO: Okay. That's kind of  
18 what I was trying to understand. Okay. Thank you.

19 THE WITNESS: Sure.

20 MS. O'KEEFE: Mr. Chairman, is it in order for  
21 me to answer that question since Chief Burke  
22 referenced? Would that be in order, or should we  
23 hold back?

24 MS. WYSOCKI: Sorry. I had to put the

1 headphones on because I was having trouble hearing  
2 you, Ms. O'Keefe, but it makes it really strange when  
3 I talk. So now I understand Chuck's constant  
4 movement.

5 It -- do you -- I would prefer that  
6 you wait to -- until the end to answer any of the  
7 Plan Commission's questions; or I don't know for your  
8 rebuttal case if you are going to present Dr. Lustig  
9 or someone who can answer those questions.

10 MS. O'KEEFE: Okay. I just wasn't sure if,  
11 you know, often with zoning there is more of a  
12 give-and-take. But we'll defer and respond to that  
13 question later.

14 MS. WYSOCKI: Thank you.

15 COMMISSIONER CARELLO: Thank you.

16 CHAIRMAN DALY: Are there any other questions?

17 Okay. Chief Burke, I just have one,  
18 and it's -- and Commissioner Russo already asked it,  
19 so I'm just going to ask for a little further  
20 clarification.

21 Back in mid April, you know, I was  
22 taking notes, and I did write down that you said the  
23 cap ex was really \$1 million for that first year for  
24 the ambulance plus the six additional personnel. And

1 there was the referendum, and that \$1 million  
2 referendum was able to generate, you know, the funds  
3 to do something of that nature.

4 But for us to -- and when I say  
5 "us," for the Fire Protection District to add an  
6 additional ambulance and six personnel would be a  
7 one-time downstroke of \$1 million, but the recurring  
8 fee or cost in salaries and benefits of \$700,000 per  
9 year, like would that mean that we -- the Village  
10 would need to approve a referendum every year in  
11 order to cover that shortfall, or would that be --  
12 like financially how would the Fire Protection  
13 District swing that?

14 THE WITNESS: Well, currently we wouldn't.

15 That's -- and just understand, the  
16 referendum that we were successful with from 2018 in  
17 no way, shape, or form reflects anything to do with  
18 Haymarket, obviously. So that was -- that was a  
19 referendum that obviously the taxpayers were gracious  
20 enough to pass for us purely for operational, you  
21 know, considerations and keeping staffing levels  
22 where they currently are.

23 This would be an additional six --  
24 six staff members, excuse me, and the one-time

1 purchase of the ambulance.

2 But you are correct in your  
3 statement that the ongoing personnel cost would  
4 exist, you know, well into the future. So funding  
5 for that, for us, you know, would be problematic  
6 right here right now.

7 CHAIRMAN DALY: Okay. Thank you for that.

8 And just as a follow-up, in addition  
9 to the operational expense, at the fire station is  
10 there currently room to add two more full-time  
11 employees for every shift? Do you have the physical  
12 capacity at the firehouse?

13 THE WITNESS: It would be tight. It would be  
14 tight.

15 CHAIRMAN DALY: Okay. And then one final  
16 question from me is, if you added more staff,  
17 firefighter/paramedics, would that change the  
18 leadership on an organizational chart where now there  
19 have to be certain people promoted to now manage the  
20 additional people coming in, or would you be able to  
21 just add those people and everything kind of stays  
22 static with leadership?

23 THE WITNESS: You know, that's -- that really  
24 is a great question. Truthfully, that decision would

1 have to be discussed with the Board.

2 Adding two more shift personnel to  
3 our existing organizational chart doesn't necessarily  
4 automatically mean that you'd need more, you know,  
5 administrative staff or officers, as we say, shift  
6 officers. But I think that's something we would  
7 definitely need to take a look at because our minimum  
8 staffing level would be higher on any given day.

9 CHAIRMAN DALY: Okay. Thank you. That's all  
10 the questions I have.

11 Any final follow-up questions from  
12 the Plan Commission at this time?

13 Okay. With that, thank you very  
14 much for being here these past evenings. We  
15 appreciate your testimony, and wish you a good night.

16 THE WITNESS: Thank you.

17 CHAIRMAN DALY: Before we move on, just a  
18 question for Mr. DiNolfo: Does the Fire Protection  
19 District have any other exhibits to be entered into  
20 the record?

21 MR. DI NOLFO: I believe I admitted my  
22 exhibits prior to completing my direct of  
23 Chief Burke. If I did not, I would move for  
24 admission of, I believe it was -- I have 19 to 41

1 listed on these. So if I haven't moved for admission  
2 of those, I would at this time.

3 CHAIRMAN DALY: Okay. We accept those. Thank  
4 you.

5 (Itasca Fire Protection District  
6 Exhibit Nos. 19-41 admitted.)

7 CHAIRMAN DALY: At this time,  
8 Mr. Ellenbecker, I believe your next witness is  
9 Mr. Kevin Wrigley; is that correct?

10 MR. ELLENBECKER: That's correct, Mr. Chairman.

11 CHAIRMAN DALY: Okay. Would the court  
12 reporter please swear in Mr. Wrigley at this time?

13 And where is Mr. Wrigley? Is he on  
14 camera somewhere?

15 MR. ELLENBECKER: There he is. He's on the  
16 middle right on my screen.

17 (Witness sworn.)

18 CHAIRMAN DALY: Okay. There he is. Thank  
19 you.

20 Mr. Ellenbecker, your witness.  
21 Please start your presentation.

22 MR. ELLENBECKER: Thank you, Mr. Chairman.

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KEVIN WRIGLEY

called as a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. ELLENBECKER:

Q. Good evening, Mr. Wrigley.

A. Good evening.

Q. Could you please introduce yourself to the Planning Commission?

A. My name is Kevin Wrigley. I currently am living in Greenville, South Carolina.

Q. Where do you currently work in Greenville, South Carolina?

A. I work for an organization called The Budd Group. We're a facility management company.

Q. Before moving to South Carolina, where did you live and work?

A. Well, right before we moved, I lived in Elgin, Illinois, and I worked at Leyden Family Services, the SHARE Program, in Hoffman Estates.

Q. And how long did you work for the SHARE Program?

A. From early 1999 until about May of 2017 when we moved to South Carolina.

1 Q. And could you give the Commission just a  
2 thumbnail of your education, I guess post-high  
3 school, including any certificate programs or  
4 accreditation programs or continuing education?

5 A. So my undergrad was at Bob Jones  
6 University in Greenville, South Carolina in criminal  
7 justice. At the time that I was at school, I  
8 finished an EMT Basic program at Greenville Technical  
9 College also in Greenville, South Carolina. I no  
10 longer hold that.

11 I have no other certifications.

12 Q. Okay. What is a -- what is an EMT-B  
13 certification, if you could?

14 A. So in -- there's layers to becoming a  
15 paramedic, and the EMT-B is the basic. It's the very  
16 first step.

17 And at least when I was going  
18 through the program, the next would be EMT-I, which  
19 would be intermediate, and then after that you would  
20 go on to get your paramedic license.

21 Q. Have you ever -- you're testifying here  
22 this evening, you've taken an oath to tell the truth.

23 Have you ever testified in a legal  
24 proceeding like this before?

1 A. No.

2 Q. And you've heard some mention so far this  
3 evening of the lawyers that are involved. There are  
4 several lawyers involved: Bridget O'Keefe, Mary  
5 Dickson, Steve DiNolfo, Jennifer Smith, Yordana  
6 Wysocki, I think Chuck Hervas or Charles Hervas is  
7 involved.

8 Have you ever worked for any of  
9 those lawyers before?

10 A. No.

11 Q. Have you ever worked on a case or a  
12 matter involving any of those lawyers before?

13 A. No.

14 Q. Do you know any of those lawyers I  
15 mentioned, either professionally or personally?

16 A. Of the names you mentioned, I know Chuck  
17 Hervas.

18 Q. And how do you know Mr. Hervas?

19 A. We attended the same church together  
20 while -- while living in the Chicagoland area.

21 Q. Okay. And I notice, maybe it's just a  
22 coincidence, but the two of you went to Bob Jones  
23 University.

24 Did the two of you graduate

1 together?

2 A. No. No, he graduated sometime before me.

3 Q. Okay. We won't say how many years.

4 A. Yeah, I don't want to get in trouble,  
5 yeah.

6 Q. And at some point did I contact you  
7 asking you if you might be willing to testify in this  
8 matter?

9 A. Yes.

10 Q. And since the time I contacted you, have  
11 any of the lawyers I mentioned to you previously been  
12 in contact or had any involvement with you?

13 A. No.

14 Q. What was your understanding as to why I  
15 reached out to you and was interested in seeing if  
16 you might testify?

17 A. If I recall correctly, you inquired about  
18 my experience in working with Leyden Family Service.

19 Q. And you mentioned SHARE before. I think  
20 in this proceeding, people have referred to it -- to  
21 Leyden Family Services.

22 What should we call it? Is it  
23 Leyden Family, or was the rehabilitation facility  
24 known as SHARE?

1           A.     So I would imagine that the facility that  
2 they're -- that would be in question would be the  
3 SHARE Program. It's an inpatient treatment center  
4 located in Hoffman Estates.

5                     So Leyden Family Services would be  
6 the parent company. They're located in  
7 Franklin Park, and they have several locations in  
8 that area, Franklin Park and Leyden Township, and  
9 they focus primarily -- primarily on outpatient  
10 mental -- mental -- working with chronically mentally  
11 ill on an outpatient basis.

12                     In Hoffman Estates, they -- we have  
13 a -- or they had a treatment center. And I would  
14 imagine that that's the facility that's in -- that  
15 they're referencing.

16           Q.     So if I say Leyden or SHARE, can we agree  
17 we're talking about the Hoffman Estates facility?

18           A.     Sure.

19           Q.     What roles did you have in the nearly 20  
20 years working at SHARE?

21           A.     Well, I started on the medical staff as  
22 an EMT and then later on moved into various  
23 positions.

24                     The milieu tech was -- the medical

1 staff had transitioned into what was called milieu  
2 techs; unit staff, basically.

3 The EMTs kind of went away, and they  
4 kept the nursing portion; but the other -- the EMTs  
5 went into more unit techs.

6 And so I went into what was  
7 called -- my title at the time was milieu tech  
8 supervisor, and later my position changed to unit  
9 supervisor, and then my -- my role expanded.

10 Q. Okay. Explain for a second, you talked  
11 about when you first started there there was kind of  
12 a medical unit and there was a clinical unit.

13 What was your understanding as to  
14 why those two units were kind of blended together?

15 A. Say that again. I'm not sure what you're  
16 asking.

17 Q. Yeah. When you first started at SHARE,  
18 it sounds like there was an EMT or a medical  
19 department and there was also a clinical  
20 department --

21 A. Okay.

22 Q. -- and at some point the clinical -- or  
23 the medical was merged into the clinical; is that  
24 right?

1           A.     So we were a clinically managed facility.  
2     And at the time our director, Donna Santoro, who has  
3     since passed away, her -- her belief -- she had just  
4     come in, and she was relatively new, she had started  
5     right before I did, and so she was making some  
6     changes early on in my employment there.

7                     And one of her -- she felt that the  
8     medical staff was too large and had too much, I guess  
9     you would say, control, and she -- -- for a  
10    clinically managed program.  And so she wanted to  
11    separate those, the EMT -- she wanted to kind of do  
12    away with that, have a nursing staff and then have a  
13    clinical staff and then have these unit techs, these  
14    what we called milieu techs, that supported both  
15    clinical and nursing staffs.

16           Q.     Okay.  Let's talk about SHARE a little  
17    bit.  We're going to talk about it a lot, but just at  
18    the top of your testimony here, what type of services  
19    does SHARE offer?

20           A.     So currently I believe they offer a  
21    medical detox, which would be in ASAM criteria, it  
22    would be 3.7D.  That would be obviously on the  
23    inpatient side.

24                     There is also a residential

1 treatment center, which would be classified in ASAM  
2 criteria as 3.5. That's your traditional 28-day  
3 program.

4 On an outpatient basis, we did some  
5 gambling treatment. We had an intensive outpatient  
6 and then you would step down to regular outpatient  
7 and then you would step down to aftercare. That was  
8 the idea.

9 We did some DUI testing and  
10 evaluation, all of that on an outpatient basis.

11 Q. Did SHARE have any type of program where  
12 residents could stay up to 365 days?

13 A. No.

14 MR. ELLENBECKER: I'm not sure who is working  
15 exhibits tonight, but is it possible to pull up  
16 Exhibit 47, slide 15?

17 THE REPORTER: Mr. Ellenbecker, is there any  
18 way that you can be more directly to your microphone?  
19 You're a bit muffled.

20 MR. ELLENBECKER: I'll try. Is that a little  
21 better?

22 THE REPORTER: Yes. Thank you.

23 (Document displayed.)

24 MR. ELLENBECKER: Yes, there is Exhibit 47.

1 If you could go to slide 15.

2 MR. KHAN: You said 15, correct?

3 MR. ELLENBECKER: Yes, please.

4 BY MR. ELLENBECKER:

5 Q. Mr. Wrigley, can you see slide 15 of  
6 Exhibit 47 that's up on the screen?

7 A. Yes.

8 Q. And in terms of looking at facilities and  
9 determining whether you can use a facility to compare  
10 it, this was a slide that was used earlier in the  
11 proceeding -- it doesn't matter by who -- but of  
12 these four, is there one of these four that you think  
13 is probably most important, based on your experience,  
14 in terms of comparing?

15 A. Of those four, I would say number of beds  
16 would probably be the most significant.

17 Q. And would you, I guess, equate number of  
18 beds to size or capacity of the facility?

19 A. Yes.

20 Q. And for the SHARE Program, could you just  
21 tell us what the size -- I guess the overall size and  
22 then break it down, if you could, into the different  
23 types of treatment programs?

24 A. Okay. So there was a total number --

1 when I was there, there was a total number of 64  
2 total beds. That was our total capacity.

3 So we had that broken up by detox  
4 which was, I believe, if I remember correctly, 11  
5 beds total for male and female detox; for inpatient  
6 rehab for the women's unit, we had a max capacity of  
7 16; and so what does that leave us, 30-something beds  
8 for the inpatient men's rehab program.

9 Q. Okay. And if we could go back to medical  
10 detox, you said -- if I understood you correctly, you  
11 said there were 11 total beds for both male and  
12 female combined?

13 A. If I remember correctly, yes, 11 total  
14 beds.

15 Q. And then the remainder of that 64  
16 capacity at the time would be made up of level 3.5  
17 care; is that right?

18 A. That's correct.

19 Q. Was your facility at SHARE when you were  
20 there usually full? Were you usually operating at  
21 capacity?

22 A. We went through a period in 2008, '9, if  
23 I recall, where we had some -- we were regularly at  
24 max capacity with a waiting list; but for most of my

1 time there, we were not -- we were not full.

2 Q. Okay. And I think you indicated this --  
3 the SHARE Program is located at 1776 Moon Lake in  
4 Hoffman Estates; is that right?

5 A. That's correct.

6 Q. And were you located -- was SHARE located  
7 at that facility for your whole time with that program?

8 A. Yes.

9 Q. Was it there operating out of that  
10 facility before your time there?

11 A. Yes, both as another organization called  
12 ARC, and then also then we occupied it, I want to  
13 believe -- I want to -- if I remember correctly,  
14 Leyden Family Services purchased that building in  
15 the -- in the mid to late '90s.

16 Q. Okay. Generally speaking -- and maybe I  
17 should have done this at the outset, but generally  
18 speaking, are you personally a proponent of substance  
19 use disorder treatment?

20 A. Oh, my goodness, yes. I'm a -- I would  
21 consider myself a huge advocate of community mental  
22 health and inpatient treatment services.

23 Q. And -- and from that position, do you  
24 also agree that there are right ways and wrong ways

1 to be offering those services?

2 A. Yes.

3 Q. What type of population does SHARE serve?

4 A. We -- our population was 18 years of age  
5 and older.

6 Q. And within that, so the adult population  
7 range, you described what type of services, but what  
8 type of needs do -- does the patient population when  
9 they come to SHARE?

10 MS. DICKSON: One moment, please, Mr. Wrigley.

11 Mr. Ellenbecker, when you're asking  
12 your questions, you're -- you're asking as if the  
13 question is in the present tense, and I'm getting an  
14 answer in the past tense.

15 Can you be more clear so we know  
16 what time we're talking about?

17 MR. ELLENBECKER: Sure. I'll --

18 MS. DICKSON: (Inaudible.)

19 MR. ELLENBECKER: -- tell you right now --  
20 stop. I'll address it.

21 MS. DICKSON: Thank you.

22 MR. ELLENBECKER: I'll tell you right now  
23 we're talking about what his understanding is when he  
24 was at SHARE.

1 MS. DICKSON: Okay. So pre-2017, then. Thank  
2 you.

3 MR. ELLENBECKER: Sure.

4 BY MR. ELLENBECKER:

5 Q. Keep going, if you could, Mr. Wrigley.

6 MS. DICKSON: My apologies, Mr. Wrigley. I'm  
7 sorry.

8 THE WITNESS: That's okay. Repeat your  
9 question, though.

10 BY MR. ELLENBECKER:

11 Q. Yeah. In your time at SHARE, what type  
12 of needs did the adult population have?

13 A. Well, their primary diagnosis at the time  
14 of admission had to be chemical dependency, but they  
15 were oftentimes -- and I don't have statistics for  
16 you, but oftentimes they had a dual diagnosis.

17 So we had a separate track at the  
18 time that I was there called a MISA track, a MISA  
19 program, mentally ill substance abuser. So we were  
20 able to provide some additional support and guidance  
21 and coping skills to those that had a dual diagnosis,  
22 but their primary function -- or their primary  
23 diagnosis at the time of admission had to be chemical  
24 dependency. They had to be -- they had to be

1 stable and -- on their medication and stable to be  
2 admitted.

3 As far as medical requirements, we  
4 had a nursing staff; but, again, their primary  
5 diagnosis and concern at the time of admission had to  
6 be chemical dependency, so we were limited to what we  
7 could assist them, with even from a medical  
8 standpoint. They had to be stable and able to  
9 perform -- and able to function in a treatment  
10 setting.

11 Q. Okay. And you indicated earlier that  
12 aside from a couple years, the SHARE Program was not  
13 operating -- operating at capacity.

14 Do you have a recollection of what  
15 the average number was at any given time in the SHARE  
16 facility while you were there?

17 A. Sure. So it -- it changed over the years  
18 and increased over the years. So that when I left,  
19 we were operating in the -- in the high 40s to the  
20 low 50s pretty consistently.

21 Q. Was there an admission process for  
22 patients who wanted to receive services at SHARE?

23 A. There was.

24 Q. And what was that process?

1           A.     So that -- that process was -- it started  
2 with an initial what we called a phone screen. It  
3 traditionally took place over the phone.

4                     Although, if someone was to present  
5 at our facility, what we -- what we would call a  
6 walk-in, then we would still meet with them and  
7 assess them with the same screening.

8                     Based on the phone screen, and if we  
9 felt that they -- that we thought they would be a  
10 good candidate for treatment and that every -- all  
11 the other issues had been resolved and they could  
12 come in and meet criteria for treatment, we would  
13 schedule -- then we would schedule them for an  
14 appointment to come in for an assessment.

15                    The assessment would be someone from  
16 the clinical staff would come and assess them through  
17 a biopsychosocial assessment, which was a lengthy --  
18 a lengthy assessment, and then they were also  
19 assessed by our nursing staff at that time.

20                    If at that time we made the decision  
21 that they were able to be admitted, that they met  
22 criteria for whichever level of care they were being  
23 admitted to, we would then go ahead and make the  
24 decision to admit same day, if we could. If not, we

1 would rescheduled for them to come back for a final  
2 appointment to be admitted.

3 There also was drug screening as a  
4 part of that process.

5 Q. What was the purpose of having an  
6 admission process like you just described?

7 A. Well, so the purpose of that is obviously  
8 the more rigorous the -- your screening process,  
9 you're limiting -- you're creating an environment  
10 where they can successfully complete treatment  
11 because the issues have been resolved the best you  
12 can while they come in.

13 So I'll give you an example: When I  
14 had first started there in the early '90s, I don't --  
15 I don't want to paint an ugly picture of the SHARE  
16 Program at the time, but we would really -- we would  
17 really admit almost really just anybody. If you  
18 walked in -- most of our admissions were walk-in.  
19 There was no official intake department at the time.  
20 The medical staff did all of the intakes and  
21 admissions. Most of them were after hours. Most of  
22 them were walk-ins.

23 This created a pretty chaotic  
24 environment, because we would admit the person, and

1 then we would try to resolve their issues, their  
2 psychiatric or their medical needs, after they --  
3 once they've been admitted.

4 And what we found was this usually  
5 created an environment where people were not able to  
6 successfully complete treatment. We were either  
7 having to call law -- local law enforcement to help  
8 respond or local EMS to come respond because we  
9 hadn't -- we hadn't done that due diligence on the --  
10 on the process.

11 And over the first couple years that  
12 I was there, that process changed. That screening  
13 process became more rigorous because of that.

14 Q. And in your experience, did that rigorous  
15 admission process have any affect on the need to call  
16 on public EMS services?

17 A. Yes, it -- it declined.

18 Q. Was the SHARE Program -- while you were  
19 there, was the SHARE Program accredited by any  
20 organization or body?

21 A. Yes. I don't -- I believe it was '98, it  
22 might have been '97, but was the first year that we  
23 were accredited from the Joint Commission of Health  
24 Care Organizations, JCAHO.

1           Q.    And what's the significance of that?  
2    What other types of organizations are  
3    JCAHO-accredited?

4           A.    Well, hospital settings are the most  
5    common ones that have the JCAHO seal when you're  
6    walking into the hospital.

7           Q.    And does being JCAHO-accredited or having  
8    the seal, does that impose any obligations or  
9    criteria on SHARE and other organizations?

10          A.    Well, there was an auditing process, if  
11    that's what you're asking.  There was an auditing  
12    process.  So independently JCAHO would come and  
13    provide an audit every three years.  They would come,  
14    and they would be there for a full week.

15                   And then if you passed that -- they  
16    would make recommendations of what needed to change.  
17    You would get a score.  If you passed it, great.  If  
18    not, they would tell you what your score is, and they  
19    would give you a period of time to respond and to  
20    make changes, and then they would come back and make  
21    sure that those changes have been in placed and then  
22    decide whether or not you would -- you would be  
23    recertified then for the next three years.  It was an  
24    intense process.

1 Q. Did the fact that SHARE was  
2 JCAHO-accredited, did that impose any obligation on  
3 SHARE to track EMS calls and reliance on EMS?

4 A. So you'll have to forgive me because I  
5 don't recall the exact JCAHO standards, but we -- as  
6 a result of our JCAHO audits, one of the things that  
7 they would look at would be what was called the  
8 environment of care, so EOC.

9 For -- for most of my time there, I  
10 was involved, and toward the end, I was in charge of  
11 the environment of care. And one of the things I had  
12 to do every single month was collect a site audit.  
13 So there would be a safety audit. There would be a  
14 maintenance audit. There was routine, you know,  
15 preventative maintenance that had to be done that we  
16 had to track. There was -- every time there was an  
17 incident in the facility, we were required to keep  
18 incident reports.

19 So just to give you an example, if  
20 we did call 911 for EMS or local law enforcement, we  
21 would have to -- the staff would be required to put  
22 that into a -- an incident report. And every staff  
23 that was involved in that in whatever capacity was  
24 required to do their own incident report.

1                   And what we would do in the incident  
2 report is because of -- because of protected  
3 information, health care information, we would put  
4 the patient ID record so that there was no patient  
5 information in that, but that we could independently  
6 go back and evaluate.

7                   And then those incident reports were  
8 collected and gathered, and every month there was an  
9 EOC committee that would meet and go through. We  
10 would look for patterns, areas for improvement. We  
11 would do risk assessments based on those root cause  
12 analysis based off of those.

13                   So we kept binders for every year  
14 based by -- broken down by month of all incident  
15 reports, and in those incident reports would be EMS  
16 calls, local law enforcement responding to the site  
17 for whatever reasonable, for a gas leak, for someone  
18 having a seizure, for someone making threats of  
19 violence, for whatever reason. We would keep that.  
20 We would do all of that tracking independently every  
21 single month.

22                   Q.     In other words, if I called you up in  
23 2016 and had a question about how many times SHARE  
24 called local EMS, you would have been able to put

1 your finger on the data and tell me, if you could,  
2 assuming no HIPAA violations?

3 A. Yes, yes.

4 Q. Did SHARE -- being in Hoffman Estates,  
5 did SHARE have any programs or partnerships with area  
6 organizations, police organizations, or any of that  
7 type of entity?

8 A. Well, we had a -- we had a very good  
9 relationship with Alexian Brothers Behavioral Health,  
10 which was right -- if you notice the complex that we  
11 were nestled in, we're surrounded by St. Alexius  
12 Medical Center, Alexian Brothers Behavioral Health,  
13 then there's some doctors' offices around. And  
14 there's also a Hoffman Estates Fire Department. One  
15 of the -- one of the station houses is right there  
16 also, and we're nestled in that.

17 We had a really -- we had a strong  
18 relationship with Alexian Brothers Behavioral Health  
19 where we had a memorandum of understanding, in case  
20 of disaster planning, we were part of their disaster  
21 planning; they were part of ours.

22 And then towards the end, the last  
23 several years that I was there, one of the things  
24 that I was pretty excited about and proud of was we

1 had partnered with an organization called CHUG. It  
2 was, if I remember correctly, the Chicagoland Health  
3 Care Urgency Group or something like that. But it  
4 was a local collaborative that brought health care  
5 organizations together. We had -- there were nursing  
6 homes involved, treatment centers, hospitals, and we  
7 would -- it was basically just part of -- part of our  
8 disaster planning. So part of our emergency  
9 preparedness was having this collaborative.

10 So if for some reason all of the  
11 electricity went out of our building, we were going  
12 to have to stop services, we could call this agency  
13 and they would find -- they would find  
14 transportation, they would find housing and whatever  
15 support we needed through other partner in that  
16 group.

17 MR. ELLENBECKER: Mo, could you pull up the  
18 aerial photo? I probably should have pulled it up  
19 sooner.

20 (Document displayed.)

21 MR. ELLENBECKER: Thank you.

22 BY MR. ELLENBECKER:

23 Q. Mr. Wrigley, do you recognize what's  
24 shown in this -- this aerial photo?

1           A.     I do.

2           Q.     And what's -- could you just -- I think  
3 you just told us, but we didn't have the picture up.

4                     Could you just walk us through the  
5 area in and around SHARE?

6           A.     So what I'm seeing there on Moon Lake  
7 Boulevard is you're seeing Hoffman Estates  
8 Department 22.

9                     Right behind that is 1776 Moon Lake  
10 Boulevard. That's Leyden Family Services, the SHARE  
11 Program.

12                    And then you're seeing just sort of  
13 kitty-corner to that on the right side there, you're  
14 seeing Alexian Brothers Behavioral Health, or at  
15 least it was called that when I was there.

16                    And then behind there is you're  
17 seeing the St. Alexius Medical complex or St. Alexius  
18 medical hospital, which now it looks like it's AMITA  
19 Health Group.

20           Q.     Okay. And you indicate already your  
21 partnerships and affiliations with some of those  
22 around you.

23                    Did you come to learn based on your  
24 discussions with me that SHARE or Leyden Family

1 Services in Hoffman Estates was being used as a  
2 comparable or a comp facility on which to project the  
3 needs of the proposed Haymarket facility?

4 A. Yes.

5 Q. And did I give you some -- some testimony  
6 and some materials to review with regard to the  
7 support and the claim that SHARE Leyden was a good  
8 comp?

9 A. Yes.

10 Q. Can you -- before we get into, you know,  
11 a direct comparison, can you just describe the impact  
12 that SHARE itself had on the surrounding medical  
13 community to its Moon Lake address?

14 A. So the surrounding medical community  
15 would be the hospital behind us. We -- we used them  
16 quite often. We -- they were actively involved in  
17 our -- our treatment from one way or another, either  
18 through our patients having to be transported there  
19 through EMS or just having -- having the need to go  
20 over there to stabilize for a medical issue that  
21 might just have come up during treatment.

22 And then obviously the fire  
23 department we were heavily dependent upon.

24 Q. And in describing -- I guess focused on

1 St. Alexius for a bit, was it a good relationship  
2 between SHARE and St. Alexius, or did it sometimes  
3 get contentious?

4 A. Oh, it was -- it was very strained  
5 throughout the years.

6 It was way better towards the end.  
7 And by "end," I guess I would say over the last maybe  
8 10 years that I was there, it had really strengthened  
9 and had turned into a better relationship.

10 But it was strained because we  
11 really were a drain on their resource, specifically  
12 the outpatient. We would use their chest X-ray --  
13 their outpatient services for chest X-rays a lot --  
14 I can explain if needed -- but we would also use the  
15 ER an awful lot. And so that relationship was -- was  
16 actually strained because, you know, they looked at  
17 us as just sort of a burden at times. But it -- it  
18 varied throughout the years but definitely was  
19 strained at times.

20 Q. Were there circumstances with regard to  
21 SHARE's physical location that actually reduced the  
22 need to call EMS on every necessary occasion?

23 A. Oh, goodness, yes, absolutely. I mean  
24 just its proximity would prevent us oftentimes

1 from -- from not having to call EMS.

2 As an example, I guess -- so if we  
3 had someone show up let's say at 10:00 p.m. at night  
4 and they're highly intoxicated and they walk in with  
5 a family member and they don't qualify or they don't  
6 meet criteria for our treatment or aren't stable  
7 enough to be admitted at that moment, we would  
8 usually have that family member just drive them right  
9 behind us. We felt safe enough to have them drive  
10 right behind us. You know, let's say they're from,  
11 you know, Arlington Heights. We're not going to send  
12 them back to Northwest Community Hospital.

13 If there's -- if we didn't have that  
14 close proximity in a lot of those situations -- and  
15 it was not uncommon to have someone highly  
16 intoxicated show up at our facility unexpectedly --  
17 we would -- we would have been even more dependent  
18 upon EMS to transport to make sure that they got to  
19 a safe, higher level of care.

20 Q. And --

21 A. Or safely get to a higher level of care.  
22 Sorry.

23 Q. No. And despite that, were there reasons  
24 that prompted staff at SHARE to call EMS?

1           A.     Yes, yes.

2           Q.     What types of reasons would prompt EMS  
3 calls at SHARE?

4           A.     It would vary, but our biggest -- our  
5 most common reason for having a patient transported  
6 by EMS were -- were usually alcoholic seizures. That  
7 was the most common.

8                     But it would vary. It would be any  
9 number of things: Chest pains -- my goodness, I  
10 would be reluctant to list. There were times where  
11 there was drug use, unfortunately, drug use in the  
12 building. It would vary.

13                     But most common was alcoholic  
14 seizures.

15           Q.     Did SHARE ever use a private ambulance?

16           A.     We didn't partner with a private  
17 ambulance service. We had had -- they were usually  
18 just for transfer from one location to another and  
19 usually because of managed care required it. But we  
20 did not partner and we did not call private ambulance  
21 services. We would call 911.

22           Q.     Okay. Is it your understanding that the  
23 proposed Itasca facility would have 240 beds in it?

24           A.     That's my understanding.

1 Q. Okay. And you told us earlier that SHARE  
2 at peak capacity when you were there was 64; correct?

3 A. That's correct.

4 Q. And given your experience, do you think  
5 that difference in size, 240 to 64, is a substantial  
6 increase based on your experience with 64 or up to 64  
7 patients?

8 A. Yes.

9 Q. And why do you say that?

10 A. Well, my -- my first thought and my first  
11 concern would be does it scale up. So does  
12 everything -- if we're looking at Leyden as a comp  
13 and saying, okay, based on this number of beds they  
14 have this number of calls or incidents each year,  
15 does that really scale up, right. That would be my  
16 first question.

17 I -- you know, it may. I don't  
18 know. But that would be -- that would be my first  
19 question.

20 It also would be -- my biggest  
21 concern, though, would be just the integrity of  
22 treatment itself, an inpatient treatment. Is -- can  
23 treatment properly occur on that scale, would be my  
24 question. Will the patients get the treatment that

1 they require.

2                   And we would -- we were often  
3 strained. Anytime we got over 50, I will tell you  
4 that we were strained. Now, that's Leyden, right.  
5 But we would be strained over 50. It just became a  
6 different environment. People's needs were not --  
7 not properly being met, and it was something that we  
8 had to be aware of.

9                   MR. ELLENBECKER: Could we go back to  
10 Exhibit 47, please, and specifically slide 16.

11 BY MR. ELLENBECKER:

12                   Q. Yeah, in looking at slide 16 of  
13 Exhibit 47, Mr. Wrigley, do you see that this is the  
14 levels of service to be provided at Haymarket DuPage;  
15 and based on your earlier testimony, you'd agree that  
16 there's some overlap with those offered services  
17 compared to SHARE; right?

18                   A. That's correct.

19                   Q. Did SHARE offer any recovery home?

20                   A. No.

21                   Q. Okay. And is it your understanding that  
22 the proposed facility is currently proposing  
23 accommodating up to 140 residents in recovery home  
24 living?

1           A.     That is my understanding.

2           Q.     And based on the size that we've  
3 described of SHARE compared to the size alone of the  
4 proposed facility, do you believe in your experience  
5 in operations that SHARE is a good comp facility to  
6 project the impact of the proposed Itasca facility on  
7 the town of Itasca?

8           A.     No.

9           Q.     Now, in terms of --

10          MR. ELLENBECKER: You can take that down, Mo.  
11 I think I'm done with that. Thank you.

12          BY MR. ELLENBECKER:

13          Q.     In terms of recovery home, do you have an  
14 understanding of the activities of recovery home  
15 residents as opposed to inpatient treatment  
16 residents?

17          A.     So my understanding is that with recovery  
18 homes, oftentimes what we're talking about is really  
19 a sober living environment. Now, this does vary  
20 slightly from recovery home to recovery home. Some  
21 do provide a little bit more structure than others,  
22 but there's really no -- as I understand it, there's  
23 no requirement that treatment services be provided.

24                                 Sometimes they'll have, you know,

1 12-step programs being provided in the evening;  
2 sometimes they will have some group counseling in the  
3 evening. But usually my understanding is that it is  
4 a sober living environment. So they live there --  
5 they're away during the day to go to work, they come  
6 back in the evening, and they really just live there.  
7 That's my understanding.

8 Q. And does the coming and going of  
9 residents, can that add logistical concerns to the  
10 operation of a facility?

11 A. Yes.

12 Q. What type of logistical issues or concerns  
13 arise?

14 A. Well, I mean, so if you're -- you know,  
15 the issue would be -- they have to be away during the  
16 day, right. So this is true even at a halfway house.  
17 They're required to be out, and they can't stay there  
18 during the day for most places. And so you have to  
19 be out in the community during the day, right.

20 Most of them are going to be  
21 working. Most of them are going to find employment.  
22 They're required to find employment, at most places,  
23 within the first several weeks, and they do provide  
24 some assistance with that. But you have to be out

1 and away from the place during the day, and then you  
2 come back in the evening.

3 My concern with that -- we've  
4 explored this idea at Leyden. At my -- at my time  
5 over that, we had tossed this idea around because we  
6 would look at the number of beds we would have, and  
7 we would say, goodness, we have a certain percentage  
8 of our beds are empty at any given time for --  
9 throughout the year, and so is there a way for to us  
10 move our units around and create -- where the women  
11 were housed was kind of away and separate to where it  
12 could even be its own -- it had its own entrance if  
13 we needed it to be. And we had explored the idea of  
14 does it make sense to create our own halfway house?

15 But then the challenge was, even  
16 with having 11 beds or 12 beds, whatever it was that  
17 we could put in the unit at the time, the question  
18 is, goodness, how do you keep -- how do you maintain  
19 control? How do you keep these people from bringing  
20 drugs back to the facilities? How do you keep  
21 them -- make sure that they're taking their  
22 medication, not abusing their medication? How do you  
23 monitor all of that?

24 And there are agencies, I'm sure,

1 that do it really well from halfway houses.  
2 Three-quarter houses is a step down, and then you get  
3 into your recovery homes, and you lose a little bit  
4 of that control in the process, as I understand it.

5 So my concern with that is you're  
6 leaving and you're coming back every day. When you  
7 look at 140 beds, that's potentially 140 people  
8 leaving and coming back every single day. You know,  
9 that creates some challenges as far as searching  
10 those people to making sure that they're, you know,  
11 not coming back under the influence, drug testing,  
12 taking the Breathalyzer, making sure that they're not  
13 bringing contraband back to the facility. It just  
14 creates a lot of challenges.

15 Q. And based at SHARE, if patients were  
16 admitted to the facility for services, were they on a  
17 come-and-go-as-you-please type basis?

18 A. No. If they wanted to complete  
19 treatment, they had to stay there.

20 It was not a locked unit. As I  
21 understand it, in Illinois there is no -- there are  
22 no locked units. So if they decided to leave against  
23 medical advice or against staff advice, they were  
24 allowed to do so. But they were not allowed to come

1 and go.

2 If they wanted to leave, they left.  
3 They were discharged. That was it. They were not  
4 allowed to return. In fact, we had a strict policy  
5 that if they left against staff advice, it was -- it  
6 was at least 30 days before they could be readmitted.

7 Q. Based on your involvements in the  
8 rehabilitation services for almost 20 years, was it  
9 ever proven or had you ever heard of it being proven  
10 that facilities as large as 240 people are good  
11 treatment models?

12 A. Well, I don't know of any other than  
13 Haymarket that are on that scale.

14 Q. Based on your involvement in the industry  
15 for almost 20 years, had you ever heard of Haymarket  
16 before I gave you a call and talked to you about  
17 this?

18 A. Yes.

19 Q. And what was your understanding of  
20 Haymarket's reputation?

21 A. So most of my understanding from -- about  
22 Haymarket was from our -- from the -- from our  
23 patients. And the information that they would  
24 provide over the years was not -- was not good. It

1 was not a good -- it was not a good reputation from  
2 the information that I had and was the information  
3 that I was hearing.

4 MR. ELLENBECKER: Thank you, Mr. Wrigley.  
5 That's all I have.

6 CHAIRMAN DALY: Okay. At this time I would  
7 ask Ms. Dickson if you'd like to begin your  
8 cross-examination?

9 MS. DICKSON: Mr. Daly, I believe our protocol  
10 has been that the other counsel, Mr. DiNolfo and  
11 Ms. Smith, go with Haymarket taking the last position  
12 in questioning.

13 CHAIRMAN DALY: You are correct. Thank you.  
14 Thank you for that.

15 Mr. DiNolfo, do you have any  
16 questions?

17 MR. DI NOLFO: I do not.

18 CHAIRMAN DALY: Ms. Smith, do you have any  
19 questions of Mr. Wrigley?

20 MS. SMITH: I do not.

21 CHAIRMAN DALY: Okay.

22 MS. DICKSON: At this time, Mr. Chairman, it  
23 is 8:05. It would be -- if we follow our past  
24 practice, I think it might be a good time to take a

1 5- or 10-minute break.

2 CHAIRMAN DALY: That'd be fine. We can --  
3 we'll take 10 now. So let's reconvene at 8:19 per my  
4 watch. Thank you.

5 MS. DICKSON: Thank you, Mr. Chairman.

6 (Recess taken.)

7 CHAIRMAN DALY: If we could see everybody's  
8 screens again, make sure we're all here.

9 MR. KHAN: We're waiting on Commissioner  
10 Russo, it looks like.

11 CHAIRMAN DALY: Okay. I see the Plan  
12 Commissioners, I see Mr. Wrigley, and I see  
13 Ms. Dickson.

14 So at this time, Ms. Dickson, if  
15 you'd like to begin your cross-examination, please.

16 MS. DICKSON: Certainly. Thank you, Chairman  
17 Daly.

18 CROSS-EXAMINATION

19 BY MS. DICKSON:

20 Q. Oh, there you are. I'm sorry,  
21 Mr. Wrigley. I couldn't see you there for a moment.

22 I know Mr. Ellenbecker identified  
23 all the attorneys in the room for you, but I did want  
24 to introduce myself to you. My name is Mary Dickson,

1 and I do represent Haymarket. And it's very nice  
2 that you're able to attend this hearing tonight  
3 remotely.

4 Mr. Ellenbecker started out with his  
5 questioning of you talking about how he came to find  
6 you. And if I understand correctly, Mr. Ellenbecker  
7 was able to find you because of a relationship that  
8 you had with the Village's attorney, Chuck Hervas?

9 A. I'm not sure how Mr. Ellenbecker came to  
10 know me.

11 Q. And --

12 A. (Inaudible.)

13 Q. Did he tell you how he -- did he tell you  
14 how he came to find you?

15 A. I don't recall.

16 Q. Okay. Did you have any conversations  
17 with the Village attorney Chuck Hervas about the fact  
18 that Mr. Ellenbecker might be contacting you?

19 A. I remember Chuck had sent me a text and  
20 asked if he could give my name to a colleague on a  
21 case he was working on. I don't -- that's about all  
22 I remember.

23 Q. Okay. And in that text from the Village  
24 attorney Chuck Hervas, did he say anything about the

1 case or why your particular knowledge might be  
2 important to the case?

3 A. In that text I don't recall, no.

4 Q. Did he tell you that he wanted you to --  
5 he wanted this attorney to be able to reach out to  
6 you because of the work that you had done at SHARE?

7 A. I don't recall the specifics.

8 Q. Okay. When exactly did the Village's  
9 attorney Mr. Hervas send you that text?

10 A. It would have been around the same time  
11 that Steve first reached out to me, Steve Ellenbecker  
12 first reached out to me, and I don't recall what --  
13 the exact date of that.

14 Q. Was it in the year 2021?

15 A. No.

16 Q. Was it in the year 2020?

17 A. Probably.

18 Q. Do you recall spring, fall, summer?

19 A. If I -- if I had to guess, I would say  
20 late 2020.

21 Q. And did he reach out to you by text or by  
22 telephone?

23 MR. ELLENBECKER: Who is "he," Mr. Hervas  
24 or --

1 BY MS. DICKSON:

2 Q. I'm sorry. Mr. Ellenbocker.

3 MR. ELLENBECKER: Becker.

4 MS. DICKSON: I'm sorry?

5 MR. ELLENBECKER: Ellenbecker.

6 MS. DICKSON: Oh, my apologies. I've been  
7 screwing up everybody's name. Mr. Ellenbecker.

8 BY THE WITNESS:

9 A. I don't -- I don't really recall. It  
10 could have been an e-mail. I don't recall. I'm  
11 sorry.

12 BY MS. DICKSON:

13 Q. Okay. And how many telephone  
14 conversations did you have with Mr. Ellenbecker  
15 relative to your testimony this evening?

16 A. If I had to guess, I would say three or  
17 four.

18 Q. Okay. And in the first of -- to the  
19 extent you remember one from two from three, do you  
20 recall what Mr. Ellenbecker first asked you when he  
21 was able to get you on the telephone?

22 A. I don't recall exactly specifics, but it  
23 was kind of alerting me to the kind of a case he was  
24 working on, who he was representing, and asking me

1 about my -- my experience in the field.

2 Q. And what exactly did he tell you about  
3 the case that he was working on?

4 A. Again, I don't remember specifics, but he  
5 alerted me to this case that was -- that's before  
6 you -- before Itasca Planning Commission, that -- and  
7 that's really about all the specifics I recall,  
8 honestly. And that he -- and if I remember  
9 correctly -- and, again, I don't remember 100  
10 percent -- that he represented the -- the residents  
11 of Itasca, I believe is what he told me. I could be  
12 wrong about that. I'm sorry.

13 Q. Okay. After Mr. Ellenbecker contacted  
14 you, did you have the opportunity to talk with the  
15 Village's attorney Mr. Hervas about the fact that  
16 Mr. Ellenbecker had, in fact, contacted you?

17 A. No.

18 Q. Have you ever shared the basis of your  
19 testimony here this evening with the Village's  
20 attorney Mr. Hervas?

21 A. Be more specific, shared the basis.

22 Q. Right. Have you talked with Mr. Hervas  
23 specifically prior to your testimony tonight about  
24 what you were going to testify to?

1 A. No.

2 Q. Okay. Prior -- prior to Mr. Ellenbecker  
3 calling you, you testified that you had been familiar  
4 with Haymarket Center in Chicago?

5 A. Yes.

6 Q. What -- can you give us an idea of what  
7 your understanding is, at least to the best of your  
8 recollection, as to the services provided by  
9 Haymarket Center in Chicago?

10 A. So my understanding was that they offered  
11 a wide array of services, so similar to -- my  
12 understanding of Haymarket is similar to what I -- my  
13 understanding is what they're proposing. So a detox  
14 program, an inpatient rehab program, recovery home,  
15 and outpatient services.

16 Q. And the services -- if I understand you  
17 correctly, the services they provide at Haymarket  
18 Chicago would be similar to the services they would  
19 provide at Haymarket DuPage?

20 A. That's my understanding.

21 Q. Okay. Do you know how long Haymarket  
22 Center in Chicago has been in operation?

23 A. I don't know the exact number, but I  
24 believe it's -- it's close to 60 years, 50 years.

1 Q. Okay. And are you aware of Haymarket's  
2 reputation among its peers in the industry?

3 A. No, not really. I mean, I don't -- most  
4 of my information from Haymarket came from our -- our  
5 inpatient residents, just the clients that we were  
6 admitting.

7 Q. Okay. Would it surprise you if there  
8 were patients of the SHARE Program who would speak  
9 ill of the services provided at the SHARE Program?

10 A. No.

11 Q. Perhaps it would be somebody that SHARE  
12 decided not to admit into the program, and that might  
13 lead to negative comments. Wouldn't that be fair to  
14 say?

15 A. Sure.

16 Q. Okay. So when you testified this evening  
17 that your understanding of Haymarket came from people  
18 in your program, would you have been surprised that  
19 they might not have been happy with services they had  
20 received from another prior program?

21 A. Well, surprised, I don't know. You hear  
22 enough over the years of -- of the exact same  
23 information, and you just log that information away.  
24 After -- after hearing the same information from

1 different people over, you know, 18 years, it adds  
2 up.

3 Q. Okay. So in that 18-year period of time  
4 that you were with SHARE, how many patients,  
5 individual patients, came to you, to you specifically,  
6 and had something negative to say about Haymarket?

7 A. I couldn't give you a number.

8 Q. Well, in that 18 years, was it one a  
9 year?

10 A. It was -- I couldn't speak to that. It  
11 was -- it was quite a bit. It was a lot.

12 Q. What would you --

13 A. It was notable. More than --

14 THE REPORTER: I'm sorry?

15 BY THE WITNESS:

16 A. It was noteworthy. The amount was  
17 noteworthy. It was more than any other treatment  
18 center. That's why I say it was notable.

19 BY MS. DICKSON:

20 Q. Okay. And in your view, just so that I  
21 can encapsulate it, what is a noteworthy number or a  
22 noteworthy range?

23 A. I couldn't put a number to it. It was a  
24 lot, a lot of incidents.

1 Q. Okay. Did the people that were -- and  
2 those were people speaking to you specifically?

3 A. Yes, people -- usually people being  
4 admitted.

5 Q. Okay. And you were part of the patient  
6 admission process?

7 A. That's correct.

8 Q. How would that conversation commence, in  
9 general?

10 A. So usually as part of their assessment  
11 tool is we're asking about their treatment history.  
12 So at that time you're gathering information about  
13 how many times have they been in treatment and where  
14 have they been in treatment and specifically, then,  
15 when, the best of their recollection.

16 Q. And during that process, if a patient  
17 came from a treatment facility other than Haymarket,  
18 would they also comment on that prior treatment?

19 A. Usually. This was unsolicited. We  
20 weren't asking them for their opinion about their  
21 treatment centers; we were just asking them about  
22 their treatment history, and --

23 Q. Okay.

24 A. -- yes, it wasn't uncommon to hear other

1 people talk about their treatment experience. So you  
2 get to hear a wide array of opinions about treatment  
3 centers.

4 Q. And were there other treatment centers  
5 that your incoming patients spoke ill of?

6 A. I'm sure that there have been over the  
7 years other treatment centers but none that stand out  
8 to me the way -- to the way Haymarket does.

9 Q. Do you think that that would have all  
10 have been because Haymarket, because of its size,  
11 would have treated a greater majority of patients  
12 prior to coming to yours?

13 A. That's entirely possible.

14 Q. When you talk about the recovery home, if  
15 I understood you correctly, I think you testified  
16 that patients in a recovery home cannot stay in the  
17 recovery home during the day.

18 Is that your understanding?

19 A. So my understanding is that most recovery  
20 home environments require you to be away during the  
21 daytime.

22 Q. What is that understanding predicated on?

23 A. So when -- our inpatient treatment -- our  
24 inpatient clients, the minute that they are assigned

1 a counselor in rehab, they begin discharge planning,  
2 the minute, because we only have them for four weeks.  
3 So right away what we do is at the second floor  
4 nursing station for the men and at the first floor  
5 nursing station for the women, they would start on  
6 the phone. We would have a list of treatment  
7 centers, and they would start calling through based  
8 on the service -- based on the level of care they  
9 were being referred to, they would start calling  
10 through a wide array of treatment centers looking for  
11 beds.

12 And, I'm sorry, am I answering you?  
13 I've already forgotten your question. I'm so sorry.

14 Q. No, that's no problem.

15 My question was, you testified to  
16 your understanding that if a patient is in a recovery  
17 home, they cannot stay in the recovery home during  
18 the day. And my question was what -- did you ever  
19 work in a recovery home environment?

20 A. Yeah, so no. And then, so yes, my  
21 understanding is simply from patient after patient  
22 after patient calling these recovery homes or  
23 three-quarter house, again, depending on the level of  
24 care, and just gathering information back from them.

1 It's just stuff that I -- you collect information  
2 over the years.

3 Q. Are you aware of Haymarket's policy  
4 relative to those patients who are living in its  
5 recovery home and their ability to stay in the  
6 facility or leave the facility if they're living in  
7 the recovery home?

8 A. No, ma'am.

9 Q. Okay. Are you familiar at all with  
10 Haymarket's admissions policy?

11 A. No, ma'am.

12 Q. Would you have any basis to believe that  
13 the current Haymarket admissions policy is any less  
14 rigorous than that which SHARE had during the time  
15 that you worked for SHARE?

16 A. I don't believe I have any information  
17 about their admission policy.

18 Q. Are you familiar at all with the size of  
19 the Haymarket facility in Chicago?

20 A. I have a rough understanding. I believe  
21 it's around 350, 400 beds. I -- that's an  
22 understanding. I don't know if it's correct or not.

23 Q. And do you -- are you aware of what the  
24 staff-to-patient ratio is --

1 A. No, ma'am.

2 Q. -- at the Haymarket Center?

3 I'm sorry. I talked over you.

4 A. That's okay. No, ma'am.

5 Q. Okay. And when you talk about size of  
6 SHARE versus size of Haymarket, I believe you're  
7 talking about SHARE being so many treatment beds  
8 versus Haymarket's size in general.

9 Are you familiar with the number of  
10 treatment beds planned for Haymarket DuPage?

11 A. I've seen the number through, I believe  
12 it was, Mr. Dominik's testimony. I believe there was  
13 a slide show presentation. But I don't recall the  
14 number of beds, the actual number of beds.

15 Q. So when you're -- when you testify  
16 relative to the fact that SHARE had, I think you  
17 said, 46 beds -- 64 beds, I'm sorry, were you  
18 comparing the 64 SHARE beds to the 240 Haymarket beds  
19 for your testimony?

20 A. I would be looking at the total number of  
21 beds that we offered based -- compared to the total  
22 number of beds that they were offering. And then the  
23 treatment, you know, you can break it down by  
24 treatment.

1 I remember the -- I believe the  
2 detox number was around 30 or 37. I'm sorry, I don't  
3 remember the specific number of -- of treatment beds.  
4 I'm sorry, I don't.

5 Q. Okay. And, you know, when you talked  
6 about the number of beds -- or, I'm sorry, the number  
7 of capacity, you were at the SHARE -- you were  
8 working for SHARE from 1999 until August of 2017, and  
9 you talked in general.

10 Do you know what the number of beds  
11 were in the year 2014?

12 A. The number of total beds in 2014?

13 Q. Yes.

14 A. Well, I don't -- I don't believe our  
15 total number of beds changed that much, if at all,  
16 during that time span. There might have been a  
17 slight increase or decrease, but I don't recall the  
18 exact number. But I would think it would be right  
19 around the number of 64.

20 Q. Well, do you know what the capacity was  
21 in 2014; if you had 64 beds, what the average  
22 capacity was?

23 A. 64 beds. I don't --

24 Q. I'm sorry, number of people in those

1 beds. I think you testified to what your capacity  
2 was in certain years.

3 A. I don't believe I testified to capacity.  
4 I don't believe the capacity changed that much  
5 throughout the years.

6 Q. Okay. You know, and I'm -- I've got to  
7 rephrase the question because I'm not sure I'm asking  
8 it to get to what you testified to.

9 If you had 64 beds, were -- in some  
10 years you were at 100 percent capacity; would that be  
11 true to say?

12 A. There were -- there was -- I don't  
13 remember the exact year, but there was a year that we  
14 went through a period of time where we were pretty  
15 much at capacity with a wait list, but that was rare.

16 Q. Okay. In 2014, now, do you know what --  
17 how many beds you were at on average?

18 A. No.

19 Q. How about in 2015?

20 A. No.

21 Q. In 2016?

22 A. No.

23 Q. And would your answer be no for 2017 and  
24 2018?

1           A.     Well, 2017 I was only there until May,  
2     and I wasn't there in 2018.

3           Q.     Thank you.  Prior to coming to testify  
4     this evening, did you speak with anyone at the SHARE  
5     Program?

6           A.     I've been in contact with people at the  
7     SHARE Program since I left, yes.

8           Q.     Did you talk to anyone at the SHARE  
9     Program about the Haymarket DuPage proposal?

10          A.     I have talked to my former boss about it.

11          Q.     Who was your former boss?

12          A.     Her name was Jill DeLarco.

13          Q.     Is she still with the SHARE Program?

14          A.     Yes, ma'am.

15          Q.     And what would have been the purpose of  
16     you speaking with Ms. DiLarco about Haymarket Center?

17          A.     So I believe she's the first person that  
18     made me aware of it back in 2019, just making me  
19     aware of it, just conversation.

20                     We have a personal relationship.  
21     We're close.  We're friends.  So just in  
22     conversation.

23          Q.     What would she -- what would have  
24     prompted the conversation concerning the Haymarket

1 DuPage proposal, if you know?

2 MR. ELLENBECKER: I object to foundation. It  
3 calls for speculation about someone else's state of  
4 mind.

5 BY MS. DICKSON:

6 Q. To the extent she told you.

7 A. So, I mean, I -- I've been in the field  
8 for 18 years. I've worked there, and she and I  
9 worked closely together for a long time. Treatment  
10 is something that I care about. And just that's a  
11 significant event. Bringing that many beds to a --  
12 to a place is a significant event. It's not nothing  
13 in the field.

14 I know outside the field it may seem  
15 like nothing, but that's noteworthy in the field.

16 Q. Okay. On -- so you talked in 2019 to  
17 Ms. DeLarco.

18 Did you talk to her at any time  
19 after the first time when she first learned that  
20 Haymarket DuPage was making a proposal to open in  
21 Itasca?

22 A. Yes.

23 Q. How many times have you talked to  
24 Ms. DiLarco about Haymarket DuPage?

1 A. I don't know how many times. Maybe two.

2 Q. Okay. When was the last time you talked  
3 to Ms. DiLarco?

4 A. I believe it was late last evening she  
5 had texted me and said that she had received an  
6 e-mail from someone at Haymarket asking about the  
7 services that they provided and wanted to talk in  
8 preparation for tonight. And she asked me what's  
9 going on, why -- how is she getting this information,  
10 you know. So just asked me what -- what was  
11 happening.

12 Q. Okay. Prior to that time, she didn't  
13 know that you were going to testify in this  
14 proceeding?

15 A. I believe that I had mentioned it to her.  
16 I'm sorry, I don't remember time frames, but I  
17 believe I have mentioned it to her that I've been in  
18 conversations with Mr. Ellenbecker.

19 Q. And what was the nature of what you told  
20 her?

21 A. Just that exactly -- exactly this, that  
22 I've been in contact with Mr. Ellenbecker and  
23 just about the proceedings.

24 Q. Okay. And Mr. Ellenbecker said that

1 you -- he had provided to you various documents and  
2 testimony, I believe.

3 Can you tell me specifically what  
4 Mr. Ellenbocker -- Ellenbecker provided to you?

5 A. Yes. It was -- I believe it was  
6 testimony by a Mr. Dominik in -- from December, I  
7 believe, was the name of the -- I mean it was  
8 testimony back from December, but I believe it was a  
9 Mr. Dominik that was testifying.

10 Q. Okay. Did he provide to you anything  
11 other than Mr. Dominik's testimony?

12 A. There was an -- I believe a slide show  
13 presentation.

14 Q. By Mr. -- presented by Mr. Dominik?

15 A. Yes, ma'am.

16 Q. Is that the -- is that the sum total of  
17 what Mr. Ellenbecker gave to you, then?

18 A. Yes, ma'am.

19 Q. Did you take it upon yourself to review  
20 any of the other documents that have been introduced  
21 in this case?

22 A. No, ma'am.

23 Q. Are you aware that all of the proceedings  
24 have been shown live to -- during COVID to members of

1 the public?

2 A. Yes, ma'am, I'm -- I was aware of that.

3 Q. Did you have any opportunity to review  
4 any of the testimony by watching any of these  
5 proceedings?

6 A. I did not.

7 Q. Okay. Did you take any opportunity to  
8 review any of the testimony that was provided by  
9 Dr. Lustig from Haymarket Center?

10 A. I don't -- I don't recall so. I know I  
11 did not review it. I don't believe that was included  
12 in the attachments that Mr. Ellenbecker sent me.

13 Q. Okay. Are you familiar with CARF  
14 accreditation?

15 A. Actually, no, ma'am, I'm not. I'm  
16 familiar with the term only because -- from  
17 Mr. Ellenbecker asked me about it, and I don't know  
18 anything about it.

19 Q. And when Mr. Ellenbecker asked you about  
20 it, you told him you didn't know about CARF at that  
21 time?

22 A. Yes. He asked me if I was familiar with  
23 CARF, and I said no, I was not.

24 Q. Okay. Since the time that Mr. Ellenbecker

1 asked you, have you attempted to educate yourself as  
2 to the difference, if there is any, between JCAHO  
3 accreditation and CARF accreditation?

4 A. I have not done any research about that,  
5 no, ma'am.

6 Q. Are you familiar with the fact that  
7 Haymarket Center is CARF-accredited?

8 A. Only from Mr. Ellenbecker. He informed  
9 me that they were not JCAHO-accredited, and I -- that  
10 was the first I'd heard that they were  
11 CARF-accredited.

12 Q. Now, you testified that as part of your  
13 job in the environment of care, in that whole  
14 testimony you said that internal staff would keep  
15 incident reports.

16 Are you familiar with how Haymarket  
17 monitors its incidents in its facilities -- in its  
18 facility?

19 A. Only loosely. I believe, through  
20 Mr. Dominik's testimony, he said it was a part of the  
21 patient record.

22 Q. Okay. In reading -- in going through  
23 Mr. Dominik's testimony, were you able to get a sense  
24 of Haymarket's keeping of incident reports?

1 A. Not that I recall, no.

2 Q. Okay. Do you ever have the -- you  
3 testified that the SHARE Program kept incident  
4 reports, and they kept them in binders.

5 Did you ever have the need to  
6 compare your incident reports to 911 calls from your  
7 facility?

8 A. No, ma'am, not -- not that I did, no,  
9 ma'am.

10 Q. Are you aware of anyone in your facility  
11 doing any kind of comparison between your internal  
12 incident reports and the number of calls to 911?

13 A. No, ma'am.

14 Q. During the time that people were doing  
15 incident reports, did you have the opportunity -- did  
16 you sit on that committee to review the incident  
17 reports?

18 A. Yes.

19 Q. During that time did you ever -- did you  
20 ever discover opportunities where an incident may  
21 have occurred but no report was written?

22 A. Yes.

23 Q. And did you come across incidents  
24 where -- because a number of -- anybody involved had

1 to write up the incident, I would assume; is that  
2 correct?

3 A. Everybody involved in the incident was  
4 required to complete an incident report, yes.

5 Q. And were there times when the reports  
6 themselves might not have been matching up  
7 completely? Some were more descriptive than others?

8 A. Some were more descriptive than others,  
9 sure, and there were usually -- that's where usually  
10 we found that there was an incident report missing,  
11 was usually because someone put that they did  
12 something with someone else and that other person did  
13 not complete an incident report.

14 Q. In reading Mr. Dominik's report and at  
15 least some of the parts of his testimony, I would  
16 assume you became familiar with the fact that  
17 Haymarket was going to contract with a private  
18 ambulance service to assist in its EMS transport?

19 A. Yes.

20 Q. Did SHARE ever -- and I'm sorry if  
21 Mr. Ellenbecker asked this, I just don't remember.

22 Did SHARE ever study the hiring of a  
23 private ambulance service for that purpose?

24 A. If they did, I was not aware of it.

1 Q. Okay. Did SHARE ever transport any of  
2 its own patients to medical facilities?

3 A. Did our own staff transport?

4 Q. Yes.

5 A. Yes, ma'am.

6 Q. Okay. And in what occasions would SHARE  
7 have transported its own patients?

8 A. Nonemergency situations.

9 Q. And --

10 A. You know, everyone was required to have a  
11 tuberculosis test upon admission. So if a person  
12 tested positive for tuberculosis, the doctor would  
13 write a prescription for them or an order to have a  
14 chest X-ray. Usually in those type situations, we  
15 would transport them to the outpatient facility  
16 behind us to get those chest X-rays. It's a  
17 nonemergency situation.

18 Q. For every -- when SHARE, then, when --  
19 during the period of time that you were there, when a  
20 determination was made to call 911, who made that  
21 determination?

22 A. Any -- any staff member could make that  
23 determination.

24 Q. Did it matter if the patient was

1 presenting with what we would call a basic life  
2 support versus an ALS incident? Was there ever any  
3 demarcation as to either of those?

4 A. So most incidents that were not what you  
5 would say maybe as obvious emergencies would go to  
6 the nurse, and the nurse would usually make that  
7 decision at that time.

8 Q. Okay. Were the nurses -- did you believe  
9 that the nurses at SHARE were professionally  
10 qualified to make that decision?

11 A. Yes.

12 Q. And by "make that decision," I should be  
13 more clear.

14 Did you believe that the nurses  
15 employed by SHARE were professionally qualified to  
16 make a decision as to whether to call 911?

17 A. Yes.

18 Q. And you used a phrase that I in -- in all  
19 of these proceedings have not heard before, and that,  
20 if I'm understanding it correctly, it's milieu tech?

21 A. Milieu tech.

22 Q. Could you spell that, please?

23 A. M-i-l-i-e-u.

24 Q. What does that stand for?

1           A.     Well, I believe it's a French word that  
2 stands for basically just environment. So the  
3 overall milieu, it's just the environment.

4           Q.     And then but what does it mean to be a  
5 milieu tech?

6           A.     So in like, for instance, in a hospital  
7 setting or behavioral health setting, like a mental  
8 hospital, let's say, for lack of a better term -- I'm  
9 sorry -- they would usually have unit secretaries or  
10 unit techs. They were just support staff for the  
11 clinicians and the nurses.

12                         So a milieu tech is just that. It's  
13 just a support staff member there to assist the  
14 nurses and the clinicians. Usually this was a  
15 nonprofessional staff member.

16           Q.     And you testified that after you were  
17 there for a period -- after you were employed by  
18 SHARE for a period of time, the new director -- I  
19 don't know if it was Ms. DiLarco or someone else --  
20 but made a change in how the SHARE Program operated,  
21 moving it more into a clinically managed facility, I  
22 think you said?

23           A.     It was a clinically managed facility, but  
24 she felt at the time that the nursing staff was --

1 was heavily weighted. And because all of -- there  
2 was no other support staff. It was clinicians and  
3 then the medical staff. And so the nursing staff,  
4 the ratio, was -- in her opinion was heavily weighted  
5 towards the medical side. And she felt that we were  
6 a clinically managed facility; those resources should  
7 be directed more towards the clinical side of things  
8 and supporting the clinical staff.

9 Q. So what was the change in staffing, then?  
10 Did -- did -- was a determination made to reduce the  
11 medical staff, the nursing staff, and move it over to  
12 more of a clinical staff?

13 A. The decision was to keep the nurses in  
14 place as the medical staff and then to take the EMTs  
15 at the time or the paramedics we had on staff and  
16 transition them into a medical -- into the milieu  
17 tech position.

18 We had a lot of -- the EMTs around  
19 that time were leaving at the same time, also, and so  
20 it was -- they were either rehired or repurposed into  
21 that milieu tech position.

22 Q. And you said that you participated in the  
23 screening process during the period of time that you  
24 were employed there.

1                   From the time of your employment in  
2 1999 until the termination of your employment in  
3 2017, were you involved in the screening process?

4                   A.    Yes, ma'am.

5                   Q.    What role did you personally play in the  
6 screening process?

7                   A.    So early on it was -- it was the phone  
8 screen, and then I would also be a part of the  
9 medical assessment portion of the admission process.

10                   And then towards the end, it was the  
11 phone screen and then -- basically there was non --  
12 nonclinical paperwork that I would sign with the  
13 patient; so, you know, releases of information,  
14 consent for treatment, things like that that didn't  
15 need to be performed by a clinician or a nurse.

16                   Q.    Okay.  Would you be able to make a  
17 decision as to the level of care that an admittee  
18 should receive?

19                   A.    I didn't hear that last part.  That who  
20 should receive?

21                   Q.    The person seeking admission.

22                                Could you make that decision?

23                   A.    Could I personally make that decision;  
24 like did I have the right information, or did I have

1 the authority?

2 Q. Did you have the authority?

3 A. No, ma'am.

4 Q. Who would have had that authority?

5 A. The nurses and the clinicians.

6 Q. Were they part of the admissions team,  
7 then, as well?

8 A. We had clinicians in the intake  
9 department, and then there clinicians that provided  
10 the -- for the rehab patients, we did the  
11 biopsychosocial assessment at the time of admission.  
12 At the detox patients, we had 24 hours to do that.

13 Q. And are you familiar at all with the --  
14 with any type of assessments that Haymarket Center --  
15 or, excuse me, that Haymarket DuPage proposes for its  
16 patients?

17 A. No, ma'am.

18 Q. You did say that in -- when you started,  
19 the admissions process at SHARE was not rigorous.  
20 What -- but that that changed.

21 And what was the change that SHARE  
22 made to its admissions process that provided that  
23 greater rigor?

24 A. Well, the most significant change was

1 creating an admissions department, an intake  
2 department, that was primarily responsible. So all  
3 admissions came through that admission department.

4 And then all of the screening  
5 happened at the -- pretty much at the time of  
6 admission, within the best -- with the best we could.

7 Obviously with detox patients, there  
8 were times that you were admitting someone that was  
9 under the influence, and you wouldn't want to conduct  
10 an assessment at the time. You would do your medical  
11 assessment. The clinical assessment would come  
12 later.

13 But the most significant change was  
14 the creation of the admission department, the intake  
15 department.

16 Q. And was it -- was it as a result of the  
17 creation of the admissions department, was that what  
18 led to a better relationship with the neighboring  
19 hospital?

20 A. I wouldn't say that that led to a better  
21 relationship with the hospital, but it led to us  
22 depending on EMS far less than we were.

23 Q. And what led to that?

24 A. So what we had -- what we started to

1 pursue from each of our -- from each of our -- the  
2 potential clients was, you know, if they were on  
3 medication, we would require that they had their  
4 medication, that they had a 30-day supply of their  
5 medication if they were coming into rehab, and that  
6 they had a clearance form filled out by their primary  
7 care physician. So if it was a psychiatric  
8 medication, their psychiatrist or the prescribing  
9 doctor was to fill out a clearance. If it was a  
10 medical condition, they were required to be -- same  
11 thing, they had to have their medication, have a  
12 30-day supply, and their primary care physician had  
13 to sign a clearance.

14 So this is making the patient go  
15 back to the doctor to be -- to make sure that the  
16 doctor understands the program they're being admitted  
17 into and that they can perform those.

18 That was something we didn't do in  
19 the beginning. It was not -- we would try to -- our  
20 goal was to admit people, right, I mean to try to get  
21 people off the street for harm reduction. And  
22 bringing them in -- but when you bring people in that  
23 aren't stable on their medication, they're not on  
24 their medication, they haven't been on them for a

1 long time, it just creates challenges, especially  
2 when they lack funding.

3 So it's harder to get them -- get  
4 that assessment done, get the new med prescribed, get  
5 it filled, get it brought to them. All of those  
6 things were challenges that we were eliminating. So  
7 people were able to then successfully complete  
8 treatment. So you didn't have people that were --  
9 that had an acute anxiety diagnosis that weren't on  
10 any medication for acute anxiety. And then as you  
11 can imagine, someone not on their medication for  
12 acute anxiety, they have trouble functioning, right.

13 The same is true for a  
14 schizophrenic, for someone that's bipolar. It  
15 doesn't mean that they're not able to perform  
16 treatment, but their primary concern without their  
17 medication would be -- that would be their primary  
18 diagnosis, not chemical dependency.

19 So once we went -- once the intake  
20 admission process was more rigorous and we were  
21 making sure that they were coming in the door with  
22 everything they needed to complete treatment, they  
23 were able to then successfully complete treatment.

24 I don't want to paint a picture that

1 people did not leave against staff advise. Our  
2 turnover was high. It's high in the field. But it  
3 was far -- it was greatly improved by making the  
4 process more rigorous.

5 Q. When somebody wasn't allowed to be  
6 admitted to your facility for any reason during the  
7 time that you were there, what would SHARE do, if  
8 anything, to assist that person who's now been  
9 refused admission?

10 A. Refer them to the appropriate level of  
11 care; and then do our best, within reason, to help  
12 them gain access to the appropriate level of care.  
13 And, again, that -- depending on what it is, right.

14 Q. Okay. Would SHARE transport that person  
15 to a different program?

16 A. No.

17 Q. Would SHARE call a different program for  
18 them to ease the pathway so that they could gain  
19 admittance?

20 A. Not for them. We would assist them when  
21 making those calls themselves.

22 Q. Okay. And what would be -- you said that  
23 you would -- before -- and I think it was before this  
24 process, that you would use the ER an awful lot, but

1 once you got better, your use of a neighboring ER  
2 also was reduced?

3 A. That -- that's correct. Once we got  
4 better, we depended less on the ER.

5 Q. Okay.

6 A. So I don't know what information you  
7 want, but a lot of that had to do with -- with there  
8 was a doctor that was on staff, he had admitting  
9 privileges at St. Alexius -- it wasn't St. Alexius at  
10 the time, I don't believe -- but he came in -- we  
11 brought him on staff as an internist. And what that  
12 did was that created an opportunity for us to resolve  
13 far more issues without them having to be discharged,  
14 right.

15 The whole purpose of that was, this  
16 issue, there were several doctors in the emergency  
17 room who -- who were upset and angry that we were  
18 constantly bringing -- filling the ED with  
19 nonemergent patients. And so when Dr. Hashmi came  
20 over, that was one of the reasons he was coming over,  
21 was to help us solve that, get the patients the best  
22 possible care they could outside of a hospital  
23 setting.

24 Q. So you -- prior to that process, you

1 might have been -- to assist the patient to the best  
2 you knew at that time, you might have been forwarding  
3 them to an emergency room where if you had had proper  
4 care onsite, they could have stayed onsite; is that  
5 what you're saying?

6 A. That's correct.

7 Q. Okay. Are you familiar with any of the  
8 medical staff employed at Haymarket Center?

9 A. No, ma'am.

10 Q. So you don't have any knowledge as to the  
11 experience level of the professional medical staff at  
12 Haymarket Center?

13 A. Outside of understanding that there's  
14 nurses there. That's --

15 Q. Okay. You were talking about the scaling  
16 up from what SHARE had to what DuPage proposes, if I  
17 understand your testimony correctly.

18 And correct me if I'm wrong:  
19 Scaling up from that number of beds to a facility the  
20 size that Haymarket proposes, you believe, would  
21 create an impact? Am I understanding you correctly?

22 A. Well, my understanding, if I remember  
23 correctly from Mr. Dominik's testimony, was the idea  
24 was to look at the number of calls per treatment bed,

1 right.

2 Q. Okay.

3 A. So obviously the idea, then, would be  
4 theoretically, because we're not looking at data from  
5 a -- from a comparable facility, we're saying that  
6 the reason that you're doing that from my  
7 understanding from the testimony is to look at, okay,  
8 so if you have this many calls per bed and we're  
9 proposing 240, then we can say this number of calls.

10 My question would just be, does it  
11 scale up. I'm not -- that's not my -- that's outside  
12 of my wheelhouse. That would be my question.

13 If I remember the question --

14 Q. Okay.

15 A. -- I was being asked, I was just stating  
16 my opinion that my question would be does it scale up  
17 like that.

18 Q. Okay. Are you familiar at all with  
19 Haymarket's security protocol?

20 A. No.

21 Q. Just give me a moment. I'm going to just  
22 make sure that I've answered -- I've asked you all  
23 the questions that I had.

24 Are you familiar with the level of

1 support that the Haymarket DuPage proposal has from  
2 the hospitals located in DuPage County?

3 A. I don't recall seeing anything about the  
4 hospitals. I'm sorry.

5 Q. Okay. Are you aware of any of the  
6 support that the proposal of Haymarket DuPage has to  
7 open in DuPage County?

8 A. No, ma'am.

9 Q. During the time that you were employed by  
10 SHARE, were you responsible for the creation of any  
11 programs, any treatment programs?

12 A. No, I had no -- I was not -- there was a  
13 clinical director that handled all clinical matters.

14 Q. You testified that you were an EMT, I  
15 think a basic certification?

16 A. Yes.

17 Q. Was it as a result of your EMT basic  
18 certification that you were employed at SHARE?

19 A. At the initial hire, yes.

20 Q. And did you stay with -- did you -- I  
21 believe you said that there -- that you don't have  
22 any other certification?

23 A. That's correct.

24 Q. Okay. So during the time you worked at

1 SHARE, you didn't take any certification programming  
2 in drug addiction counseling or anything to do with  
3 substance abuse?

4 A. So we -- monthly we were required to take  
5 CEUs. So SHARE provided people from the field and  
6 from the community coming in.

7 We had a good relationship with the  
8 College of DuPage, so a lot of times we would have  
9 people from their program come in and provide  
10 training.

11 So we had -- we provided CEUs once a  
12 month. And they also would send you to seminars, but  
13 I -- that was the extent.

14 Q. Okay. And just so you and I are talking  
15 the same language, is a CEU a clinical education  
16 unit, or what does CEU mean?

17 A. Continuing education unit.

18 Q. Very good. Did -- can you -- do you  
19 recall any of the continuing ed units you might have  
20 taken while you were at SHARE?

21 A. Well, most of them surrounded MISA  
22 programs, so mentally ill substance abusers, people  
23 with dual diagnosis.

24 Q. Okay. Now, you did -- you did recall --

1 one question I had for you: As I read about the  
2 SHARE Program, one of the programs was related to  
3 gambling addictions?

4 A. Yes.

5 Q. If somebody had a gambling addiction, did  
6 they have to come in with a primary diagnosis of  
7 substance use disorder?

8 A. That's correct. So the gambling -- the  
9 gambling addiction was treated -- if that was the  
10 primary diagnosis, that was treated on an outpatient  
11 basis only. We could have inpatient residents that  
12 had a secondary diagnosis, but their primary  
13 diagnosis had to be chemical dependency.

14 Q. And the primary diagnosis for anyone  
15 inpatient had to be chemical dependency?

16 A. Yes.

17 Q. Okay. Are you aware of the -- because I  
18 recognize that you don't live in the State of  
19 Illinois anymore, but are you aware of the -- any of  
20 the statistics relative to substance use disorder in  
21 Illinois?

22 A. Statistics relative to -- no, I mean --

23 Q. The incidence of substance use disorder?

24 A. No, nothing currently. And I would have

1 to refresh my memory.

2 Q. As someone still involved or at least  
3 interested in the industry, are you aware of the fact  
4 that other than the current COVID pandemic, the other  
5 pandemic that we still face in the United States is  
6 the opioid epidemic?

7 A. Yes.

8 Q. And I appreciate the fact, sir, that  
9 you've testified that you do support treatment.

10 Do you support treatment for  
11 substance use disorder?

12 A. I do.

13 Q. And -- and isn't it a benefit to a  
14 community to have a treatment center located within  
15 the community?

16 A. Yes.

17 Q. Let me just ask this, too: During the  
18 time that you worked at SHARE, could you -- did you  
19 have a typical type of patient; meaning were they  
20 members of the community, typically?

21 A. So --

22 MR. ELLENBECKER: I object to form. I object  
23 to form, foundation.

24 Go ahead.

1 THE WITNESS: Go ahead and answer?

2 MR. ELLENBECKER: Yeah, if you can, the way  
3 she asked it.

4 BY THE WITNESS:

5 A. So I don't have hard numbers for you, but  
6 most of our patients were not from the immediate  
7 surrounding area. They were from all over the  
8 suburbs.

9 BY MS. DICKSON:

10 Q. Did you maintain any statistical  
11 breakdown of homeless versus those who had  
12 residences?

13 A. Yes, that information -- I don't know --  
14 I don't have it readily available, but that  
15 information was kept, yes.

16 Q. Did the fact that some -- did you -- did  
17 you yourself -- were you able to draw any conclusions  
18 relative to patient success based on whether a  
19 patient was homeless or not homeless?

20 A. Can you maybe ask the question again?  
21 I'm not sure I understand what you're asking.

22 Q. Okay. Were you able to yourself draw any  
23 conclusion as to whether someone would successfully  
24 complete treatment if they presented as a homeless

1 individual?

2 A. No.

3 Q. You treated both males and females in  
4 your facility; is that true?

5 A. Yes.

6 Q. During the period of time that you worked  
7 for the facility, are you aware of whether you would  
8 admit females who were pregnant?

9 A. That was very rare, but there were times  
10 early on in pregnancy that we -- we would have  
11 someone. But that was extremely rare. They would  
12 usually go to another treatment center.

13 Q. Do you know why they would go to a  
14 different treatment center other than SHARE?

15 A. Well, so the most common reasons was the  
16 understanding in the field, at least when I was in  
17 the field, was someone addicted to opiate should  
18 not -- that was pregnant should not come off of the  
19 opiate. So they should stay on some maintenance  
20 program. The baby should under no circumstances go  
21 through withdrawal.

22 So usually they would go to a  
23 treatment center where they could receive some  
24 maintenance program. So early on that was methadone,

1 but then also with the advent of Suboxone, there were  
2 treatment centers that would provide that to their  
3 residential treatment patients.

4 Q. Did SHARE not offer that?

5 A. We offered Suboxone, but, I'm sorry, I  
6 don't -- I should remember this, but I don't remember  
7 if we did it -- if we did it for inpatient.

8 I know we did go through a period of  
9 time when I was there when it was provided to our  
10 medical detox, but I don't remember if our  
11 residential patients were on it. I'm sorry.

12 Q. That's all right.

13 I understand, and maybe you -- you  
14 would know this better than myself, but I understand  
15 there's some concern in the medical community in  
16 terms of providing treatment to a female who is  
17 pregnant and suffering from drug addition.

18 Were you aware of -- would that be a  
19 true statement?

20 A. Yes.

21 Q. Was that a concern in your facility?

22 A. Yes. Having -- having a pregnant female  
23 was -- they were at additional risk.

24 And then if we weren't able to

1 admit, finding them the appropriate level of care  
2 that would take them was -- was challenging.

3 Q. Okay. And so rather than admit them,  
4 would it be SHARE's preference to find a treatment  
5 program better suited for them?

6 A. Yes.

7 Q. During the time that you were at SHARE,  
8 and I -- and I know it was a long period of time, but  
9 do you remember at all what the organizational chart  
10 might have looked like to the extent it didn't change  
11 year by year?

12 Like who would have been at top of  
13 the org chart?

14 A. So when I first -- when I first started,  
15 it was the CEO, Dennis Vaccaro. When he passed away,  
16 it became the COO. Donna Santoro was moved into the  
17 CEO spot, and then she was over the clinical  
18 directors.

19 There was a clinical director over  
20 Leyden Family Service in Franklin Park, and there was  
21 a clinical director at the SHARE Program. And then  
22 under each of them, they had the clinical directors  
23 under them, the medical -- the nurse manager, and  
24 then intake supervisor and outpatient supervisor, and

1 then so on and so forth.

2 Q. And at the -- at the end of your  
3 employment there in 2017, how many employees did  
4 SHARE have, do you know? Do you recall?

5 A. SHARE specifically, I don't recall the  
6 exact number. But Leyden as a whole had around 200.

7 Q. With the treatment center, do you know  
8 what the staff -- the professional medical staff to  
9 patient ratio was?

10 A. I knew it was set, but I don't recall  
11 what it was. I'm sorry.

12 Q. You're not currently -- I looked up your  
13 new company, and am I correct in assuming that it is  
14 not in the -- you don't currently work within a  
15 substance use treatment facility?

16 A. That's correct.

17 MS. DICKSON: Mr. Chairman, I would ask just  
18 for five minutes. So instead of taking the witness's  
19 time while I look at my notes, if I could have five  
20 minutes. I think I'm completed, but I just want to  
21 make sure because of the paperwork I have surrounding  
22 me.

23 CHAIRMAN DALY: That would be fine. Let's  
24 break for five minutes, and we'll reconvene at 9:15.

1 MS. DICKSON: Thank you, sir.

2 (Recess taken.)

3 CHAIRMAN DALY: If we can please see  
4 everybody's cameras up and running again so we can  
5 resume.

6 MS. DICKSON: I'm technologically challenged.  
7 I need assistance.

8 UNIDENTIFIED SPEAKER: She's not lying.

9 MS. DICKSON: If I can, Mr. Chairman.

10 BY MS. DICKSON:

11 Q. When I -- when I was asking you about the  
12 organizational chart, I neglected to ask you,  
13 Mr. Wrigley, where did you place on the  
14 organizational chart for the predominance of your  
15 time or -- and let me rephrase that.

16 The highest level on the  
17 organizational chart that you held, what was that?

18 A. I answered directly to the clinical  
19 director.

20 Q. And what position did you hold when you  
21 answered directly to the clinical director?

22 A. My title at the time was unit supervisor.

23 Q. What were your duties as the unit  
24 supervisor?

1           A.     I oversaw the inpatient units; I oversaw  
2 the facilities; I oversaw the admission process.

3           Q.     Did you oversee the personnel working in  
4 those units?

5           A.     Yes.

6           Q.     Okay. And then going back to the first  
7 opportunity you learned about this case from the  
8 Village attorney Mr. Chuck Hervas who asked, I  
9 believe, if Mr. Ellenbecker could contact you, did  
10 you get the sense from that contact that Mr. Hervas  
11 and Mr. Ellenbecker were on the same side of this  
12 proceeding?

13           MR. ELLENBECKER:  Objection --

14           BY THE WITNESS:

15           A.     I don't recall.

16           MR. ELLENBECKER:  -- calls for speculation.

17           MS. DICKSON:  Okay. Well, I'm asking him his  
18 sense --

19           MR. ELLENBECKER:  That's just the way lawyers  
20 try to get him to speculate about somebody else's,  
21 but, anyway, he answered it.

22           BY MS. DICKSON:

23           Q.     Okay. You weren't -- you didn't  
24 understand at any time that because Mr. Hervas

1 represents the Village and your understanding was, I  
2 believe you said, that Mr. Ellenbecker represented  
3 the residents, you didn't at any time draw any  
4 conclusion relative to their personal or their  
5 professional role in this proceeding?

6 A. So I know this is going to sound like I'm  
7 trying to be difficult, but I don't know how to  
8 separate what I know from what -- and when I knew it.

9 I'm sorry, I don't have a specific  
10 event I remember that was when I became aware.

11 MS. DICKSON: Okay. Well, I thank you so much  
12 for providing the testimony you did this evening.  
13 It's very much appreciated.

14 And I have no further questions of  
15 the witness, Mr. Daly.

16 CHAIRMAN DALY: Thank you very much.

17 At this time I would ask if there's  
18 any redirect or follow-up from Mr. Ellenbecker first,  
19 and then Mr. DiNolfo and Ms. Smith.

20 MR. ELLENBECKER: Briefly, Mr. Chairman.

21 REDIRECT EXAMINATION

22 BY MR. ELLENBECKER:

23 Q. Mr. Wrigley, if your staff at SHARE was  
24 expected or required to chart 911 calls, you'd expect

1 that your internal documentation would closely track  
2 external 911 call data; wouldn't you?

3 A. Yes.

4 Q. And based on size and services offered,  
5 based on what you know about Haymarket West Loop and  
6 the proposed Itasca facility, would it be your  
7 expectation that Haymarket West Loop would be the  
8 best or closest comp to the proposed facility in  
9 Itasca?

10 A. Yes.

11 Q. You were asked some questions about  
12 whether treatment facilities would be good for a  
13 community.

14 Would you agree that for a treatment  
15 facility to be good, that facility has to be a good  
16 fit for that -- that community?

17 A. Yes, I mean, it would have to be a good  
18 fit for the community, but it would also have to  
19 effectively do its -- to provide treatment.

20 Q. Right. And are you aware of any facility  
21 at or around the size of 240 beds in a town the size  
22 of Itasca anywhere in the country?

23 A. The only one that I'm aware of is  
24 Haymarket West Loop.

1 Q. Right. And that's in the City of Chicago  
2 that has considerably more people; correct?

3 A. That's correct.

4 Q. And you testified earlier that with a  
5 64-bed capacity at SHARE, there were times that the  
6 SHARE facility overwhelmed the emergency department  
7 at St. Alexius; correct?

8 A. Yes.

9 Q. And the proposed facility has 240 beds;  
10 correct?

11 A. That's my understanding.

12 MR. ELLENBECKER: No further questions.

13 CHAIRMAN DALY: Mr. DiNolfo?

14 MR. DI NOLFO: Chairman Daly, I have no  
15 questions. Thank you.

16 CHAIRMAN DALY: Thank you. Ms. Smith, any  
17 questions of the witness?

18 MS. SMITH: No questions. Thank you.

19 CHAIRMAN DALY: Okay. At this time,  
20 Ms. Dickson, I'd ask if you had one more shot at this  
21 before we turn it over to the Plan Commission?

22 MS. DICKSON: I have no other questions,  
23 Mr. Daly. Thank you.

24 CHAIRMAN DALY: Thank you. At this time I'd

1 ask the Plan Commission, if you have any questions of  
2 Mr. Wrigley at this time, please ask him.

3 Hearing none, I do have one  
4 question, Mr. Wrigley: I believe it was midway  
5 through your testimony you had, quote, the same  
6 information, I had written that in quotes, and then  
7 as a note underneath, over and over.

8 So can you give us an example or  
9 two examples of the types of comments you would hear  
10 about Haymarket that were pervasive over your 18  
11 career -- 18-year career there?

12 THE WITNESS: So most of my understanding from  
13 Haymarket, as I said, comes from inpatient -- from  
14 our residents. And most of the information that was  
15 being provided to me was usually around the detox  
16 program. And the consistent information that I would  
17 hear would be that it was similar to a drunk tank,  
18 that the police could up in a back alley, drop  
19 residents off, put them into a room that had -- the  
20 detox had no beds, sandwiches were on a cart. There  
21 was no clinical attention, very little medical  
22 attention.

23 And understand, please, that that  
24 spans over 18 years of time. So that -- that -- just

1 keep that in mind when you're thinking through that,  
2 going back to 1999. But those were the most  
3 consistent things that people were -- or there was no  
4 treatment being provided. Most of the information  
5 that I heard was from just the detox program.

6 CHAIRMAN DALY: And just a quick follow-up on  
7 that.

8 Did you ever hear any comments --  
9 no, strike that.

10 I have no further questions of you  
11 at this time.

12 Any other members of the Plan  
13 Commission?

14 Hearing none, Mr. Wrigley, I thank  
15 you for your time this evening. Appreciate it. And  
16 you are excused.

17 THE WITNESS: Thank you.

18 CHAIRMAN DALY: At this time, I believe the  
19 next witness this evening, the Village's witness --  
20 okay. Mr. Ellenbecker, do you have any exhibits to  
21 enter into the record this evening that weren't  
22 previously submitted?

23 MR. ELLENBECKER: Mr. Chairman, I'm not sure  
24 what number it would be in succession, but it was the

1 aerial photo I showed on direct examination.

2 MS. WYSOCKI: Mr. Ellenbecker, the last  
3 exhibit you entered was November 13th of 2019. It  
4 was labeled Exhibit 9.

5 MR. ELLENBECKER: So am I just continuing  
6 with --

7 MS WYSOCKI: So the next would be 10 --

8 MR. ELLENBECKER: -- my numbers or -- Okay.  
9 So I'll say exhibit -- I'd like to move to admit  
10 Exhibit 10, which was the aerial photograph.

11 CHAIRMAN DALY: We accept that Exhibit No. 10  
12 into the record.

13 MS. WYSOCKI: Are you going to admit the  
14 résumé or CV or no?

15 MR. ELLENBECKER: Yeah, we'll -- I submitted  
16 the -- last Friday Mr. Wrigley's résumé. We'd ask to  
17 admit that as Exhibit 11.

18 CHAIRMAN DALY: All right. Thank you.

19 (865 Irving Park Road, LLC Exhibit  
20 Nos. 10-11 admitted.)

21 CHAIRMAN DALY: At this time, the next witness  
22 is the Director of Police O'Connor, and I believe he  
23 is in police headquarters.

24 Do we have him on camera, Mo?

1 MR. KHAN: We do, sure.

2 CHAIRMAN DALY: Good evening, Director  
3 O'Connor.

4 THE WITNESS: Good evening.

5 CHAIRMAN DALY: Can we please ask that you are  
6 sworn in by the court reporter at this time before we  
7 begin your testimony this evening.

8 THE WITNESS: Sure.

9 (Witness sworn.)

10 CHAIRMAN DALY: Thank you. You may begin.

11 DIRECTOR O'CONNOR: Thank you. I want to  
12 start tonight by thanking the Commission for its time  
13 and attention to this matter.

14 As many of you know, my name is  
15 Robert O'Connor, and I'm currently the Director of  
16 Police for the Village of Itasca. I've been with the  
17 department for 39 years; and in those 39 years, I've  
18 held every position in the department from patrol to  
19 chief and director. I became the Chief of Police in  
20 2014 and then the Director in 2016.

21 I have a Bachelor of Arts in Law  
22 Enforcement from Governors State University and have  
23 dedicated my career to law enforcement in Itasca.

24 The police department is an

1 accredited agency here in Illinois through an  
2 Illinois Law Enforcement Accreditation Program known  
3 as ILEAP which is managed by the Illinois Chiefs of  
4 Police. The department was recently reaccredited in  
5 2020.

6 The police department is currently a  
7 22-person force, including myself. We have 14 patrol  
8 officers, two which work in investigations and 12 on  
9 the street. We have five sergeants, two deputy  
10 chiefs, and, again, myself.

11 Our department is the smallest  
12 department in the area, smaller than Wood Dale,  
13 Elk Grove, Roselle, Addison, or any of the other  
14 towns identified by Haymarket in comparison.

15 Our officers work on three shifts  
16 throughout the day. Each shift has two patrol  
17 officers and one sergeant or an officer-in-charge.

18 With sufficient forewarning we can  
19 handle large-scale events such as Itasca Fest or the  
20 annual large-scale fireworks show for 4th of July.  
21 However, our daily operations consist of just three  
22 sworn officers for each shift.

23 Each shift has its own peak times.  
24 Day shift is busiest from around 7:00 a.m. to 9:30

1 a.m.; afternoon shift from about 4:00 o'clock to 7:00  
2 p.m.; and midnights from about 11:00 p.m. to 2:00 a.m.  
3 and again about 5:30 a.m. and through morning rush  
4 hour. As you may guess, the days of the week matter  
5 too. Monday morning and Friday nights are especially  
6 busy for our officers.

7 The Village of Itasca is a member of  
8 the Addison Consolidated Dispatch Center otherwise  
9 known as ACDC. ACDC is a police and fire dispatch  
10 service to several communities. When a call is  
11 received by ACDC, ACDC determines which agency is  
12 sent to a scene based on an incoming phone number or  
13 location reported by the caller. ACDC, not the  
14 Village of Itasca, then determines the type of  
15 response needed -- an ambulance, fire engine, squad,  
16 or combination thereof -- and directly dispatches  
17 personnel and equipment accordingly. Although the  
18 sergeant or officer-in-charge has the authority to  
19 weigh in and manage resources on that shift, ACDC  
20 handles the actual dispatch.

21 It is important to understand that  
22 ACDC dispatches a police officer to a scene even when  
23 the call is for EMS or fire. ACDC does this with  
24 every town that it dispatches for. Thus, ambulance

1 called for injuries, illness, juveniles, mental  
2 health, will result in an officer being dispatched  
3 with the fire department.

4           However, calls for known nursing  
5 home transports, alarms for medical -- mechanical  
6 issues and fire suppression equipment, and calls for  
7 lift service results in police being informed but not  
8 dispatched. The purpose behind this policy is  
9 twofold: To ensure immediate response to an  
10 emergency, and then make the scene safe for others.

11           Police officers are typically  
12 already mobile because they are on patrol and often  
13 arrive faster than EMS or fire. The officers carry  
14 Narcan, AEDs and other immediate care equipment. The  
15 officers are also there to determine that the scene  
16 is safe before EMS or fire enters to provide aid.

17           The police officers respond to EMS  
18 or fire calls even if the location already has its  
19 own security. From a logistics standpoint, it would  
20 be very difficult to exclude an entire class of  
21 individuals based on a possibility of security being  
22 on the site.

23           I'd like to give you some historical  
24 information about the economics and finances of the

1 Itasca Police Department to help you understand the  
2 potential impact of a large-scale facility.

3 Over the last 15 years, the police  
4 department has seen many budget cuts as a result of  
5 pension and similar costs. The cuts have been  
6 economically driven and have made the department more  
7 lean and efficient.

8 After 2008 through 2010, each shift  
9 went from three to two patrol officers. Recently,  
10 the department decreased the number of sergeants from  
11 six to five. The bottom line, that policing is  
12 expensive, and personnel costs are especially high.

13 I want to assure you and the public  
14 that despite reduction in staff, the department is  
15 running at an acceptable level. It is more efficient  
16 than it was in previous decades.

17 However, the lean size of the  
18 department cannot be cut much more. Personnel  
19 reductions or significant increase in activity will  
20 have an impact on policing in Itasca.

21 Some of that impact will be felt in  
22 call response times. Now sergeants triage calls so  
23 that big emergencies are handled first. An increase  
24 in calls will make these decisions much more complex.

1 Multiple calls at the same time will become  
2 problematic and may require an increase in personnel  
3 for the same level of service.

4 The comparison made by James Dominik  
5 of averages across a year, a month, or even a day  
6 does not address how multiple calls will be  
7 prioritized or how one of the smallest departments in  
8 DuPage will handle an increase in these calls during  
9 peak times.

10 As an aside, police call numbers  
11 presented by Mr. Dominik are problematic. First, he  
12 used figures from the Wood Dale Police Department  
13 which I have been unable to verify.

14 Second, his calculations are  
15 confusing. He notes in his report that the average  
16 police calls for Itasca is 8,665 annually, which is  
17 the smallest number of calls on his chart. He fails  
18 to note that Itasca has the smallest number of calls  
19 because it's the smallest town on his list.

20 Mr. Dominik then calculates 23.7  
21 calls per day by dividing 8,665 by 365 days a year,  
22 and then he divides that number by 23 to reach the  
23 average calls of 1.5 calls per officer. However,  
24 this calculation is deceptive. For one, our

1 department only has 21 sworn officers, six of which  
2 are on the street at any given 24-hour -- 24-hour day  
3 to handle the average calls per day.

4           Moreover, the number of calls  
5 annually -- annually do not occur in an even spread  
6 throughout the day or even the year. There are busy  
7 days, peak hours, slow times, but our personnel must  
8 be present and ready to handle the unexpected  
9 emergency 24/7, requiring the department to have  
10 adequate staffing at all times to handle the call  
11 load.

12           Personnel increase -- increases are  
13 expensive and not an option under the current budget  
14 for the department. A new officer costs the  
15 department approximately \$100,000 in year one,  
16 including his or her wages, benefits, pension  
17 contributions, outfitting, and training.

18           Additionally, new officers have 30  
19 weeks of the academy and field training before they  
20 can run solo, meaning that the department does not  
21 see the benefit of those startup costs until week 31,  
22 assuming the officer successfully completes all the  
23 required training.

24           To run another officer on each shift

1 will run the department about \$300,000 the first  
2 year. The union contract requires increases in wages  
3 after year one, and there are continued costs  
4 associated with outfitting and training officers  
5 throughout their career.

6 More officers means more wear and  
7 tear on the squad cars and on other equipment.  
8 Currently, the department replaces its cars every  
9 18 to 24 months on a rotating basis. More officers  
10 will result in a sooner replacement.

11 Perhaps no less important to our  
12 community will be impact of increased activity on  
13 programs. As District 10 Superintendant Craig Benes  
14 testified, our department works closely with the  
15 Itasca schools to ensure that officers are a visible  
16 presence at the schools and are involved in building  
17 relationships with our students and staff. Officers  
18 on shift visit the schools to engage class and make  
19 themselves available for students.

20 The amount of time officers have to  
21 participate in these activities will be diminished.  
22 However, I do not think programming with the schools,  
23 including the DARE program, will be going away  
24 completely.



1 events and not everyday minutia.

2 The Village has resources on a  
3 county level. There is a DuPage-wide response team  
4 called MERIT, which stands for Metropolitan Emergency  
5 Response Investigation Team, which works like a task  
6 force. It is called upon for major crime  
7 investigations, hostage negotiations, SWAT, forensic  
8 teams, which allow DuPage police departments to share  
9 resources for these larger events.

10 Since its inception in early 2020,  
11 the Itasca Police Department has called on MERIT only  
12 once, last week during a gas leak at a resident's  
13 home.

14 We have had two officers from the  
15 Itasca Police Department that are also part of MERIT  
16 on the investigatory unit. They have provided  
17 assistance approximately eight to 10 times since  
18 MERIT's inception.

19 Finally, the Village is also part of  
20 NIPAS, know as the Northern Illinois Police Alarm  
21 System, as a limited member with its civil unrest  
22 division known as a mobile field force. We can call  
23 upon them only in cases of civil unrest.

24 I've worked with Fire Chief Jim

1 Burke for over 10 years and trust his department and  
2 his testimony before this Commission. I share his  
3 concerns about the impact of Haymarket on the Village  
4 and the Fire Protection District and rely on his  
5 testimony about the likely increase in EMS and fire  
6 calls. Such an increase will impact Itasca Police  
7 Department by increasing its call volume as well.

8 Again, thank you for your time and  
9 attention tonight. None of you have an easy task,  
10 and the police department appreciates the commitment  
11 you have made to weigh the evidence and testimony of  
12 the witnesses fairly in this matter.

13 I'm now happy to answer any of your  
14 questions.

15 CHAIRMAN DALY: Thank you, Director O'Connor.

16 At this time I'd ask first if  
17 Mr. Ellenbecker has any questions?

18 MR. ELLENBECKER: Chairman Daly, I don't have  
19 any questions. Thank you.

20 CHAIRMAN DALY: Mr. DiNolfo, any questions?

21 MR. DI NOLFO: Chairman Daly, no question.  
22 Thank you.

23 CHAIRMAN DALY: Ms. Smith, any questions?

24 MS. SMITH: No questions. Thank you.

1 CHAIRMAN DALY: Ms. O'Keefe, any questions of  
2 Director O'Connor?

3 MS. O'KEEFE: Mr. Chairman, I do have  
4 questions for Director O'Connor, and it is likely  
5 that we are going to go into next week. So could we  
6 give everybody an early evening and start fresh next  
7 week?

8 CHAIRMAN DALY: Do I hear any object --

9 MS. O'KEEFE: Because it's unlikely I can  
10 finish him in a half an hour.

11 CHAIRMAN DALY: Understood.

12 Mr. Ellenbecker, Mr. DiNolfo, and  
13 Ms. Smith, do you have any issues with ending at this  
14 time?

15 MS. SMITH: No. Thank you.

16 MR. ELLENBECKER: I don't. I don't know what  
17 the lineup is for next week. I know there was  
18 concern about us, you know, dragging into June as it  
19 is. So if we're still going to get done with Chief  
20 O'Connor next week, maybe there is no issue. But if  
21 it looks like pushing this another -- this 30 minutes  
22 into next week meaning we don't get done with him  
23 next week, then I think we are extending it, which is  
24 something Haymarket had actually commented as being

1 something it wanted to avoid.

2 MS. O'KEEFE: I see no reason why we can't get  
3 done next week.

4 MS. DICKSON: And we don't have any other  
5 witness.

6 MS. O'KEEFE: And we have no other witnesses.  
7 It's the only witness we're going to have next week,  
8 is Director O'Connor.

9 MR. ELLENBECKER: Okay. Then I have no  
10 objection.

11 MR. DI NOLFO: I have no objection as well,  
12 Chairman Daly.

13 CHAIRMAN DALY: Okay. So next week, let's  
14 talk about that for a second.

15 Director O'Connor will be  
16 cross-examined by Ms. O'Keefe.

17 Are there any other witnesses being  
18 brought forth by the Village that would be called to  
19 testify next week?

20 MS. WYSOCKI: The Village has one other  
21 witness, Sarah Ketcham, who is the -- she's the  
22 expert that provided the economic report in the  
23 original staff report, and she'll be testifying, but  
24 she's not available next week. She's -- and I know

1 the Plan Commission is unavailable because of other  
2 matters until June 2nd, I believe. So she's  
3 available at the June 2nd meeting, but she's not  
4 available on the 13th.

5 CHAIRMAN DALY: Okay. That being said, next  
6 week we will continue with Director O'Connor,  
7 hopefully finish his testimony and  
8 cross-examination -- finish the cross-examination at  
9 that point, and then we would continue to June.

10 So at this time, knowing that that  
11 is the plan, can I please get a motion to continue  
12 this case until May 12th?

13 COMMISSIONER HOLMES: So moved, Chairman.

14 COMMISSIONER CARELLO: Second. Commissioner  
15 Carello.

16 CHAIRMAN DALY: We have a motion and a second.

17 Would the secretary please call the  
18 vote to continue the meeting.

19 MR. KHAN: Commissioner Carello.

20 COMMISSIONER CARELLO: For.

21 MR. KHAN: Commissioner Drummond.

22 COMMISSIONER DRUMMOND: For.

23 MR. KHAN: Commissioner Holmes.

24 COMMISSIONER HOLMES: For.

1 MR. KHAN: Commissioner Russo.

2 COMMISSIONER RUSSO: For.

3 MR. KHAN: Chairman Daly.

4 CHAIRMAN DALY: For.

5 Motion carries. This meeting will  
6 be continued until next Wednesday.

7 At this time I would ask for a  
8 motion to adjourn for the evening.

9 COMMISSIONER HOLMES: So moved, Chairman.

10 CHAIRMAN DALY: Thank you.

11 COMMISSIONER CARELLO: Second. Commissioner  
12 Carello.

13 CHAIRMAN DALY: Thank you. Mo, would you  
14 please call the vote to adjourn.

15 MR. KHAN: Commissioner Carello.

16 COMMISSIONER CARELLO: For.

17 MR. KHAN: Commissioner Drummond.

18 COMMISSIONER DRUMMOND: For.

19 MR. KHAN: Commissioner Holmes.

20 COMMISSIONER HOLMES: For.

21 MR. KHAN: Commissioner Russo.

22 COMMISSIONER RUSSO: For.

23 MR. KHAN: Chairman Daly.

24 CHAIRMAN DALY: For.

1                                   We will see you all next week. And  
2 for those of you who are mothers, Happy Mother's Day.

3                   MS. O'KEEFE: Thank you, Mr. Chairman. Thank  
4 you.

5                   CHAIRMAN DALY: Take care.

6                                   (Whereupon, the matter was continued  
7 to May 12, 2021, at 7:00 p.m.)

8                                   \*    \*    \*    \*    \*

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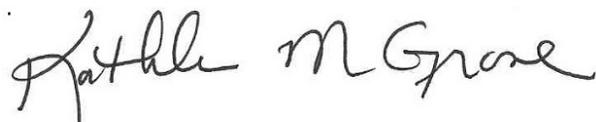
1 STATE OF ILLINOIS )  
 ) SS.  
2 COUNTY OF DU PAGE )

3 I, Kathleen M. Grove, CSR. No. 84-002197, RPR,  
4 do hereby certify that I reported in shorthand the  
5 remote video proceedings had at the hearing of the  
6 above-entitled cause and that the foregoing Report of  
7 Proceedings, Pages 1 through 139, inclusive, is a  
8 true, correct, and complete transcript of my  
9 shorthand notes taken at the time and place  
10 aforesaid.

11 I further certify that I am not counsel for  
12 nor in any way related to any of the parties to this  
13 suit, nor am I in any way, directly or indirectly  
14 interested in the outcome thereof.

15 This certification applies only to those  
16 transcripts, original and copies, produced under my  
17 direction and control; and I assume no responsibility  
18 for the accuracy of any copies which are not so  
19 produced.

20 IN WITNESS WHEREOF I have hereunto set my hand  
21 this 12th day of May, 2021.

22  
23 

24 Certified Shorthand Reporter

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