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STATE OF ILLINOIS  
HEALTH FACILITIES AND SERVICES REVIEW BOARD  
525 West Jefferson Street, 2nd Floor  
Springfield, Illinois 62761  
217-782-3516

LONG-TERM CARE ADVISORY SUBCOMMITTEE  
MEETING

The meeting of the State of Illinois Health Facilities and Services Review Board, Long-Term Care Advisory Subcommittee was held on November 30, 2010, beginning at the hour of 10:00 a.m., at the Wingate by Wyndham, 101 McDonald Drive, Joliet, Illinois.

Reported by:  
Karen K. Keim  
CRR, RPR, CSR-IL, CRR-MO  
Midwest Litigation Services  
401 N. Michigan Avenue  
Chicago, IL 60611

- 1 PRESENT:
- 2 Michael Waxman - Chairman
- 3 James Burden
- 4 Jonathan Lavin
- 5 Lorena Dodgin (phonetic) (for Dave Vinkler)
- 6 Greg Will (for Dave Lowitski)
- 7 Stephanie Altman
- 8 Patricia O'dea Evans
- 9 Michael Bibo
- 10 Carolyn Handler
- 11 Phyllis Mitzen
- 12 Michael Scavotto
- 13 Timothy Phillippe
- 14 Eli Pick
- 15 Rick Dees
- 16 Diane Shiner (for Neyna Johnson)
- 17 Teri Dederer
- 18 ALSO PRESENT:
- 19 Frank Urso - Legal Counsel
- 20 Bill Dart - IDPH Staff
- 21 Bonnie Hills - IDPH Staff
- 22 Charles Foley
- 23 Terry Sullivan
- 24 Ann Guild

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AGENDA

- 1. CALL TO ORDER
  - 1. Approval of Agenda
  - 2. Approval of September 28, 2010 minutes
  - 3. Selection of Vice Chairman
  - 4. Discussion of past and current Certificate of Need rules
  - 5. Discussion of group activities, future rules and policies
  - 6. Unfinished business
    - a) Clarify MR/ICFDD facility and the Act
    - b) Open Meetings Act and HFS Rate Review
- Workgroup and OASAC
  - 7. Dates and locations of subsequent meetings
  - 8. Adjournment

1 START TIME: 10:02 A.M.

2

3 CHAIRMAN WAXMAN: Can we call the meeting to  
4 order? I understand we have a quorum, so one of my golden  
5 rules is we start on time. Otherwise, we can't end on time  
6 or end earlier than on time. So, we are going to start.

7 So, if I can ask all of you to introduce  
8 yourself so that we can do roll call for our official note  
9 taker, Karen. Welcome. We appreciate your work on our  
10 behalf.

11 But if we could start that way (indicating)  
12 and we'll go this way (indicating), and tell us who you  
13 are.

14 MR. LAVIN: Jonathan Lavin with Age Options,  
15 the area agency in suburban Cook County.

16 MR. BIBO: Mike Bibo with Long-Term Care  
17 Providers Associations.

18 MS. HANDLER: Carolyn Handler with Rainbow  
19 Hospice and Palliative Care.

20 Lorena Dodgin (phonetic) in place of Dave  
21 Vinkler AARP, Illinois.

22 MS. MITZEN: Phyllis Mitzen, Health and  
23 Medicine Policy Research Group.

24 MR. PICK: Eli Pick, Ballard Rehabilitation.

1 MR. WAXMAN: Mike Waxman; I am Chairman and  
2 with Infinity Rehab.

3 MR. BURDEN: Dr. James Burden, retired  
4 urologist, member of Healthcare Services Board.

5 MR. SCAVOTTO: Michael Scavotto, Management  
6 Performance Associates.

7 MR. PHILLIPPE: Tim Phillippe, Christian  
8 Homes.

9 Diane Shiner, Regional Ombudsman, here in  
10 place of Neyna Johnson, Aging Department.

11 MS. DEDERER: Teri Dederer, DHS Home Services.

12 MR. DEES: Rick Dees, Department of Public  
13 Health, Long-Term Care Program.

14 MR. DART: Bill Dart, Department of Public  
15 Health, Policy Planning and Statistics.

16 MS. HILLS: Bonnie Hills, Department of Public  
17 Health.

18 MR. URSO: Frank Urso, Health Facilities and  
19 Services Review Board, General Counsel and Ethics Counsel.

20 MR. WAXMAN: Okay. Thank you all. I need a  
21 motion to approve our agenda for today.

22 MR. PICK: So moved.

23 CHAIRMAN WAXMAN: I have a motion. I need a  
24 second.

1 MR. SCAVOTTO: Second.

2 CHAIRMAN WAXMAN: All in favor?

3 ("Ayes" heard)

4 CHAIRMAN WAXMAN: Any opposed?

5 (No response)

6 CHAIRMAN WAXMAN: Agenda is approved.

7 I need approval of September 28th minutes.

8 Motion, please.

9 MR. PICK: I didn't see the minutes. Was that  
10 on the web site?

11 MS. HILLS: I sent it to you by e-mail.

12 MR. PICK: I will make a motion to accept the  
13 September minutes.

14 CHAIRMAN WAXMAN: Thank you, Eli.

15 Need a second.

16 MR. PHILLIPPE: Second.

17 CHAIRMAN WAXMAN: Timothy, thank you.

18 All in favor?

19 ("Ayes" are heard)

20 CHAIRMAN WAXMAN: Any opposed?

21 (No response)

22 CHAIRMAN WAXMAN: Motion carries.

23 Okay. It is my honor and privilege to make a  
24 selection of Vice-Chair. Last time at this meeting, I

1 asked if anyone was interested, if they'd let me know. I  
2 have had one contact, and I'm very happy to announce that  
3 Eli Pick will be our Vice-Chair of the committee.

4 Thank you, Eli. I really appreciate your  
5 stepping up.

6 MR. PICK: Just like Illinois politics.

7 CHAIRMAN WAXMAN: What's cool is I've known  
8 Eli for a lot of years, so it will be fun to have somebody,  
9 and he lives north of Springfield, as I do, so that's even  
10 cooler. So now they're going to call us a clique north of  
11 Springfield.

12 MS. DEDERER: Yes, they will.

13 CHAIRMAN WAXMAN: Okay. Anyway, that  
14 housekeeping, I think, is all done. As last time, I am  
15 totally comfortable if you need to use the facilities.  
16 They're right outside the door, this door (indicating), not  
17 the outside door, that door (indicating), and feel free to  
18 get up and walk around as you need be.

19 Second housekeeping task is, again, turn off  
20 your cell phones or put them on "vibrate", please, so we  
21 can enjoy the meeting and anything else that will keep our  
22 interruptions down to a bare minimum.

23 I do have a golden rule, which is to start on  
24 time and to end on time, or if we can complete our

1 business, tacit of our end time, which is about two  
2 o'clock, we will certainly do that.

3 So, moving on, anyone have any questions or  
4 issues at this point in time before we hit the heavy part  
5 of the agenda.

6 MS. DEDERER: I hate to ask this, but what  
7 are your thoughts regarding lunch, or are we just going to  
8 try to make it through.

9 CHAIRMAN WAXMAN: We did last time.

10 MS. DEDERER: We stopped at noon, too.

11 CHAIRMAN WAXMAN: Well, I don't know.

12 MS. DEDERER: I didn't know if you wanted us  
13 to bring food, just skip it.

14 CHAIRMAN WAXMAN: I'm totally open. Are you  
15 suggesting a process?

16 MS. DEDERER: No.

17 CHAIRMAN WAXMAN: Why don't we see where we  
18 are around the noon time and then look at that issue then,  
19 if I may.

20 MS. DEDERER: That's good. Thank you.

21 CHAIRMAN WAXMAN: We've asked Staff to  
22 prepare a couple of presentations, so I'm not sure if  
23 they're into hours or minutes of time; and that being said,  
24 any other questions before I turn it over to Staff to

1 present?

2 (Pause)

3 CHAIRMAN WAXMAN: Okay. What we asked is  
4 that -- our task is to come up with some new proposals in  
5 terms of rules and regulations, and we all felt that in  
6 order to make that happen, we needed to know exactly what  
7 was in place prior to this committee being formed, and so  
8 that's what we've asked Staff to do.

9 Before I do that, though, if I can ask the  
10 last people to come in to identify themselves, please.  
11 Greatly appreciate it.

12 MS. O'DEA EVANS: Hi. I'm Patricia O'dea  
13 Evans.

14 CHAIRMAN WAXMAN: And anyone else of the  
15 committee that came in late?

16 (Pause)

17 CHAIRMAN WAXMAN: Just for kicks, do you guys  
18 in the back want to introduce yourself, also?

19 MS. GUILD: Ann Guild from the Illinois  
20 Hospital Association.

21 MR. SULLIVAN: Terry Sullivan with the  
22 Long-Term Care Associations.

23 MR. MANAK: Tom Manak, Provena Health.

24 MR. FOLEY: Charles Foley, consultant out of

1 Springfield.

2 CHAIRMAN WAXMAN: Okay. There is a separate  
3 quorum going on in the back of the room.

4 (Laughter)

5 CHAIRMAN WAXMAN: Okay. As I said, we've  
6 asked the Staff to come to us and talk about what's  
7 currently in place, what's been done in the past, so that  
8 we understand where things are today, so that we can make  
9 things better in the future.

10 So, Mike, are these your presentations?

11 MR. CONSTANTINO: Yeah, Bill and I and Frank  
12 put together a small presentation.

13 CHAIRMAN WAXMAN: Okay. So, however you guys  
14 have arranged to do the presentation, the floor is yours.

15 MS. MITZEN: Will this Power Point be  
16 available to us?

17 CHAIRMAN WAXMAN: I think he handed it out,  
18 or he has them to be handed out.

19 MS. MITZEN: Great. Thank you.

20 MR. CONSTANTINO: This is -- the first slide  
21 represents sometimes what I think our relationship is with  
22 the nursing care industry. For those who can't read it,  
23 we're saying, "Oh, gawd, I'm convinced my mind is almost  
24 gone." "I'm not surprised. You've been giving me a piece

1 of it every day for the last twenty years."

2 (Laughter)

3 MR. CONSTANTINO: What we'd like to discuss  
4 today are the facilities, the long-term care facilities  
5 subject to the Act; projects requiring CON; our current  
6 planning process; our current need requirements; then our  
7 financial requirements; then a short overview of the  
8 application process; and then a short review of how we  
9 compile the State agency reports.

10 The facilities we believe subject to the Act  
11 now are skilled and intermediate care nursing facilities as  
12 defined by the Nursing Home Care Act; and the ICF/DD, Adult  
13 and Children.

14 Not subject to the Act is sheltered care;  
15 assisted living; and supportive living.

16 Projects requiring a Certificate of Need  
17 establish and replace a long-term care, ICF/DD facility;  
18 modernization projects in excess of approximately six and a  
19 half million dollars; or a project that adds beds in excess  
20 of twenty beds or ten percent of the total authorized beds  
21 of the long-term care facility or ICF/DD facility.

22 MR. BIBO: Mike Bibo.

23 Just as a point of statement -- and I talked  
24 to Frank about this -- there is no sense in debating it in

1 this room. Frank and I need to get together, I think. But  
2 we disagree. There are a large group of people that  
3 disagree that ICF/DD's are subject to this Act. The Act  
4 does not mention ICF/DD's. The Act only mentions things  
5 licensed under the Nursing Home Care Act, and ICF/DD's and  
6 the skilled pediatrics are not licensed under the Nursing  
7 Home Care Act anymore, and they're exempt for the same  
8 reason, that it also doesn't talk about assisted living and  
9 the other things you mentioned earlier as exempt.

10 So, I understand your presentation is set.  
11 And that's been sort of the Department's thinking  
12 historically. But we believe that as of July 1st, 2010,  
13 the ICF/DD and the skilled pediatrics are no longer under  
14 this. It's not going to change your slide, but I did want  
15 to make it known to this Board that me passively not  
16 commenting does not mean that there is an agreement to  
17 this.

18 MS. DEDERER: I agree. I would agree with  
19 Mike on this.

20 MR. CONSTANTINO: We've had discussions within  
21 the Department, and I've had discussions with Frank, and  
22 it's our opinion that they still are subject to the Act.

23 MR. BIBO: And Frank and I talked before the  
24 meeting, and we're going to get together and talk later

1 instead of tie this whole group up, but I did want to say,  
2 for the members of this committee and for the record, that  
3 there is a dispute about that issue, because you can't find  
4 anywhere in the Act where it says it. I'm not talking  
5 historically what it has been; I'm talking about we can't  
6 find anything in the act that supports that ICF/DD or  
7 skilled pediatrics are under this provision.

8 CHAIRMAN WAXMAN: I guess as a point of  
9 clarification then, how does that question get resolved?

10 MR. BIBO: You have to -- without getting into  
11 a lot of detail, I think it's just got to be reviewed, and  
12 I think people are going with "historically it has and  
13 therefore we think it still does", which is what the  
14 Department has done since this Act has been in place. The  
15 Department in many cases continues to act as the Nursing  
16 Care Home Act applies. The Notice of Deficiency says,  
17 "Pursuant to Nursing Home Care Act, you're being decided"  
18 -- it doesn't apply.

19 So, there's lots of things like that that have  
20 to be addressed. I think that's the issue. I think  
21 there's the other issue to this is does it make any sense?  
22 You're talking about 6800 individuals living in ICF/DD's or  
23 skilled pediatric facilities in this state. You'll have at  
24 least two different initiatives, if not more: To decrease

1 the number of ICF/DD beds in this state, not increase them;  
2 and then you have the entire \*\* sill a and Medicare waiver  
3 population, which is over 14,000 people, that you're not  
4 even considering the Planning Board has no say over. And,  
5 so, therefore, does it make any sense to govern this type  
6 of facility when that's a small portion of everything else  
7 that serves residential for developmentally disabled.

8           Again, I don't think that's a debate for here,  
9 because this is an overview. I just didn't want to go on  
10 record that, as people are sitting here listening, there is  
11 not necessarily the assumption that everyone is in  
12 agreement that DD is applicable here, because I've gone  
13 over this 20 ILCS 3/916 and all of that, and it's not  
14 mentioned anywhere in here, not by reference, not by any --  
15 anything.

16           MR. URSO: Mike, what I would say is we do  
17 have disagreement here, but we're open to talk about it and  
18 get it out on the table. I don't think this is the proper  
19 forum to do that.

20           CHAIRMAN WAXMAN: And I think we all agree.

21           MR. URSO: Mike Bibo and I have agreed that we  
22 will continue to talk about it, and I want to understand  
23 completely what his position is so that I can share that  
24 with the Board and Staff, so we can move forward correctly.

1 CHAIRMAN WAXMAN: Maybe we can ask that when,  
2 and if, it gets resolved, you'll bring the resolution back  
3 to this committee.

4 MR. URSO: Absolutely.

5 MS. DEDERER: Could I suggest that you also  
6 involve the folks from the Division of Developmental  
7 Disabilities and DHS on this discussion, because everybody  
8 needs to be on the same page, whatever is resolved.

9 MR. URSO: Sure, definitely, definitely. And  
10 I didn't see your name. What's your name, ma'am.

11 MS. DEDERER: Teri Dederer. I'm sorry. I'm  
12 really representing Rehab, but I just know how these things  
13 don't necessarily get coordinated. So it would really be  
14 nice --

15 MR. URSO: We'll try to get everybody around  
16 the table then.

17 MS. DEDERER: At least informed, and this  
18 might go to the Governor's office.

19 MR. URSO: Thank you.

20 MR. CONSTANTINO: Projects not requiring a  
21 Certificate of Need include discontinuation of a nursing  
22 care facility or ICF/DD Facility; change of ownership;  
23 projects below the capital expenditure minimum of six and a  
24 half million dollars; addition of beds, less than ten

1 percent of total authorized capacity, or twenty beds,  
2 whichever is less. Again, exceptions: County nursing  
3 homes; illinois veteran's homes; and State facilities.

4 MS. DEDERER: May I ask a question? Has the  
5 addition of beds always been in place at that level, where  
6 you could add twenty beds?

7 MR. CONSTANTINO: No, that's a change.

8 MS. DEDERER: And what was it before?

9 MR. CONSTANTINO: Ten beds, ten percent, ten  
10 beds.

11 MS. DEDERER: Thank you.

12 MR. CONSTANTINO: This is our most current  
13 statistics on long-term care. You can find this  
14 information on our web site, the Illinois Health Facilities  
15 and Service Review Board web site. This was just  
16 published. This is kind of an overview where we're at  
17 right now.

18 There's approximately a 113,000 licensed beds  
19 in the state. Approximately a 103,000 are nursing care  
20 beds; skilled care under 22, approximately 900;  
21 intermediate DD, about 6,300; and shelter care, about 3,700  
22 beds. The percentages to the right of that, that tells you  
23 the occupancy percentage at the end of December of 2009.

24 MS. DEDERER: Can I ask one other question?

1 MR. CONSTANTINO: Sure.

2 MS. DEDERER: Is shelter care licensed?

3 MR. CONSTANTINO: Yes. It's not governed --

4 MS. DEDERER: And it's always been licensed?

5 MR. CONSTANTINO: But it's not governed by  
6 Certificate of Need. We do collect information regarding  
7 utilization and that type of information.

8 MS. DEDERER: Okay. Thank you.

9 MR. CONSTANTINO: We also collect capital  
10 expenditure information for long-term care facilities. As  
11 of the end of 2009, reported to us, total capital  
12 expenditures by approximately 1,100 facilities was  
13 approximately \$211,000,000, an average capital expenditure  
14 of about a 198,000 per facility. As you can see, 34  
15 facilities accounted for 51 percent of the total capital  
16 expenditure in 2009.

17 MR. PICK: Is that new construction?

18 MR. CONSTANTINO: Yes -- I'm sorry,  
19 modernization and new.

20 MR. PICK: Okay.

21 MR. CONSTANTINO: Now, this is -- when we get  
22 into planning, this is how State Agency Staff often looks:  
23 Confused.

24 (Laughter)

1 MR. URSO: At least we're sitting down.

2 MR. CONSTANTINO: Okay. This is what our  
3 current planning policies are. You can find this at 77 IAC  
4 1100, specifically 660.

5 There is a difference between licensed beds  
6 and authorized beds. Even though you're approved by a  
7 Certificate of Need Board, the State Board, we consider  
8 them to be authorized. You can't operate a bed in this  
9 state without it being licensed. So, at times we have what  
10 we call "permitted beds", distinct from licensed beds.  
11 There's -- I think in the last year, we identified two  
12 facilities that have permitted beds, that they never were  
13 licensed, and we removed them from the inventory.

14 MR. URSO: Mike, does everybody know what IAC  
15 means?

16 CHAIRMAN WAXMAN: Why don't you --

17 MR. URSO: Illinois Administrative Code, and  
18 you can find these code sections on the General Assembly  
19 page, if you want, under "Administrative Rules", as well as  
20 the Health Facilities and Services Review Board page.

21 MR. CONSTANTINO: The State is divided into 11  
22 Health Service Areas, and then we're subdivided into 95  
23 Health Planning Areas, and these are located within the 11  
24 HSA's. We then divide the population into three age

1 groups: 0 to 64; 65 to 74; and, 75 and above. Our target  
2 occupancy is 90 percent for long-term care; and bed  
3 capacity of a long-term care facility is the licensed bed  
4 capacity.

5 MR. LAVIN: Could you explain -- why do you  
6 have 11 areas divided into 95 sub-areas?

7 MR. CONSTANTINO: Well, I won't be much help  
8 in that regard. A lot of this work on these Health Service  
9 Areas and Health Planning Areas was done years ago, and I  
10 tried to find some historical information on that. I  
11 wasn't able to. Maybe someone in this room might have an  
12 idea. Charlie Foley probably will.

13 Charlie, do you want to speak up?

14 MR. FOLEY: Well, I was just going to say  
15 that -- Charles Foley -- back in the 70's, when the Health  
16 Planning Law 93-641 came in effect, which was obviously  
17 nationwide, Illinois was, in fact, divided into 11 Health  
18 Planning Areas, Health Service Areas as they referred to,  
19 HSA's. From that the Board -- at that point in time, in  
20 order to calculate some kind of a bed need for Illinois and  
21 to not use such large, large numbers for an HSA, the  
22 Planning Board, at that time, has subdivided the Planning  
23 Areas into HSA areas into Planning Areas, which was  
24 identified here as the number that you see. These

1 so-called Planning Areas are small. It was easier to plan  
2 the future for a smaller geographic area, obviously, than a  
3 larger geographic area. So, bed need was based on the  
4 population and the occupancy based on the smaller  
5 population stats, without going in further detail.

6 MR. LAVIN: So, these 11 regions go back to  
7 the Health Systems Agency planning?

8 MR. FOLEY: Oh, yes, way back.

9 MR. CONSTANTINO: Generally, the Health  
10 Planning Areas are the counties, the 95. That's a general  
11 statement.

12 MS. MITZEN: So, each one of these 11 has  
13 95 --

14 MR. CONSTANTINO: No, no.

15 MS. MITZEN: Oh, the total state. So the  
16 11 -- okay.

17 MR. CONSTANTINO: On the next page, I believe  
18 there should be a map of the Health Service Areas. I  
19 apologize. I tried to get the biggest picture I could.  
20 I'll be happy to e-mail this to anybody that may be -- I  
21 have it in a Word document, and I'd be happy to e-mail it  
22 to you guys, if you'd like it.

23 MS. DEDERER: That would be nice, if you  
24 wouldn't mind.

1 MS. O'DEA EVANS: I'm sorry. It's basically  
2 counties in each of those boxes, though, correct, except  
3 for Cook?

4 MR. CONSTANTINO: Cook and suburban -- Cook  
5 Counties --

6 MS. O'DEA EVANS: Are split? But otherwise,  
7 it's not split, it's counties in those boxes.

8 MR. CONSTANTINO: Yes.

9 MS. O'DEA EVANS: There are some that --  
10 they're all multi-county, actually, except for 6.

11 MR. CONSTANTINO: 6 is the City of Chicago. 7  
12 is the suburban Cook County.

13 MR. LAVIN: Suburban Cook County DuPage, the  
14 old HSA area. Is that considered one of the 95 or are  
15 there --

16 MR. CONSTANTINO: No, one of the 11.

17 MR. LAVIN: And then there are sub-areas  
18 within that?

19 MR. CONSTANTINO: Within that HSA 7, there's 3  
20 sub areas, 7-A, B, and C, and that's part of the 95. And  
21 you can find these -- the definitions of those Planning  
22 Areas at 660, I believe, 1100 660.

23 By statute, we are required to revise our  
24 bed-need calculations every two years for both long-term

1 care and the hospitals.

2 MS. DEDERER: Can I ask one question? I'm  
3 sorry.

4 MR. CONSTANTINO: Sure.

5 MS. DEDERER: Before, you said the target  
6 capacity is 90 percent. Is that set by the fed or the  
7 state, or that's just a nice number?

8 MR. CONSTANTINO: That's been set in rule.

9 MS. DEDERER: But it is a state rule not a  
10 federal rule?

11 MR. CONSTANTINO: Yes.

12 MS. DEDERER: It doesn't have anything to do  
13 with the feds?

14 MR. CONSTANTINO: Not that I'm aware of. This  
15 methodology we followed has been in place for quite a  
16 number of years, and I'm going to try to give you this  
17 methodology the best I can.

18 These are essentially the inputs. We  
19 determine the base year population estimate for both the  
20 Health Service Area and the Health Planning Area. Now,  
21 when we say "estimate", we mean -- I'll give you an  
22 example. Right now our inventory is comprised of 2005  
23 population estimates. We take the population that is  
24 provided to us by the Department of Commerce -- and I

1 believe Economic Opportunity -- and then we adjust it. The  
2 Department of Public Health -- part of Bill's division --  
3 Policy and Statistics adjust that population by the births  
4 and deaths, to come up with the estimate for 2005. So, we  
5 try to -- we have to take the most current population  
6 estimate that we have -- in other words, the most current  
7 births and deaths for a given year that we have -- and  
8 correlate that with the utilization data at that time.

9           So, for example, we're using 2005 estimated  
10 population. We also have to use 2005 utilization data.  
11 Generally, that utilization data is -- we would have 2008,  
12 but we have to use the 2005. That's an example. We have  
13 to correlate those two.

14           MS. MITZEN: The birth and death ratio is  
15 2005 or --

16           MR. CONSTANTINO: The births and deaths, we  
17 take the population that is provided to us for 2005 by the  
18 Department of Commerce and Economic Opportunity. Then we  
19 adjust that by the births and deaths for a given year that  
20 we have in its entirety, and in this case it was for 2005.  
21 For example, we do not have -- at the time we did our  
22 inventory, we did not have the births and deaths complete  
23 for 2006 or 2007. The most accurate data we had was for  
24 2005. That's why we had to use that data. Okay. Then we

1 had to use -- correlate that with the 2005 utilization data  
2 that we collect on our annual surveys that we do. We  
3 couldn't use 2007, 2008.

4 MS. MITZEN: Okay.

5 MR. CONSTANTINO: That's all I'm saying. We  
6 try to correlate that year.

7 MR. PICK: And how often is the base updated?

8 MR. CONSTANTINO: We have to do it every two  
9 years. That's the way we're reading the statute now.

10 MR. PICK: So, how long will 2005 be the base?

11 MR. CONSTANTINO: We projected that out to  
12 2015. We're in the process of updating our inventory now,  
13 and I believe we're looking at 2008 as a base year, because  
14 that's the most complete information we have.

15 MR. SULLIVAN: Terry Sullivan.

16 Just a comment. The bed-need formula,  
17 basically, was started back in the 1970's, when nursing  
18 homes were about the only senior care option, and from  
19 that, we projected bed need based on how many seniors were  
20 going to need care. The current formula doesn't take into  
21 account anything that's happened in the past 35 years in  
22 terms of the development of community services and home  
23 health and adult daycare and supportive living and assisted  
24 living and whatever. So, it's still projecting that

1 nursing homes are the single, end game of all of the senior  
2 population.

3 MS. MITZEN: That's the assumption for the  
4 numbers, even though the world has changed.

5 MR. SULLIVAN: Right.

6 CHAIRMAN WAXMAN: Terry, was that a statement  
7 or a question.

8 MR. SULLIVAN: That was a statement -- or is a  
9 question. Is that correct?

10 MR. CONSTANTINO: Unfortunately, we don't have  
11 jurisdiction, though, over those other entities you  
12 mentioned. We'd be happy to collect the data, if someone  
13 would give us the authority.

14 MS. MITZEN: But I think that's not the  
15 issue. I think what Terry is asking is what are the  
16 assumptions based on that dictate bed need? Is that the  
17 question.

18 MR. SULLIVAN: Essentially.

19 MR. CONSTANTINO: Yeah, this is -- this  
20 formula has been used for years. I'm not questioning that.

21 MS. DEDERER: But do you have a static  
22 percentage that you use to calculate bed need based on the  
23 population, or does it change year by year so it reflects  
24 the changing --

1 MR. CONSTANTINO: If I understand your  
2 question correctly, we do a projection out 10 years, as  
3 required by statute. So, we're projecting out 10 years for  
4 long-term facilities.

5 MS. DEDERER: Based on current utilization?

6 MR. CONSTANTINO: Based on 2005 utilization.

7 MS. MITZEN: This may be a premature  
8 question. We're raising a lot of issues that will at least  
9 have an impact on, I think, what we will be deliberating.  
10 Will we have any say on this? Will this committee have any  
11 authority to make recommendations for changing those  
12 assumptions?

13 MR. DART: Absolutely. I think that's why we  
14 wanted to give this presentation, so these issues would be  
15 raised and you'll be thinking about this.

16 CHAIRMAN WAXMAN: I think at the first  
17 meeting, we discussed that. Our role is defined to do  
18 certain things, but we also have the ability to make  
19 suggestions to the CON Board, who is sort of our parent and  
20 our guidance, so that we can -- you know, at any point I  
21 can take questions and presentations to that meeting, just  
22 ask to be put on their agenda, and that's one of my duties  
23 as Chair, is be this group's representative at the CON  
24 Board meeting and raise questions for them to look at.

1 They then can decide whether they want to bring it to other  
2 people to see if they can get legislation changed.

3           So, our role is, obviously, to carry out the  
4 rules and policies that we're asked to do, but also to  
5 bring to the CON Board the aggregate expertise of the  
6 people in this room, which is why they're in this room, to  
7 raise issues that may need to be addressed, because we may  
8 see things quite differently than what other people are  
9 seeing who have, you know, established things in the past.  
10 I think we all live through -- the whole world -- where  
11 it's this way because it's been done this way for the last  
12 hundred years. So, I think that is one of our -- to me,  
13 that's one of our roles and challenges, is to bring current  
14 information to the CON Board. So, yes, but it's a  
15 recommendation process.

16           I have a question behind me, Michael.

17           MR. FOLEY: Well, thank you. But I think  
18 Phyllis asked a question, and you gave an excellent  
19 response to that. I think it's very important that this  
20 committee recognize that we do have a serious problem out  
21 there and that bed need is calculated on not -- I don't  
22 want to use the word "current" data, but it's not including  
23 everything. We're not seeing the total planning picture.  
24 As Terry indicated, we need to look at assisted living, we

1 need to look at supportive living, we need to look at other  
2 options out there and basing that to recalculate what we  
3 feel is a more accurate bed need.

4 So, thank you for your question, and thank you  
5 for your response, Michael.

6 CHAIRMAN WAXMAN: My pleasure.

7 I think one of the things that caught me the  
8 first meeting -- and Frank was kind enough to set me  
9 straight -- is that in my mind, if somebody doesn't wrap  
10 their arms around the entire question of assisted living  
11 and skilled beds, I think we're kind of moving different  
12 directions, because there's no doubt in my mind that I'm  
13 going to -- hate to say it, but you walk through assisted  
14 living and there are people there that need skilled  
15 services.

16 MR. FOLEY: Thank you.

17 CHAIRMAN WAXMAN: Do I want that on the  
18 record?

19 MS. O'DEA EVANS: This is true.

20 CHAIRMAN WAXMAN: But, I think -- I guess at  
21 this point, the only way we can address that issue is  
22 recommendations to the CON Board, for them to make  
23 recommendations to legislators to do something about that.

24 Frank, am I right?

1 MR. URSO: Yes.

2 DR. BURDEN: Frank, will you clarify for me,  
3 what is the CON Board? We've never dealt with that. Is  
4 that the Health Facilities Planning Board?

5 MR. URSO: That's the acronym.

6 DR. BURDEN: I pay more attention when he's  
7 talking to us.

8 (Laughter)

9 CHAIRMAN WAXMAN: Frank, do you want to  
10 address that?

11 MR. URSO: I just wanted to say that you are  
12 right and that it's really important when we talk on this  
13 subject matter and we pull out the things that we think  
14 need to change or we need to take a look at. That's why  
15 we're taking the time to show you what the lay of the land  
16 is right now. We need to dissect this and we need to make  
17 notes and say, okay, this is one of the issues we need to  
18 discuss and come up with some recommendations on. So, I'm  
19 glad we're challenging that, and that's the way, I think,  
20 we should be marking the transcript perhaps: "Okay. The  
21 bed-need formulas need to be taken a closer look at as we  
22 move into proposing new rules." And I think that's how we  
23 should be progressing, and I think that's an excellent  
24 dynamic that we need to continue.

1                   CHAIRMAN WAXMAN:     And I think I can speak for  
2     the group. I don't think any of us are here to find fault  
3     with the people who are currently doing what they have been  
4     directed to do, but raising the issue that maybe they need  
5     to look at doing it a different way.

6                   MR. URSO:     More creative.

7                   CHAIRMAN:     Yeah. I don't think anyone is  
8     pointing a finger and saying you're doing it wrong.

9                   MR. CONSTANTINO:   The current statute requires  
10    a comprehensive health planning function. It has not been  
11    funded. We do not know if it will be. So some of these  
12    questions could be addressed as part of that.

13                  CHAIRMAN WAXMAN:   That's a whole new  
14    ballgame, funding.

15                  MR. LAVIN:     I got a simple question here. Is  
16    this number the number of people who need care in each of  
17    these regions and sub-regions? Is that what we're aiming  
18    at? At the end of the calculation, what do we have?

19                  MR. CONSTANTINO:   We try to estimate the  
20    number of beds needed for long-term, acute care.

21                  MR. LAVIN:     So, it's just the number of beds  
22    that are actually there?

23                  MR. CONSTANTINO:   And we take the number of  
24    beds existing and compare it to our projected number and

1 whether or not that's an excess or an addition is needed.

2 MR. LAVIN: But there is nothing in here about  
3 ADL's or IADL's or any type of need data to --

4 MR. CONSTANTINO: Yeah, we do use --

5 MR. LAVIN: Where does this come in?

6 MS. O'DEA EVANS: Maybe we should go through  
7 the presentation.

8 MR. LAVIN: Yeah, maybe that would shut me up.

9 MR. CONSTANTINO: What I'd like to do is walk  
10 you through one planning area that I took, Sangamon County,  
11 long-term care bed need, and the first thing we do is we  
12 look at the HSA, and this is the -- Sangamon County is  
13 located in HSA-3, and as we go back to that map, that's  
14 this area right in here (indicating), and it takes in a  
15 number of counties. That's Springfield, Sangamon.

16 As we talked about before, we divide the  
17 population into three age groups: 0 to 64, 65 to 74, and  
18 75 and over. And then we take the patient days, and these  
19 patient days are collected from the annual surveys we do at  
20 the agency to all long-term care facilities. This is  
21 patient days per year. In this case it's 2005, because  
22 this year has to coincide with the most recent births and  
23 deaths that we have. So that's why we used, in this case,  
24 2005 data.

1                   And then we take an estimated population, and  
2                   this estimated population is what we adjusted at IDPH for  
3                   2005. And then the use rate is calculated by dividing the  
4                   patient days by the estimated population, times a thousand,  
5                   for each age bracket. And then we calculate a minimum and  
6                   a maximum, and the minimum is sixty percent of the use rate  
7                   for each age bracket; maximum is a hundred sixty percent.

8                   You ask me why we use sixty and a hundred  
9                   sixty? I don't know. That is what is in our rules, and  
10                  it's been in existence, as Charlie has said, for a number  
11                  of years.

12                  MR. PICK: Michael, is it possible to get  
13                  these formulas?

14                  MR. CONSTANTINO: Oh, sure. They're on line.

15                  MR. PICK: In the rules?

16                  MR. CONSTANTINO: Yeah. They're in our  
17                  inventory. If you like, I can send all of you guys those  
18                  rules.

19                  MR. PICK: That would be helpful.

20                  MR. LAVIN: And so what -- the 22,000 versus  
21                  the 60,000, what does that mean? What does that represent?  
22                  Days?

23                  MR. CONSTANTINO: Where are you looking at?

24                  MR. LAVIN: At 75-plus, you have minimum and

1 max; the minimum is twenty-two three, I guess it is.

2 MR. CONSTANTINO: Minimum number is 60 percent  
3 of the use rate, sixty percent of this use rate, 37,520,  
4 and the max is 160 percent of the use rate or 60,032.

5 MR. LAVIN: And what does that mean?

6 MR. CONSTANTINO: Days.

7 MR. LAVIN: So between 22,000 and 60,000 days  
8 are needed or used in that region?

9 MR. CONSTANTINO: Yes.

10 MS. MITZEN: This is based on use, correct?  
11 It's called "need", but it's based on use?

12 MR. CONSTANTINO: We look at historic  
13 utilization. This is historic utilization, 2005.

14 MS. MITZEN: It seems to me that there's a  
15 difference between what's needed and used, but -- that just  
16 occurred to me, that there could be a difference between  
17 what somebody needs versus what's being used.

18 MR. CONSTANTINO: What we're trying to  
19 determine is how many beds are needed. We're trying to  
20 look at the beds that are needed.

21 MS. MITZEN: But we're using that based on  
22 what's used.

23 MS. HANDLER: This is the first half of the  
24 equation.

1 MS. MITZEN: And opposed to what John was  
2 talking about.

3 CHAIRMAN WAXMAN: I think you need to let  
4 Michael finish.

5 MS. MITZEN: I'm sorry.

6 MR. CONSTANTINO: The next part, part two, we  
7 look at the same county planning area. This is one of the  
8 95 planning areas in the state, Sangamon County. We again  
9 have our age brackets; we again have our patient days for  
10 the facilities in the Sangamon County planning area in  
11 2005. We estimate the population again for this Sangamon  
12 County planning area in these age groups. We then --

13 MR. URSO: So a lot of deaths?

14 MR. CONSTANTINO: A lot of deaths and births.  
15 HSA-3 takes in all those counties, and this brings it down  
16 to this one county, Frank. So Sangamon County -- this  
17 HSA-3 includes a number of different counties.

18 We then calculate the use rate, as we did up  
19 here (indicating), again dividing the patient days by the  
20 estimated population to get use rates for all three age  
21 brackets. We again take the minimum and maximum from up  
22 here, within the HSA. We use those numbers, determine the  
23 plan use rate for 2015, which is 10 years from the -- our  
24 base year of 2005.

1           In this case, the use rate that we use for the  
2    0 to 64 age bracket is 252.50, because it is more than the  
3    minimum but less than the maximum. And as you can see,  
4    we're doing the same here for all these age brackets.

5           We then take the projected population for  
6    2015 -- and this is data we get from the Department of  
7    Commerce and Economic Opportunity -- times the planned use  
8    rate to get the planned patient days. We then get -- we  
9    total the planned patient days of approximately 458,000 and  
10   divide that by 365 to get the average daily census.

11   Planned bed need is then calculated based upon 90 percent  
12   occupancy, and in this case, 1,395 beds that are needed.  
13   And, unfortunately, I did not put the number that are  
14   currently in the Sangamon County planning area. I think it  
15   turned out to be approximately a need for a  
16   hundred-some-odd beds in this planning area for this  
17   calculation that we did.

18           And that's how we break it down to those  
19   individual planning areas.

20           CHAIRMAN WAXMAN: Michael, I think you said  
21   you're using 90 percent occupancy then?

22           MR. CONSTANTINO: Yeah, that's in rule -- as  
23   provided in our rules. That's what we follow.

24           MR. SULLIVAN: Terry Sullivan.

1                   So, every county would end up having a  
2 different use rate and, generally, in that county the more  
3 nursing homes there are, most likely the use rate is going  
4 to be higher. So something like 6-J, which is Sheridan  
5 Road in Chicago --

6                   MR. FOLEY: 6-A.

7                   MR. SULLIVAN: 6-A -- sorry -- would have a  
8 very high use rate because of all of the nursing homes  
9 along Sheridan Road. But then that would translate into  
10 saying we need more nursing homes in that area because the  
11 use rate is so high.

12                  MS. MITZEN: But people are coming from all  
13 over.

14                  MR. PICK: The counter to that is, look at the  
15 occupancy rate. It's below target. So, even though the  
16 use rate is high, the target occupancy rates are below the  
17 target, which would then lead you to the opposite  
18 conclusion, that there is no additional bed need, even  
19 though there is a high use rate. As an observation, I  
20 think one of the elements that needs to be addressed is the  
21 lag time, that in years past, having a 10-year lag was  
22 probably acceptable, because the rate of change was low.  
23 We're in a time frame now where the rate of change is  
24 accelerated, particularly from 2000 forward with having the

1 development of alternative services that are not  
2 incorporated in the planning process and it's reflected in  
3 the state-wide average of 78 percent. That's why the  
4 target -- we're seeking lower and lower below target,  
5 because the formula is not taking into account -- and it's  
6 not statutorily established to take into account -- these  
7 other services, and we're still planning based on 2005 data  
8 in 2011, when the dynamics in the market are changing much  
9 more rapidly than they had prior decades.

10 MR. CONSTANTINO: Previously, we used to use a  
11 five-year projection, but that was changed in statute when  
12 the statute was changed. It's now ten years.

13 MR. PICK: And when was the statute changed?

14 MR. CONSTANTINO: April of 2009 -- I'm sorry.  
15 2009 -- June, I guess, of 2009.

16 MR. PICK: So, it's recent. So, it was  
17 probably the opposite of what we need to do, is compress  
18 the time frame rather than expand it.

19 MR. FOLEY: I was just going to make a comment  
20 that the Health Facilities Planning Board has never  
21 indicated that this was the perfect formula, but when the  
22 formula was developed back in its time, obviously it was  
23 great, and I think our task here, as you had said, Eli, is  
24 that now we have to take in all these other services.

1 There's nothing wrong with the formula. Unless someone can  
2 come across with a better bed-need formula, all this  
3 formula needs is to be tweaked in order to accommodate the  
4 other services that are available.

5 MS. MITZEN: Just clarification. I see that  
6 long-term care bed need. So the formula is based on  
7 long-term care bed need, it's not the hospitals? This has  
8 nothing to do with the hospitals?

9 CHAIRMAN WAXMAN: No.

10 MS. MITZEN: So, at least we're all talking  
11 about long-term care.

12 MR. CONSTANTINO: Now, there are some  
13 hospitals with long-term care units.

14 MS. MITZEN: Right.

15 MS. DEDERER: Has Public Health ever done the  
16 math to see retrospectively how the plan days matched up  
17 with the actual days and then some calculations to maybe  
18 build in a reduction each year, since it probably has been  
19 just a minutely steady reduction?

20 MR. CONSTANTINO: I won't be able to answer  
21 that. I don't know.

22 MS. DEDERER: That would be another way to  
23 handle it. Mathematically that could be done.

24 CHAIRMAN WAXMAN: Any other questions for

1 Michael before we allow him to continue?

2 (Pause)

3 MR. CONSTANTINO: We have another -- I did put  
4 in some information regarding specialized long-term care or  
5 ICF/DD facilities, and we see very few of these projects.  
6 The last time we had an ICF/DD facility was in 2007. That  
7 was for Misacordia, and they then subsequently have been  
8 written out of the Act. Misacordia is no longer subject to  
9 the Act.

10 MR. PICK: It's good to have pull.

11 MR. CONSTANTINO: I would also like to mention  
12 the long-term medical care for children category of service  
13 has also been removed as a category of service, effective  
14 April of 2010. Of course, this is only applicable to these  
15 two hospitals in Chicago that -- the two children's  
16 hospitals in Chicago.

17 MR. PICK: Michael, again, this is a question.  
18 My facility is part of a demonstration project that was  
19 under the Alternative Healthcare Act established back in  
20 the mid 90's and, you know, we're a specialized long-term  
21 care environment as a sub-acute hospital demo, and I know  
22 there are a few sites that are still participating in this  
23 project but -- although it was under the auspices of the  
24 Planning Board to establish the demonstration, it moved to

1 the Department of Health. It's collecting the data, but  
2 nothing seems to be happening with the data or any  
3 evaluation of whether these alternative healthcare  
4 models -- which, in review of that recently, when I looked  
5 at it there are five specific areas that include children,  
6 Alzheimer's, ambulatory surgery, the sub-acute, and I  
7 forget the fifth.

8 So, how does that relate to any of this?  
9 There's no role from a planning standpoint?

10 MR. CONSTANTINO: We consider that separate  
11 from this type of planning we're to do here, and I couldn't  
12 help you where we're at in evaluating those alternative  
13 healthcare models. I thought we had done some work on that  
14 a few years ago, but I don't know where that stands.

15 MR. PICK: We're still submitting data, which  
16 is the requirement of the project, but I don't know -- and  
17 the reason I raise it is I would think that that's maybe  
18 one of the vehicles for this body to consider, since it's  
19 already in place, as a method to begin to -- number one,  
20 let's look at the data that's been collected over the last  
21 15 years; and, number two, are these models some part of a  
22 solution to looking at how we plan?

23 MS. MITZEN: Just to review what our work is,  
24 I think we talked -- there's something in there about using

1 the evidence-based models. So that's what your comment  
2 triggered for me.

3 MR. PICK: The reason I raise it is there's  
4 been some historic work that -- rather than starting over  
5 again, let's capitalize on some of the stuff that's already  
6 been done, rather than just casting it aside and then  
7 starting fresh.

8 MR. CONSTANTINO: And we do have planning  
9 areas for specialized long-term care: Chronic mental  
10 illness; this has to do with the State facilities. And  
11 then DD for children; it's just the 11 Health Service  
12 Areas. And then the DD adult. These are the planning  
13 areas for these. And then we combine six, seven, eight and  
14 nine.

15 Bed need for specialized long-term care,  
16 there's no formula bed need for MI or DD children. There  
17 is bed need for DD adult, calculated in two parts: ICF/DD,  
18 16 bed or fewer, dividing planning area's projected adult  
19 developmentally disabled population by 21.4 to determine  
20 the total number of beds. Again, I don't know where this  
21 number came from, the 21.4 I'm not much help with that. I  
22 apologize.

23 There's no bed-need formula for 16 beds and  
24 over.

1                   And, here again, I put this in. This is how  
2 we calculate the bed need for ICF/DD facilities. Again,  
3 this is for Health Service Area 3. 16 or less, 423 beds;  
4 there's our 2005 patient days, and those are our 2005  
5 admissions.

6                   And then we do a projected DD population for  
7 this planning area, which in this case is this HSA-3; not  
8 Sangamon County, it's HSA-3. And we take that and then we  
9 get beds needed and existing beds, and there's an excess of  
10 beds.

11                   MR. PICK: Michael, are these divided by a  
12 thousand also?

13                   MR. CONSTANTINO: Yes.

14                   MR. PICK: The numbers seemed awfully small.

15                   MR. CONSTANTINO: My little comments regarding  
16 planning.

17                   (Laughter as slide 17 is shown.)

18                   MR. CONSTANTINO: I'd like to talk a minute  
19 about where we are at and what we do with our bed need  
20 calculations. We do have a need section in our rules for  
21 long-term care. It's at 77 IAC 1110, I believe 1730.  
22 Essentially we ask six questions regarding need when we  
23 review a Certificate of Need application.

24                   Is there a need for beds as calculated by the

1 bed-need formula?

2 Will the number of beds provide service to the  
3 planning area residents?

4 Is there a service demand for the long-term  
5 care beds in the planning area?

6 Will the beds improve access?

7 Will the beds result in a duplication of  
8 service or a maldistribution of service?

9 And then, finally, will the beds have a  
10 negative impact on other service providers?

11 CHAIRMAN WAXMAN: Michael, would you like a  
12 five-minute break.

13 MR. CONSTANTINO: No, I'm fine, Mike. Thank  
14 you.

15 MS. DEDERER: Do we take into account anything  
16 about free market and the fact that some nursing homes may  
17 attract more residents than others, possibly because some  
18 people like some nursing homes better than others?

19 CHAIRMAN WAXMAN: I'm not sure that can be  
20 taken into account.

21 MS. DEDERER: But I'm saying if one nursing  
22 home has a waiting list but the HSA has lots of other beds  
23 in lots of other nursing homes conceivably, looking at this  
24 might not approve more beds when that nursing home has a

1 confirmed waiting list.

2 MR. PICK: That's why there's the 10 percent  
3 rule. You can add 10 percent without a CON, or twenty beds  
4 regardless of the bed need.

5 MS. DEDERER: How often can you do that?

6 MR. PICK: Two years.

7 MS. DEDERER: Nonetheless, I think that's  
8 something that needs to be looked at here. I mean, this is  
9 almost saying "Let's protect our current service providers  
10 regardless of the quality of service".

11 CHAIRMAN WAXMAN: Also, my opinion is --  
12 again, I don't -- I think you also have to allow the market  
13 conditions to take care of some of the issues, and any  
14 provider that is not meeting market needs will not exist.  
15 That's the natural effect of supply and demand. So, I  
16 don't think we're protecting. I think that the operators  
17 who are not meeting the current demands of their population  
18 or their market area or service area will face the  
19 consequences of diminishing occupancy, out of business.

20 MR. PHILLIPPE: I don't know that that always  
21 works in practice. In some markets, all the facilities  
22 maybe are old and haven't been maintained in a certain  
23 area. People don't have a choice. They have to go  
24 somewhere.

1                   CHAIRMAN WAXMAN:    And I agree with you.  
2    Having traveled the state, there are certain areas where  
3    you have, you know, several homes that are 50 beds and, you  
4    know, that's what is available.  That is also true.  But I  
5    think there is still some supply and demand that will  
6    affect even those situations.

7                   MR. FOLEY:  I just want to comment.  I think  
8    it goes back to what Mr. Urso was saying earlier.  I think  
9    it's very important that we look at this during the entire  
10   planning process.  I know at one point in time -- to answer  
11   your concern, Terry, at one point in time in these proposed  
12   rules that have been drafted out there, was in fact looking  
13   at a high occupancy variance to accommodate for those  
14   facilities that are maintaining a very high occupancy rate.  
15   Even though the other facilities in the area have a very  
16   low occupancy rate, why should that deter one facility as  
17   doing such a good job and cannot add beds because there is  
18   not a bed need?  So, again, I think that's something to  
19   look at and that's something we should asterisk and talk  
20   about further.

21                  MR. PHILLIPPE:  I think these are good  
22    questions, actually.

23                  One question I do have.  The field really is  
24    moving quite rapidly, as has been mentioned, and so,

1 really, the ideal types of services for skilled care today  
2 would be very different than what might have been built 50  
3 years ago. I'm just curious. How do we have some vehicle  
4 for innovation to really provide the kind of services that  
5 consumers need and want?

6 CHAIRMAN WAXMAN: Let me just to tell the  
7 committee what I have envisioned, is that when Michael is  
8 done, I'd like to divide this group up into, I think, four  
9 groups and have each of you spend a few minutes coming up  
10 with what you think are the five most important areas that  
11 we need to look at, and then we'll chart them and see where  
12 the agreement is and we'll come up then with our master  
13 list of where we, as a group, need to go. So, we are  
14 establishing a base line of where things are now, and then  
15 I'm going to ask you to break into groups, and I'm  
16 hopefully going to mix you up a little bit. Some of you  
17 have been mixed up most of the meeting.

18 (Laughter)

19 CHAIRMAN WAXMAN: But, anyway, see if we can  
20 then come up with some agreement as to where we all feel,  
21 based upon the group's -- small group and then to the  
22 larger group, to where this group needs to go in our future  
23 meetings. I hope that's acceptable to all of you.

24 Michael, please continue.

1 MR. CONSTANTINO: I'd just like to run through  
2 how we -- the documentation we request to address those six  
3 questions. Documentation of service to planning area  
4 residents: 50 percent of the projected patient volume must  
5 come within the planning area. We like to see a market  
6 study, if possible. Claritas data, demographics and census  
7 data. Identify by zip codes individuals that may use the  
8 proposed facility.

9 And the documentation of demand for long-term  
10 care facilities: We're asking for referral letters from  
11 hospitals that attest to referrals to existing facilities  
12 within the planning area within the past 12 months; and  
13 then the estimated number of patients the hospital will  
14 refer annually within the next 24 months.

15 MS. DEDERER: May I ask a question?

16 MR. CONSTANTINO: Sure.

17 MS. DEDERER: If a hospital knows that you're  
18 all full, they will stop sending referrals, correct? So,  
19 how --

20 MS. O'DEA EVANS: You're full one day and not  
21 full the next.

22 MS. DEDERER: Okay. Thank you.

23 MR. LAVIN: The 50 percent targeting of people  
24 in the region, is that -- my guess would be that's less

1 than the number of people who actually come to a facility.

2 MR. CONSTANTINO: I'm sorry?

3 MR. LAVIN: The 50 percent of the projected  
4 patient volume must come from the planning area, and my  
5 guess is that figure would be low, that it would be 70 or  
6 80 percent.

7 MR. CONSTANTINO: Generally that's what we  
8 see, yes.

9 MR. LAVIN: So why 50?

10 MR. CONSTANTINO: I don't know the reason  
11 behind it. That's how the rule was developed.

12 MR. LAVIN: Okay.

13 MR. CONSTANTINO: And then we ask the  
14 documentation of access limitations within the planning  
15 area: Is there an absence of beds in the area? Generally  
16 that's no.

17 Again, access limitations due to payor status?  
18 This refers to Medicaid and Medicare, whether or not there  
19 is sufficient Medicare and Medicaid beds within the  
20 planning area.

21 Is there restrictive admission policies at the  
22 facilities in the planning area? This we would have to see  
23 documentation of those admission policies.

24 Again, are there medical care problems in the

1 planning area? And this refers to health planning --  
2 health shortage areas identified by the government.

3 And then finally, do all the services -- and  
4 this is just specific to this question. Do all services  
5 meet or exceed the 90 percent target occupancy within 45  
6 minutes of the proposed facility? In other words, are all  
7 the facilities within 45 minutes of the proposed facility  
8 at or in excess of the 90 percent target occupancy.

9 MS. O'DEA EVANS: Guess we're not going to  
10 plan much.

11 MR. CONSTANTINO: And that is generally no.

12 MR. PHILLIPPE: Can I ask one question?

13 MR. CONSTANTINO: Yes.

14 MR. PHILLIPPE: That's based on licensed beds?

15 MR. CONSTANTINO: Right, that's the only thing  
16 we look at.

17 MR. PHILLIPPE: I think we talked about that  
18 before. Where there are many facilities that may have 200  
19 licensed beds but they actually have the facility set up  
20 for a 150, so by strategy, they cannot be at 90 percent.

21 MR. CONSTANTINO: That's correct.

22 MS. DEDERER: There's a difference between the  
23 number of beds that we can get the hospital tax on or bed  
24 tax -- whatever it's called -- and the number of beds that

1 we actually expect to see people in? That's kind of the  
2 question.

3 CHAIRMAN WAXMAN: Bed tax is on licensed  
4 beds, but you're getting reimbursed on occupied beds, so  
5 I'm not sure --

6 MS. DEDERER: But the State has an interest in  
7 keeping licensed beds for the bed tax.

8 CHAIRMAN WAXMAN: Right.

9 MS. DEDERER: Okay.

10 CHAIRMAN WAXMAN: But the value of your  
11 nursing home is based on licensed beds. If you go to sell  
12 it, you're going to sell it on licensed beds.

13 MS. DEDERER: And mortgage rates are dependent  
14 on that.

15 CHAIRMAN WAXMAN: It's not my field. I don't  
16 know that.

17 MR. PICK: Based on licensed beds and  
18 percentage of occupancy.

19 CHAIRMAN WAXMAN: Right. Well, that's your  
20 revenue source.

21 MR. PICK: Right. It is based on licensing.

22 Again, Tim's comment, we do on an annual basis  
23 -- we're required to report to the Department the number of  
24 set-up beds versus licensed beds, and you're not allowed to

1 maintain a licensed bed if you can't have that operational.  
2 So if those beds are off line and they're no longer capable  
3 of being operational, the facility has an obligation to  
4 report to the Department that those beds are not  
5 operational and they have to be taken out of inventory.  
6 So, whether people are actually doing that or not is  
7 another question.

8 MR. PHILLIPPE: But being capable of being  
9 operational is not the same as being operational.

10 MR. PICK: There's actually three levels:  
11 Incapable, which means beds and equipment and furniture are  
12 no longer there. Versus capable, that the furniture may be  
13 available in storage and you can set it up relatively  
14 quickly. And then the third is occupied. So, these are  
15 all important operational decisions that, you know,  
16 licensed facilities have to make, and are reporting to the  
17 State on an annual basis as to whether that's true or not.

18 MR. PHILLIPPE: It seems like a fine point,  
19 but, actually, in practice maybe we should start looking at  
20 90 percent of census of licensed beds. Actually, it's a  
21 pretty important issue.

22 MR. PICK: It's a critical issue especially as  
23 we move to private rooms in the current market where  
24 semi-private have been converted.

1 CHAIRMAN WAXMAN: Right.

2 MR. CONSTANTINO: And then documentation of  
3 unnecessary duplication of services: We look for a list of  
4 facilities within 30 minutes and their utilization. We  
5 look to the ratio of beds to population that is one and a  
6 half times the State average. And attest that the  
7 applicant will not lower utilization of other area  
8 providers 24 months after project completion.

9 MR. PICK: Is that considered a white lie.

10 (Laughter)

11 MR. PICK: Historically, the accepted standard  
12 in the industry is that it takes 24 months to fill. So,  
13 although that's an old number also, it's been historically  
14 accepted.

15 MS. ALTMAN: So it means look out two years  
16 and see if you've had that negative impact.

17 MR. PICK: Or projected. I think one of the  
18 things that was mentioned earlier is why is the State so  
19 concerned about existing operators? It's because there is  
20 state and federal money going into those buildings.

21 MR. CONSTANTINO: Yes.

22 MR. PICK: So, there is -- after putting all  
23 of those public resources into those facilities, there is a  
24 financial obligation to make sure that there's two things

1 going on: One is that we're maintaining the integrity of  
2 the organization because we've invested so many public  
3 funds in getting it going; and, secondarily, that the  
4 Department of Health in its survey process is making sure  
5 that they're operating at an appropriate level and  
6 providing services that they should be providing.

7 MR. SCAVOTTO: Yes, but the presumption there  
8 is that the opening of a new project is the sole cause of  
9 the lower utilization, and it may not be.

10 MR. PICK: And that's exactly right.

11 MS. DEDERER: Another question is the issue --  
12 are there medical care problems in the planning area.  
13 Public Health does go in and does cite nursing homes for  
14 various for various things, I guess, and there's -- isn't  
15 there something on --

16 MR. PICK: That's not what this is  
17 referencing. This is referencing shortage of services.

18 MS. DEDERER: But to continue my thought,  
19 isn't there a web site that lists nursing facilities and  
20 citations and all of that? So those things influence  
21 people going to nursing homes.

22 MR. PICK: Absolutely.

23 MS. DEDERER: Okay. So, you know, perhaps the  
24 medical care problems maybe needs to take some of that into

1 account and the State needs to invest in nursing homes that  
2 are falling under the line, assuming that -- I mean, just  
3 because you build a building 50 years ago doesn't mean that  
4 right now that building is still okay. Owners are getting  
5 such low reimbursement for nursing home beds that it's hard  
6 to keep your facility up and why as it's easier to go in  
7 and build a new building.

8 MR. SCAVOTTO: I bet we could get a secret  
9 list from Public Health, that if we opened up some new  
10 facilities, you would not shed a tear for the old  
11 facilities going out of business. You don't have to answer  
12 that. I think there's more than one reason here.

13 MS. DEDERER: But if we want to maintain  
14 existing buildings because we've invested in them, then we  
15 have to do something to keep the infrastructure of those  
16 buildings at a usable, attractive level.

17 MR. PHILLIPPE: Can I ask a question about the  
18 investment? I've only been in the field 10 years, but I  
19 don't know that the State has invested in any of our  
20 buildings, outside of what we're reimbursed for residents  
21 on Medicaid.

22 MR. PICK: The capital component of Medicaid  
23 rate.

24 MR. PHILLIPPE: And I haven't noticed that the

1 rate has gone up significantly, based on our costs or  
2 anything.

3 MR. SCAVOTTO: Because it doesn't.

4 MR. PICK: Well, it does very slowly.

5 CHAIRMAN WAXMAN: We're still using what year  
6 cost reports, that we're basing rates on.

7 MR. SULLIVAN: Capital rates were frozen in  
8 1994.

9 MR. PHILLIPPE: We're not being -- I just want  
10 to mention all of that because I think his -- at some point  
11 I guess we'll discuss this but I think originally there was  
12 more of a tie between the cost and the reimbursement, and  
13 that's really not the case today. So that would allow us  
14 to allow a little more market -- allow market forces to  
15 have more influence.

16 MR. PICK: I think your point is well taken,  
17 Terry. This is a Medicaid component. For facilities who  
18 have low or no Medicaid, there's no public funds going into  
19 that building.

20 CHAIRMAN WAXMAN: Medicare.

21 MR. PICK: That's federal. From a state level  
22 there is -- you get matching -- feds match 50 percent of  
23 the State, but the formula for reimbursement is based on  
24 the percentage of Medicaid patients that are being served

1 in that building.

2 MS. DEDERER: I'm sorry. One more question.  
3 Has anybody been here long enough to know when the old  
4 method of cost-based rate setting stopped? At some point  
5 in time, the rates were fixed, and then we've just done  
6 COLA since then.

7 MR. SULLIVAN: There was an overall freeze of  
8 all the rates in 1994, and then over various periods of  
9 time, parts of the rate got unfrozen. Support rate was  
10 unfrozen -- was updated from '94 to '99, then '99 to 2004.

11 MS. DEDERER: But only via COLAs, artificially  
12 set COLAs.

13 MR. SULLIVAN: Some COLAs, and they moved the  
14 support rate up. Capital has stayed at 1994 levels. And  
15 then the third component of the rate is nursing wages, and  
16 nursing wages have been frozen at the '99 level.

17 MS. DEDERER: Okay. Thank you. I'm sorry.

18 MR. SULLIVAN: But so, yes, as Tim pointed  
19 out, there is a significant divorce at this point between  
20 rates and costs.

21 CHAIRMAN WAXMAN: I think the average is  
22 about 78 percent, I heard in the past, the average nursing  
23 home is getting for a Medicaid resident, is getting about  
24 78 percent of its cost.

1 MR. CONSTANTINO: You mind if we take a short  
2 break, Mr. Chairman?

3 CHAIRMAN WAXMAN: No, not at all. Let's take  
4 a short break.

5 Before we do that, Stephanie, you want to  
6 identify yourself for the record?

7 MS. ALTMAN: Sorry. I was at a previous  
8 meeting. Stephanie Altman, Health and Disability  
9 Advocates.

10 CHAIRMAN WAXMAN: Is there anybody else that  
11 has joined us since we've identified everybody?

12 (No response)

13 CHAIRMAN WAXMAN: Michael, 10 minutes?

14 MR. CONSTANTINO: That's great.

15 (Recess)

16 CHAIRMAN WAXMAN: I'd like to reconvene. If  
17 someone can dim the lights for Michael, we can continue.

18 (Pause)

19 MR. CONSTANTINO: We do have additional  
20 criteria for need. We do ask for documentation of  
21 staffing. Facility size cannot exceed 250 beds. We do ask  
22 you to provide us with endorsements or support letters from  
23 community-related functions. Then we ask for the status of  
24 the -- where the facility is at in the zoning, and then we

1 again ask for assurance, by the second year of operation or  
2 24 months after project completion, that the facility be at  
3 90 percent occupancy.

4 MS. MITZEN: And what happens if it's not?

5 MR. CONSTANTINO: We never go back on any  
6 facility. We've never gone back on any facility.

7 MR. URSO: Maybe we should start now.

8 MS. MITZEN: Community-related functions.  
9 What does that mean? Do you have any --

10 MR. CONSTANTINO: We ask for letters of  
11 support from community organizations.

12 MS. MITZEN: And it can be any community  
13 organization, it can be a school --

14 MR. CONSTANTINO: Yes.

15 MS. MITZEN: So it doesn't limit it to --  
16 like the area council for aging, for example, might be a  
17 good --

18 MR. CONSTANTINO: Right. We see that. We see  
19 letters from the mayor, that type of thing.

20 MR. LAVIN: Do you know how many of the  
21 completed facilities two years out have 90 percent?

22 MR. CONSTANTINO: Probably can get you that,  
23 if you'd be interested in seeing that. I'd have to run a  
24 data poll, but we probably could get you that.

1 MR. LAVIN: Would that be helpful or not? I  
2 don't know.

3 MS. MITZEN: I wonder. I think that's a good  
4 start. I think a lot of the pieces in here have brought to  
5 mind what kind of data might we use to inform our work.  
6 So, I think that that might be -- there might be kind of a  
7 little list that we'll come up with.

8 MR. PICK: Michael, are you only getting  
9 occupancy data at 24 months, or are there other points of  
10 time where new projects are reporting occupancy?

11 MR. CONSTANTINO: Once they come on line, they  
12 have to report every year.

13 MR. PICK: 12 and 24?

14 MR. CONSTANTINO: Yes. Once the beds come on  
15 line, there is a year lag, and then they report every year.

16 MR. PICK: I would suggest we look at both,  
17 the 12-month and the 24-month occupancy.

18 CHAIRMAN WAXMAN: Just off the top of my  
19 head, if the average occupancy is 78 percent, I would  
20 suspect very few are going to be 90. That's just --

21 MR. PICK: No, but a new building may fill  
22 because it's new. That's why I'm asking for the 12-month.  
23 It may be over 90 percent at the 12-month. It may not be  
24 at the 24.

1                   CHAIRMAN WAXMAN:    I understand that.  If it's  
2   not a hard thing to pull -- if it's easy access then, yeah,  
3   please.

4                   MR. CONSTANTINO:    Sure.

5                   We also have two categories, continuum of care  
6   facilities and defined population for long-term care  
7   facilities.  Our reading of this is these used to be  
8   considered as variances to the calculated bed need.  I can  
9   find no evidence in our current rules that that is still in  
10  existence.  They are listed as separate classes of  
11  facilities.

12                  A continuum of care facility, they have to be  
13  on the same site as the healthcare facility component of  
14  the project; serve only the residents of the housing  
15  complex; and then we have just one bed for every five  
16  apartments or independent living facilities.  We also need  
17  to see documentation in their operational policies that the  
18  resident will not lose the apartment if transferred to the  
19  long-term care unit.

20                  MR. PICK:    Michael, did I understand you  
21  correctly that they're not exempted, so now they have to  
22  satisfy the community --

23                  MR. CONSTANTINO:  Yeah, they have to address  
24  the bed need.

1 MR. PICK: But they're restricted, that they  
2 can only admit from their community?

3 MR. CONSTANTINO: Yeah. I can find no  
4 evidence -- this used to be listed as variances to the  
5 computed bed need, but I can find no evidence of that in  
6 our current rules.

7 MS. MITZEN: So this is covered by all of the  
8 things that we've been talking about?

9 MR. CONSTANTINO: Yes, and this is new.

10 MR. FOLEY: Mike, wasn't the wording just kind  
11 of changed in the last rules, because it used to be called  
12 "variances to the computed bed need". That wording has  
13 changed.

14 MR. CONSTANTINO: It's been eliminated,  
15 Charlie.

16 MR. FOLEY: Yeah, but I think the implication  
17 is still there that it is a variance, because it always had  
18 been applied that way over the years.

19 MR. CONSTANTINO: I know it, but I can't find  
20 no evidence that that variance exists now.

21 MR. FOLEY: Because the word "variance" was  
22 eliminated from the language.

23 MR. CONSTANTINO: Yes, "variance" has been  
24 eliminated.

1 MR. PHILLIPPE: When was that eliminated?

2 MR. CONSTANTINO: That would have had to have  
3 been --

4 MR. PICK: June of '09, wasn't it?

5 MR. CONSTANTINO: These rules became effective  
6 February 6 of '09.

7 MR. FOLEY: Like I said, for some reason that  
8 word was eliminated.

9 MR. CONSTANTINO: I don't know why that  
10 happened, Charlie. I couldn't tell you. I was surprised.  
11 I thought I had missed it but --

12 MR. FOLEY: Because the purpose of this was,  
13 you were to address the variance if, and only if, there was  
14 an excess of beds in a planning area.

15 MR. CONSTANTINO: That's correct.

16 MR. FOLEY: So, you're saying we don't have to  
17 do that anymore?

18 MR. CONSTANTINO: That's the way it looks to  
19 me. I'll talk to Frank about it again, but I can find no  
20 evidence that the term "variance" is in our rules.

21 MR. FOLEY: Frank, can you comment on that?

22 MR. URSO: I'd have to take another look at  
23 it, but the explicit language is no longer in there, so  
24 we're just going to have to take a more comprehensive.

1 MR. FOLEY: What about implication, though?

2 The rule has never changed.

3 MR. URSO: I don't want to comment about  
4 implications.

5 CHAIRMAN WAXMAN: Has anybody filed for a  
6 CCRC since the rule changed?

7 MR. CONSTANTINO: No.

8 MS. DEDERER: I have a question. When it says  
9 "admission to long-care unit limited to the residents in  
10 the apartments or independent living units," that means  
11 that somebody in the community could not use a long-term  
12 care bed?

13 MR. PICK: Right, in the CCRC.

14 MS. DEDERER: And it also means that the  
15 residents in the apartments or independent living  
16 facilities can't go to another facility?

17 MR. BIBO: No, they can go wherever they want.

18 MR. PICK: Isn't there an exception for a  
19 spouse? I thought a spouse living in the community could  
20 go into the long-term care facility to be with their  
21 husband or wife, if they were residing in that community.

22 MR. CONSTANTINO: That I don't know Eli, I  
23 don't know.

24 MS. O'DEA EVANS: It also affected new

1 facilities, not existing CCRC. So some of the older CCRCs  
2 are able to admit from the community. So, it only affected  
3 ones that were built between a certain time frame.

4 MR. SULLIVAN: I don't know if they are able,  
5 but they do.

6 MS. O'DEA EVANS: Well, they do. Nobody is  
7 stopping them.

8 MR. SULLIVAN: No one is stopping them, that's  
9 correct.

10 MS. DEDERER: One final question. The  
11 resident not losing an apartment if transferred to the  
12 long-term care unit -- some medical conditions very clearly  
13 will indicate that they are never going to go back to the  
14 apartment.

15 CHAIRMAN WAXMAN: I think it means -- again,  
16 I shouldn't be --

17 MS. DEDERER: What does it mean?

18 CHAIRMAN WAXMAN: I'm assuming it means that  
19 the facility can't --

20 MS. O'DEA EVANS: You have to establish a  
21 policy.

22 CHAIRMAN WAXMAN: The family can choose to  
23 give it up, but the facility can't.

24 MR. LAVIN: What's the number of the people

1 who fall into the continuing care facilities? What's the  
2 number we're talking about or the number of beds in these?  
3 Do we have any information on that.

4 MR. CONSTANTINO: We don't track that  
5 information.

6 MR. PHILLIPPE: I've noticed a trend over the  
7 last years of new CCRCs not wanting to use the variance  
8 anyway, and they go through the whole process anyway.

9 MR. FOLEY: That's only because if there was a  
10 planning area that had a bed need, they don't have to apply  
11 for variance.

12 MR. PHILLIPPE: The problem they have is all  
13 the changes in the field. This rule doesn't fit as well as  
14 it used to, because they're not admitting that many from  
15 their own campus anymore. They need a much larger campus  
16 and all of the issues that go into it.

17 MR. URSO: But the 10-year projection also has  
18 an impact.

19 MR. PICK: In what way?

20 MR. URSO: It used to be five-year projection.

21 MR. FOLEY: May I add an asterisk? This  
22 conversation is another important area that we need to take  
23 a serious look at. For both the continuum care of the need  
24 criteria as well as the defined population criterion.

1 MR. CONSTANTINO: And this is the other  
2 facility -- defined population facility, this was the other  
3 variance to the computed bed need, either religious,  
4 fraternal or ethnic group. We allow them, the defined  
5 population, to define their boundaries, and we call that a  
6 Geographic Service Area. It's different than an H --  
7 Health Planning Area or an HSA. We ask them to identify  
8 the number of individuals in the defined population in the  
9 GSA; and whether or not services do exist in the GSA; and  
10 then whether or not services can be instituted as existing  
11 facilities within the proposed Geographic Service Area. 85  
12 percent of the residents of the facility must come from the  
13 defined population; and has to be directly owned,  
14 sponsored, or affiliated with that defined population.

15 MR. SULLIVAN: Michael, how many defined  
16 population facilities have come up in the past five years?

17 MR. CONSTANTINO: I know of one, and that was  
18 just recent up in Mercy, the Mercy --

19 DR. BURDEN: Mercy Circle.

20 MR. CONSTANTINO: That's correct.

21 MS. ALTMAN: What do you mean "come up",  
22 meaning new one?

23 MR. SULLIVAN: New one.

24 MR. BIBO: Michael, so it's just limited --

1 for the defined population, it's just for religious,  
2 fraternal, or ethnic?

3 MR. CONSTANTINO: That's right.

4 MS. MITZEN: Just kind of a question. So,  
5 only one new one has come up, but I'm assuming that over  
6 the years, there have been a lot of them.

7 MR. CONSTANTINO: There's been others, yes,  
8 other -- generally they're religious.

9 MR. PICK: I wouldn't characterize them as a  
10 lot.

11 MS. MITZEN: And how do those get factored in  
12 in these 10-year projections?

13 MR. CONSTANTINO: They're included, they have  
14 been included.

15 MR. LAVIN: Like the one in Wheeling, Pat,  
16 Greeks across the street?

17 MS. HANDLER: Greek American.

18 MR. LAVIN: Is that contained in this  
19 category?

20 MR. PICK: It is.

21 MS. ALTMAN: There are a lot of ones that are  
22 probably affiliated but they can just be run regularly,  
23 right? Like, just like Lutheran or Catholic, those usually  
24 aren't defined population, they're just --

1 MR. PICK: They choose to serve the specific  
2 group, but they didn't necessarily go through this  
3 variance.

4 MR. LAVIN: So, what happens if their  
5 population changes and they have twenty percent non-Greeks?

6 MR. PICK: Nothing.

7 MR. SULLIVAN: Nothing.

8 MR. LAVIN: So, it's really a front-door  
9 issue.

10 MS. O'DEA EVANS: It's a planning point, but  
11 after the planning point, it seems to --

12 MR. SULLIVAN: And there were a lot more  
13 defined and ethnic religious homes back in the 70's as  
14 facilities set up an old age home, but fewer and fewer  
15 organizations are doing that now. It's not a business they  
16 want to get into.

17 MR. CONSTANTINO: And then we look at the  
18 ICF/DD facilities. I'll just go through this shortly. It  
19 cannot be greater than a hundred beds. The last one I know  
20 of was in 2006 and was for a replacement facility down in  
21 southern Illinois, and that was for 93 beds. Again, we  
22 need documentation of community-related functions;  
23 availability of ancillary or support programs; and we need  
24 correspondence from DHS and HFS regarding whether or not

1 this is consistent with the long-term goals of the  
2 agencies.

3 Establishment of beds for ICF/DD: Must be  
4 located in a planning area where need for additional beds  
5 is calculated based upon our bed need calculation; and then  
6 we do have a variance to bed need for this category of  
7 ICF/DD.

8 I'll take a minute to talk about  
9 modernization. We do not see many of these projects at all  
10 anymore, because the capital expenditure threshold has been  
11 between six and a half million and eight-plus million  
12 dollars here for the last number of years, and our  
13 average -- the average capital expenditures we've seen in  
14 2009 was approximately \$187,000. So, we're just not seeing  
15 projects for the modernization of long-term care  
16 facilities. They can modernize their facilities without  
17 coming in for a CON.

18 MR. PICK: So, in effect, Michael, it's just  
19 really replacement building?

20 MR. CONSTANTINO: Yes.

21 MR. PICK: Otherwise, if we're just doing a  
22 wing, it's not going to meet the threshold.

23 MR. CONSTANTINO: Right, and they can add beds  
24 under the 10 percent rule.

1 Financial, we ask essentially three questions:  
2 Are funds available, is the applicant financially viable,  
3 and is the project economically feasible.

4 Generally what we're seeing in long-term  
5 projects, the model that we see most of the time are new  
6 entities established to -- generally is two LLC's, one that  
7 will own the real estate, and the other will be the  
8 operating entity. In that case, in regards to availability  
9 of funds, we're looking for a statement from the bank that  
10 there is sufficient cash available, and most of these are  
11 being funded through HUD now, that we are seeing, or, I  
12 guess, the USDA. Is that the other government program?

13 MR. PICK: Isn't it the senior -- the  
14 financing facility --

15 MR. LAVIN: Illinois Housing Development.

16 MR. PICK: IHDA is the source.

17 MR. SULLIVAN: HUD is the big one.

18 MR. PICK: There is some private capital, but  
19 it's very, very rare.

20 MR. URSO: This is in another section of the  
21 rules, by the way, in case anybody is interested. This is  
22 in 77 IAC 1120, whereas the "need" rules were in 1010.  
23 These are 1120, so it's a whole new section of rules when  
24 you get into the financials.

1 MR. CONSTANTINO: Then the next question we  
2 ask: Are the applicants financially viable? We generally  
3 ask for three years of historical financial ratio  
4 information. For new entities we're left with their  
5 projected ratios, and invariably they meet the projected  
6 ratios established by the standards established by the  
7 Board.

8 So, we then ask if the project is economically  
9 feasible: The reasonableness of debt financing. We ask  
10 them to attest that borrowing is less costly than the  
11 removal of markets -- note the removal, but the sale of  
12 marketable securities.

13 And then terms of debt financing: We ask for  
14 the terms of the debt financing, interest rates, the length  
15 of the loan.

16 Then we ask for the reasonableness of project  
17 cost, which is based upon the means data that we receive  
18 from RSMeans every quarter; and then we ask for direct  
19 operating costs for equivalent patient days and the effect  
20 of the project on capital cost for equivalent patient days.

21 We have no standard for these items. The  
22 reasonableness of project cost is based upon means data,  
23 which I have here. For Chicago, the means data is two  
24 hundred -- at present, \$200 per gross square feet for new

1 construction, and in Springfield it's a \$173 per gross  
2 square foot. Per bed, it's -- in Chicago, it's 90,500, and  
3 in Springfield it's 78,500.

4 MR. SULLIVAN: Michael or Chuck, has anyone  
5 ever -- in terms of financial viability, has anyone ever  
6 built a facility and then not be able to open it?

7 MR. PICK: Yes, there was one in Highland  
8 Park.

9 MR. CONSTANTINO: What was the name of that  
10 facility?

11 MR. PICK: Now it's a Manor Care. Before that  
12 it was --

13 CHAIRMAN WAXMAN: Rose Bud -- no. Rose was  
14 in the name, but I don't remember it.

15 MR. SCAVOTTO: There was a Rose Bud.

16 MR. PICK: It's right on 41.

17 CHAIRMAN WAXMAN: Yeah, it's a Manor Care  
18 facility.

19 MR. PICK: It was built on the old Boy Scout  
20 campus.

21 CHAIRMAN WAXMAN: He built it because the CON  
22 was going to run out and he built it.

23 MR. PICK: And it was never viable.

24 CHAIRMAN WAXMAN: Rose was in the name, but I

1 don't remember the name.

2 MR. PICK: It's now Manor Care of Highland  
3 Park. That's the one I know of.

4 MR. SULLIVAN: So he sold it?

5 MR. PICK: He sold it, because he lost so much  
6 money in it, he couldn't keep it going.

7 MR. CONSTANTINO: And this is our application  
8 process: Submittal of an application. 10-day completeness  
9 review. During that period, we post a notice for an  
10 opportunity for a public hearing. We call the project  
11 complete, and then we have a 60-day review period  
12 currently. We're asking that the 120-day review period be  
13 reinstated. Whether that happens or not, I don't know.

14 Twenty days before the Board meeting, the  
15 comment period ends, and then 14 days before the Board  
16 meeting, the State Agency Reports are published. Comment  
17 period reopens, and this is limited to comments on the SAR.  
18 So, there's four days there where we will receive comments  
19 that are related specifically to the State Agency Report.  
20 Ten days before the Board meeting, the comment period  
21 closes.

22 I'll just briefly talk about our reports.  
23 What we try to provide to the Board is an analysis of all  
24 of the materials submitted. We address the purpose of the

1 project, background, alternatives considered, size of the  
2 project, whether or not it's met our size standards, and  
3 then we ask those six questions that we talked about  
4 before: Is there a need for the service proposed? And  
5 given the fact that there is -- many of these Health  
6 Planning Areas have no calculated bed need, the answer to  
7 that question is no.

8 And then we ask the three questions related to  
9 financial viability and economic feasibility.

10 Now, that's it. Is there any questions?

11 CHAIRMAN WAXMAN: Any questions for Michael?

12 (Pause)

13 CHAIRMAN WAXMAN: Michael, thank you very,  
14 very much.

15 (Applause)

16 MS. MITZEN: This was so helpful.

17 MR. PICK: Very informative.

18 MR. CONSTANTINO: I had a lot of help from  
19 Frank and Bill, and I don't want to forget Bonnie, too.

20 CHAIRMAN WAXMAN: Are there any questions  
21 from the presentation and, again, we appreciate all of you  
22 putting this stuff together.

23 MR. SCAVOTTO: I have a question. Mike, it  
24 was on -- I just made a note on this. Don't put it back up

1 but on slide number 11, there was a comment about access  
2 limitations through the payor status. What are you getting  
3 at there?

4 MR. CONSTANTINO: We're looking at the number  
5 of Medicaid and Medicare beds in that planning area, and we  
6 consider that if it doesn't meet -- doesn't compare  
7 favorably to the state average, we look -- we can consider  
8 that as an access limitation.

9 MR. SCAVOTTO: Are you finding that hospitals  
10 are providing the referral data?

11 MR. CONSTANTINO: We have trouble getting  
12 that, yes.

13 MR. SCAVOTTO: I think you would have trouble  
14 getting that.

15 CHAIRMAN WAXMAN: Again, our gratitude to all  
16 of you. This is really, really helpful.

17 MS. DEDERER: This is great.

18 CHAIRMAN WAXMAN: What I'd like to do now is  
19 divide into four groups, and just number 1 through 4, just  
20 that way, and if you guys could find -- each group can find  
21 a spot to hang out for a little bit in the hotel. Please  
22 designate one of the group to be a recorder, secretary,  
23 spokesperson, and then come back, and what we're looking  
24 for then is from each small group -- maybe the top six

1 issues that you think we need to address, and again, they  
2 can be issues that we need to make recommendations to the  
3 CON Board, or they can be issues that we need to actually  
4 develop policies and procedures for. So, either are open  
5 and, again, six is kind of a random number. If you hit  
6 seven, I ain't going to yell, or eight, I'm not going to  
7 yell. I'm not sure -- I think we stopped with Rick. Rick,  
8 you participate, because you're a member of the committee.

9 MS. HILLS: I want you to put on the record  
10 that there is a gentleman that came in.

11 CHAIRMAN WAXMAN: I'm sorry, you did tell me  
12 that.

13 MR. WILL: Greg Will. I'm serving as proxy  
14 for Dave Lowitski, SEIU Healthcare.

15 MS. DEDERER: So are the people back here able  
16 to participate?

17 CHAIRMAN WAXMAN: I was going to let them.  
18 Does anybody have any objection? I don't think they should  
19 be in the same committee.

20 The other point is when we assemble again, if  
21 you want to be part of one of the groups, I'm fine with it.  
22 Frank, do you have an issue with them being a part of it?

23 MR. URSO: No.

24 CHAIRMAN WAXMAN: I would appreciate you not

1 being in the same group, but if you want to add your  
2 expertise to the group, that would be cool.

3 Do you think you can do this in 20 minutes?

4 And then spokesman, and then what I need from the group is  
5 someone who would be willing to put things up on the board  
6 for us to summarize and see if we can find some consistency  
7 among the group. So, if someone wants to volunteer and be  
8 the notetaker when we all come back as a big group I'd  
9 appreciate that too.

10 (Attendees count off by four's.)

11 CHAIRMAN WAXMAN: Go to it, guys, and try to  
12 be back in 20 minutes, and have fun.

13 (Individual groups meet and return).

14 CHAIRMAN WAXMAN: Any group want to be first?  
15 Do you want to be first? First group wants to be first.

16 Okay. So, do you have a spokesperson?

17 MR. LAVIN: I am speaking.

18 CHAIRMAN WAXMAN: Do we have someone who  
19 would like to take down some notes for us?

20 MR. DART: I'll try and do that.

21 CHAIRMAN WAXMAN: We're looking for just  
22 bullet points, and then what I'm envisioning, if you do the  
23 bullet points from each group, then we'll put all four  
24 sheets together and see where we maybe have some

1 commonality, and I think that's the final task for today.  
2 And then the next meeting, we'll start dealing out those  
3 topics that we all kind of agree to. Unless someone else  
4 has some other suggestions, that's kind of where I'm  
5 heading.

6 MS. DEDERER: Could we pause? Is it possible  
7 with the CON Board's budget to consider having a lunch  
8 brought in, Jimmy Johns, something based on previous  
9 orders, to subsequent meetings?

10 CHAIRMAN WAXMAN: If I understand the budget,  
11 I think the answer is going to be no.

12 MS. MITZEN: But doesn't it cover.

13 MS. HILLS: I can try again to do a working  
14 lunch. It's hard to get it through. They're not letting  
15 us do it these days, but I will try.

16 MS. DEDERER: But, essentially, since it's a  
17 non-state agency group --

18 MS. MITZEN: Quite frankly, even if we don't,  
19 it's like, a \$6 lunch or something --

20 MS. DEDERER: We could all pay for our  
21 lunches, if someone would coordinate it.

22 (Discussion held off the record.)

23 CHAIRMAN WAXMAN: The meetings have been set.

24 The next one is scheduled for --

1 MS. O'DEA EVANS: January 25th, March 29th, May  
2 24th, July 26th, September 27th, and November 29th.

3 MS. ALTMAN: Did you mail that out?

4 CHAIRMAN WAXMAN: It was sent.

5 Okay. So, we have the first group.

6 MR. LAVIN: Yeah. We definitely came to the  
7 conclusion that we need to have lunch in the middle and  
8 then have some real discussion of what our goals and  
9 objectives are for the events.

10 But the points that came off from us are we  
11 really want to talk about formula, all of the exclusions  
12 and what's included, needs to be looked at, because how do  
13 you plan if you're planning for a part of a part of a part?  
14 And that led to the idea of supportive living and assisted  
15 living being considered in a larger planning context, as  
16 well as home and community-base service availability. That  
17 also impacts the next point, which is that the financial  
18 implications seem to be missing.

19 Who is paying for care and how much does the  
20 State have to pick up of that care cost? It does seem to  
21 have an impact on the meaning of this kind of planning. We  
22 think -- we also pointed out that modernization should be  
23 part of the formula, that we should see -- try to make sure  
24 that there is quality and that what's provided, the care is

1 modern and as effective as possible.

2 We had discussion of the bed need, and there's  
3 a lot of ghost beds that -- I believe, that Public Health  
4 has been able to address in terms of acute care and  
5 hospitals, but it should be looked at in terms of beds that  
6 are on the books but nobody is in them and won't be in  
7 them, and we think that those beds -- we should have a  
8 better handle on that.

9 Then the variance issue, which really fits  
10 into the exclusion/inclusion, but we think the variance  
11 thing should be part of that whole discussion and be clear  
12 to know how many beds are out there with a variance,  
13 because we don't even know that.

14 And we need to talk about outcomes. What is  
15 it that we want to see? More private rooms? Higher  
16 occupancy rates? What other types of decisions? And the  
17 results of those decisions that we anticipate will be  
18 coming from this group.

19 What did I miss, Team?

20 (Pause)

21 MR. LAVIN: Nice group. Very interesting.

22 CHAIRMAN WAXMAN: Is that a hint that if we  
23 break again, you want the same group?

24 MS. O'DEA EVANS: One thing we kind of missed

1 was how do we define the service population versus the  
2 needs of that group?

3 MR. LAVIN: Right, right. The basically -- we  
4 were talking about if we were building a brand new state,  
5 there would be houses, there'd be churches, there'd be  
6 schools. There would also be long-term care support and  
7 services and facilities, and you know if we were able to  
8 take that 30,000 foot view, really understand who we were  
9 trying to reach and serve and how impaired they are and  
10 what they're going to do in terms of meeting their  
11 individual preferences, as well as make sure that we have  
12 the infrastructure for the growth of the population. So,  
13 that whole part of the discussion was something I missed.  
14 I'm sorry.

15 CHAIRMAN WAXMAN: Anything else from Group 1?

16 (Pause)

17 CHAIRMAN WAXMAN: Okay. We'll be simple.

18 We'll go Group 2.

19 MR. BIBO: Group 2 --

20 MS. MITZEN: I just want to make a comment,  
21 though, before we start. John referred to long-term care,  
22 and our group referred to long-term care, and we really  
23 need to make it clear, particularly in this group -- if  
24 we're talking about long-term care, we need to define are

1 we talking about nursing home beds? Because some people  
2 define "long-term care" as nursing home beds versus  
3 long-term care continuum which others in the room consider  
4 long-term care. So, I think we have to make sure our  
5 definition is clear.

6 MR. BIBO: Group 2, we wanted to talk about  
7 how do we define the needs for new facilities? What are  
8 the basic assumptions? We're going to have to redefine all  
9 of that. And what are we redesigning that as? And that  
10 gets into what she was just commenting on. What are we  
11 including? Are we talking about just nursing homes, or a  
12 broader scope when we look at the needs.

13 Number two, how does process allow for  
14 improvement and innovations, such as medical, Pioneer or  
15 Eden practices, resident centers plans, those types of  
16 things, person-centered centers?

17 CHAIRMAN WAXMAN: Does everyone know those  
18 terms? They're all geared to trying to make a skilled  
19 nursing home look more home like, so you --

20 MS. MITZEN: "Be" more. I think it's  
21 really -- it's -- but it's very different.

22 CHAIRMAN WAXMAN: It means things like  
23 gardening therapy, pet therapy, people can choose when they  
24 want to get up, people can choose when they want to have

1 their meals.

2 MS. O'DEA EVANS: Shower.

3 MR. PHILLIPPE: Choice.

4 MS. O'DEA EVANS: It's making it a residence  
5 instead of a healthcare facility.

6 MS. MITZEN: It doesn't matter how it looks,  
7 it's how it feels to a person.

8 MR. BIBO: Number three is is there a formula  
9 or methodology that adequately identifies bed need? Rather  
10 than what we're doing today, are there other options out  
11 there that is totally different than what we're doing  
12 today.

13 Number four, we talked about variances and our  
14 belief that things such as CCRC, defining populations, and  
15 maybe other things maybe ought to go back under "a  
16 variance". If that was some sort of oversight that was  
17 done, we need to put it back in there. It made no sense to  
18 put CCRC outside of a variance issue and yet have all of  
19 the requirements you have for long-term care, and then you  
20 self impose other ones on you with no benefit.

21 Number six -- we went to seven. Number six  
22 was --

23 CHAIRMAN WAXMAN: We're missing five.

24 MR. BIBO: Then we only went to six. Okay.

1 Good. Thank you. After I got off one hand, I lost track.  
2 Consistency. We need consistency and  
3 predictability of the process, that people go and put a lot  
4 of money that they expend to try to develop, whether a  
5 program, and to even propose a program, and then when one  
6 project gets approved and another one gets disapproved, and  
7 there's really no basis for it, that you can't predict  
8 that. That shouldn't be. We need a little more  
9 predictability. We understand that it's basically an  
10 advisory board or that the staff basically does the report,  
11 but the board can do what they want. But there needs to be  
12 more consistency in that -- in the proposals and in the  
13 approvals.

14 And the last thing was that we need to talk  
15 about the impact of HFS's MCO's on the Medicaid population.  
16 HFS has a program now -- Healthcare and Family Services has  
17 a program now where they're trying to get all of the  
18 collar counties of Chicago -- it's Cook and all of the  
19 collar counties with Cook, with the exception of Chicago,  
20 having integrated and/or managed care for all services,  
21 including long-term care, and they want to expand that out  
22 state-wide, and then how is that going to impact on what  
23 we're looking at doing?

24 CHAIRMAN WAXMAN: Good question.

1 MR. LAVIN: And that's Medicaid only.

2 CHAIRMAN WAXMAN: Good stuff. And, again,  
3 the old saying, whenever you do any kind of strategic  
4 planning or group thinking, no idea is bad. I mean, just  
5 let them flow and then we'll narrow them down and find like  
6 ideas. So, please don't hesitate to put things out there.

7 MS. MITZEN: There were actually two other  
8 things that we talked about at the end. One of them had to  
9 do with -- we briefly talked about the impact of or the  
10 recognize of the geographic differences, Chicago versus the  
11 downstate, rural areas and that there are some real  
12 differences there that we probably should be recognizing.

13 CHAIRMAN WAXMAN: Only if you've been into  
14 both sets of homes do you know that.

15 MS. MITZEN: Okay, there you are.

16 And the last thing had to do with we -- you  
17 talked a lot about the 90 percent occupancy rate, and the  
18 fact is that as long as I've been on committees, like for  
19 the last seven or eight years, we've been hearing about 72  
20 to 78 percent occupancy rate. So what does that 90 percent  
21 really mean? That's basically a question.

22 CHAIRMAN WAXMAN: Anything else from Group 2.

23 (Pause)

24 CHAIRMAN WAXMAN: Thank you, Group 2.

1                   Stephanie, or Stephanie's group, whoever your  
2 spokesperson is.

3                   MS. ALTMAN: Eli was in our group, but he had  
4 to leave.

5                   MR. WILL: Any of you who are still here,  
6 please chime in.

7                   CHAIRMAN WAXMAN: They don't know you.  
8 You're still on your own.

9                   MR. WILL: The first thing we came up with is  
10 basically that the formula that's supposed to describe need  
11 is just kind of inadequate to what currently happens out  
12 there, and the first way that we talked about that is that  
13 there are all these other, you know, service areas, which  
14 is, you know, not -- some of it, it's not our charge to  
15 look at but that they need to be accounted for in some  
16 fashion. I mean, that is, if we're looking at the -- you  
17 know, what Phyllis just mentioned, the difference between  
18 nursing home beds and a whole, you know, range of services  
19 that -- the description of need should account for a range  
20 of services in some fashion, and we really did not get into  
21 all of the technicalities of whether that's stuff that  
22 would be easy or difficult for us to do, whether it's just  
23 changing the formula to allow for the fact that somewhere  
24 out there there is an increase in other, you know, service

1 areas that's not described in the formula.

2           The second thing we talked about is if we're  
3 trying to describe that, how do we get information on  
4 choices people are making or how folks are navigating this  
5 long-term care system? And people -- Eli and Stephanie --  
6 I think, actually, everybody in the group, except for me,  
7 had good ideas about where we might get that information  
8 and, you know, it's the case coordination units, Triple  
9 A's, a bunch of people and, potentially, as well hospital  
10 discharge planners.

11           MS. ALTMAN: The ombuds.

12           MS. DEDERER: Non-elderly.

13           MS. ALTMAN: There's lots of ways. ARDC's  
14 were just mentioned, CILA, as well as one other we had.  
15 Hospital discharge planners.

16           MR. WILL: So, I think that's all we had. The  
17 idea here was when your looking at that, you're looking at  
18 something that's between doing some sort of like massive  
19 survey, public opinion polling, and the mechanism in here  
20 currently, that one can have a public hearing. You're  
21 looking at something that's kind of in between there, and  
22 you're looking at these organizations, because they see  
23 people flowing through and making those choices, have  
24 somewhat a realistic assessment of what's going on with

1 those.

2 Third thing we thought about is, you know, in  
3 the needs formula, it's more or less, with one or two  
4 exceptions, kind of like beds are beds, and we discussed  
5 the different ways that one might want to look, you know,  
6 programmatically at need, and there's a range of these.  
7 One is kind of emerging distinctions in nursing homes  
8 between, you know, a transitional care. That's happening  
9 more and more. That's something that I would guess  
10 historically wasn't factored in when it was decided to make  
11 this formula, the ideals that when somebody got there they  
12 stayed there, and so Eli particularly had a lot to say  
13 about how that should be factored in in some way with the  
14 distinction between that and long stay. But then there's  
15 other specialized types of care. For example, there may be  
16 areas where, you know, place is arguably over-bedded, but  
17 you would have to drive a couple counties to get care.

18 MS. ALTMAN: Dialysis.

19 MR. WILL: Yeah, specialized care. And then  
20 onward to stuff that is factored in here in some fashion.

21 The fourth thing we talked about, how there's  
22 not much checking back in this process, the occupancy data  
23 and that, I guess --

24 MS. ALTMAN: We didn't want to use the term

1 "look back".

2 MR. WILL: In aggregate something about  
3 occupancies and the utilization is used in the formula, but  
4 really there is nothing looking back, like we approved this  
5 thing, asking how did it do, how did that feed into the  
6 planning function in the future?

7 MR. URSO: Did your group have any  
8 suggestions.

9 MR. WILL: I asked the group what the  
10 mechanism would be, because it seems like a tricky thing to  
11 do. We did not have suggestions. We had the luxury of  
12 punting on this, so we did.

13 MS. DEDERER: Our group came up with a  
14 suggestion of staffing it through the CON Board, the Health  
15 Facilities Planning Board. That would be easier than  
16 staffing it through you guys.

17 DR. BURDEN: Mike doesn't have much to do.

18 MS. DEDERER: Or you know what? You could do  
19 a contract.

20 MS. HANDLER: Require the facility to report  
21 back.

22 MS. ALTMAN: We did have one idea, which was  
23 sort of the facility reporting back, which is the SDS data  
24 that the facility is already collecting and that ostensibly

1 might go to HFS under some sort of -- we've heard from HFS  
2 they don't always request it, but -- or Public Health, but  
3 go to an agency, and then be used in some sense as a check  
4 back. So SDS could be a possibility.

5 MR. WILL: Other information getting  
6 incorporated in some fashion.

7 And then our last thing that we discussed is,  
8 we want to take a look at what other states are doing with  
9 their Certificate in Need as it relates to long-term care.

10 MS. ALTMAN: And Eli had mentioned that Texas  
11 had gotten rid of it and just went to market and licensing  
12 and then went back to it for some reason, and so it got us  
13 sort of wondering, what do other states --

14 MR. URSO: We have that information with one  
15 of our people who are not here.

16 CHAIRMAN WAXMAN: We talked about that at our  
17 first meeting, that Illinois looked at those options.

18 MS. ALTMAN: So, maybe having a presentation  
19 from somebody from other states?

20 MR. URSO: We would probably have that  
21 information, but she's ill right now.

22 MS. MITZEN: A few years ago, we actually had  
23 a student do some of that, and I have a file with some of  
24 that material, so at least we have something -- may have

1 something to start with.

2 MS. ALTMAN: Or if there is a national expert  
3 on it.

4 MR. BIBO: Terry.

5 (Laughter)

6 CHAIRMAN WAXMAN: Thank you very much.

7 The fourth group's spokesperson is --

8 MS. HANDLER: -- me. And, actually, we don't  
9 have a lot of additional things to add. I'll go through  
10 quickly.

11 We talked about the whole concept of the way  
12 the bed-need formula is currently operationalized. We  
13 specifically also talked about the validity of the 90  
14 percent target and felt that that whole process needs to be  
15 debated and discussed further.

16 The second thing that we identified really  
17 came out of -- the first concept, really, was how to  
18 encourage creativity and innovation from a solution  
19 perspective in terms of meeting the long-term care needs in  
20 Illinois, and ultimately decided that probably where to  
21 start would be assessing need beyond bed count. It's more  
22 than beds. There are particular service areas that are  
23 needed, et cetera, et cetera. So, how do we have a little  
24 bit more broad perspective on determining need? We

1 specifically talked about encouraging modernization of  
2 aging facilities and, actually, I have a solution that's  
3 our last item. That was our third point.

4           We did use the term "look back", although it  
5 has negative connotation. We do feel that there's an  
6 opportunity to take a look at one facility's project before  
7 the CON Board to be approved. How do we assess if they  
8 actually were effective? Did they reach their occupancy  
9 targets? Did they have negative impact in the marketplace?  
10 Those kinds of things and using that as a platform to do  
11 better planning. Obviously, you can't retrospectively  
12 adjust whether you made the decision to approve the project  
13 or not, but how do you use that information to do better  
14 planning into the future.

15           The fifth was the whole concept of the  
16 variances and getting some clarification around that and  
17 having some review of whether there are facilities that  
18 should be excluded are excluded, and making sure that we  
19 have a firm stand going forward with that.

20           And then the last was -- started with how do  
21 we look at incorporating poorly-performing facilities into  
22 our equations? Because a poorly-performing facility today  
23 is not necessarily going to be a poorly-performing facility  
24 in the future. You can't just assume that, but then

1 ultimately -- Terry shared that there are some states that  
2 are actually -- they have a system in place where you buy  
3 beds from different facilities within different planning  
4 areas, et cetera, and thought that, really, we ought to do  
5 some exploring around what other states are doing and what  
6 kind of creative solutions other states may have put in  
7 place to address some of these challenges, so we can learn  
8 from them, not make the same mistakes, make our own new  
9 ones, I suppose, but certainly not reinvent the wheel, if  
10 something is out there that we can consider.

11 Anybody in the group have -- did I miss  
12 something?

13 CHAIRMAN WAXMAN: I'm impressed with the  
14 activity of each of the groups, and you certainly  
15 demonstrate the diversity of backgrounds that I think the  
16 group has and brought them to the list.

17 MR. LAVIN: There is one thing that was stated  
18 in our group that I think was important, is that the  
19 current reimbursement crunch in Illinois really has an  
20 impact on everything we talk about and everything we do,  
21 and I missed that when I was going through our points.

22 CHAIRMAN WAXMAN: That's actually true.

23 I guess I'm torn between a couple of things,  
24 and what I'm thinking is I -- two thoughts. One is that we

1 have to go through this list and decide which are kind of  
2 recommendation issues that we can develop as  
3 recommendations to the -- our parent Board, and those  
4 issues that then become places for us to begin to write  
5 suggested policy and regulation language for. I think  
6 that's two things. I'm also thinking that if you would  
7 allow us -- meaning Staff and myself -- to take those lists  
8 and come back to you at the next meeting with that list,  
9 combine those and then segregate them or divide them into  
10 those two categories, and then we'll use those as the  
11 starting point for our next meeting. Is that an  
12 acceptable --

13 MS. DEDERER: Absolutely.

14 MR. BIBO: Could we get it before the next  
15 meeting, so once we see it --

16 CHAIRMAN WAXMAN: Yeah, I'm fine with that,  
17 and maybe now that we have a Vice-Chair, we can include Eli  
18 in a conference call, and the six of us can play with that,  
19 or anybody else you want to include. So is that an  
20 acceptable way to go?

21 (Pause)

22 CHAIRMAN WAXMAN: Frank, the next two items  
23 on the agenda is yours.

24 MR. URSO: Yes, and we talked about the first

1 one --

2 CHAIRMAN WAXMAN: Frank, before you start --  
3 I don't mean to cut this off in any way, shape, or form.  
4 So, if anybody wants to say anything additionally to what  
5 we've done -- which I think is really great work, and it's  
6 built upon Staff's incredible presentation to us. Anything  
7 else want to be said before I let Frank go back to his --  
8 everybody cool?

9 (Pause)

10 MR. URSO: I'm talking about unfinished  
11 business. So, the first thing I think we talked about  
12 already is the statutory construction for MR/ICFDD  
13 facilities, and we're going to continue our discussions  
14 about those, and Mike Bibo and I and other people will get  
15 to together.

16 The other thing I want to talk about is,  
17 hopefully I can answer some questions and clarify the issue  
18 we had on Open Meetings Act and ex-parte. Let me just give  
19 you a few thoughts on that. Numbers are an important  
20 decision between open meetings and ex-parte. Ex-parte can  
21 be triggered with just two people, but the open meeting  
22 requirements for this group is triggered when you have five  
23 or more people, and that triggers an open meeting  
24 recognition. The type of meeting is important for the Open

1 Meetings Act. If you have more than five people, they  
2 should be discussing long-term care sub-committee business  
3 in a public meeting, and then once you're in a public  
4 meeting session, you have to fulfill the requirement of the  
5 open meeting.

6 So, when the meeting communication occurs and  
7 with whom is also important. In other words, with  
8 ex-parte, we're talking about ex-parte predominantly in  
9 this group after the First Notice Period. Once the  
10 regulations are proposed and the First Notice Period  
11 situation, then ex-parte comes into place, and once the  
12 First Notice Period starts, ex-parte is defined as -- and  
13 this is just a reiteration of what I mentioned before --  
14 "any written or oral communication by any person that  
15 imparts material information or makes material argument  
16 regarding potential action concerning any of the Board's  
17 rule making under the Administrative Procedures Act and  
18 that is communicated to members of the sub-committee."  
19 That's just the definition of "ex-parte" after First Notice  
20 Period.

21 So, the specific question, as I recall when I  
22 reviewed the transcript, was there are a number of people  
23 that are in other groups or meetings and they may be  
24 getting to five or six people -- well, actually more than

1 five people. And my answer to that is if it's a public  
2 meeting, then it should be fine to discuss sub-committee  
3 business. So, if more than five of you are in another  
4 public meeting and one of the topics is going to be what's  
5 going on in this committee and that's an open meeting,  
6 that's not a problem. However, if six of you people get  
7 together for a private meeting to talk about sub-committee  
8 business, that's a problem. That meeting needs to adhere  
9 to the Open Meetings Act by virtue of the fact of the sheer  
10 number of people that are getting together. Okay? So you  
11 need to be careful. If you're having lunch with six people  
12 and you start talking about sub-committee business, that's  
13 problematic, because it triggers the Open Meetings Act once  
14 you hit that number of six or more.

15 MS. DEDERER: Question. What sub-committee  
16 business? I mean, we -- lots of us talk about long-term  
17 care on a daily basis. That is not sub-committee business.  
18 It would be if we say, "At the sub-committee we talked  
19 about X Y Z". That would be sub-committee business, I hope  
20 is going to be the answer.

21 MR. URSO: I think you're talking about  
22 technique. You're talking about "wasn't that an enjoyable  
23 meeting" or things along that nature. If it tips the scale  
24 and should be public information -- which everything we

1 talk about here is -- then I think you have crossed the  
2 line into an open meeting realm.

3 MS. DEDERER: But my question is, something  
4 that we can't talk about because it would be ex-parte or  
5 subject to open meetings would be, "We sat at this meeting  
6 and we developed a list of stuff and it's going to be put  
7 together for future action." That would be talking about  
8 sub-committee business. But if we have conversations in  
9 the course of our daily activities or whatever that are on  
10 long-term care but not the business of this committee per  
11 se, that's okay, right?

12 MR. URSO: I would say so.

13 MS. DEDERER: Yes.

14 MR. URSO: These are all individual fact  
15 patterns. Okay? There's a lot of gray here because you  
16 people are in the long-term care industry. So, you know,  
17 if somebody complains that "I saw six people from the  
18 Health Facility and Services Review Board, Long-Term Care  
19 Committee, sitting down, and it looks like they were  
20 talking about sub-committee business and" if somebody  
21 complains that it wasn't an open meeting, then we've got  
22 take a close look at all of the facts. Same thing with  
23 ex-parte.

24 So, what I would just say, on a closing note,

1 is try to refrain from getting in groups of more than six  
2 people and talk about sub-committee business, unless it's  
3 in a open meeting forum, and then it's permissible.

4 MS. DEDERER: Then I have to ask this  
5 question. You all are getting together to -- regurgitate  
6 the step of the next meeting. How is that not ex-parte?

7 MR. URSO: We're not voting members, we're  
8 Staff.

9 MS. DEDERER: But the Chair and the  
10 Vice-Chair.

11 MR. URSO: But there's only two.

12 MS. DEDERER: Oh, I thought you said two  
13 people.

14 CHAIRMAN WAXMAN: More than six. There are  
15 nineteen members.

16 MS. DEDERER: But more than two is ex-parte.

17 CHAIRMAN WAXMAN: Time out. There are  
18 nineteen members. A quorum is ten. Greater than half of  
19 the quorum --

20 MR. URSO: The majority of the quorum is six.

21 CHAIRMAN WAXMAN: That's the number that  
22 triggers an open meeting, the six.

23 MS. DEDERER: How about ex-parte?

24 MR. URSO: Well, ex-parte could be two people.

1 MS. DEDERER: That's my point. So the  
2 Vice-Chair --

3 CHAIRMAN WAXMAN: That only comes into  
4 existence if there are rules that have been written and are  
5 standing out for passage.

6 MS. DEDERER: So, we can talk freely about  
7 everything until rules are up?

8 MR. DART: In small groups.

9 MS. ALTMAN: Or in an open meeting.

10 MR. URSO: And the purpose behind ex-parte is  
11 a third party -- a third party comes in and wants to try to  
12 influence a sub-committee member's thinking about, "Well,  
13 you need to have a rule on this, because that will help my  
14 organization." Then that gets into ex-parte issues. Okay?  
15 And, in fact, the ex-parte that we're talking about in rule  
16 making is that you have to document and report that that  
17 ex-parte took place. It doesn't necessarily mean that it's  
18 prohibited, because it happens all the time where you have  
19 associations helping the State Agency prepare rules. That  
20 kind of stuff happens. But it has to be documented.

21 MS. MITZEN: What would really be helpful to  
22 me, who is not familiar with that whole issue of ex-parte,  
23 to know when we as a body have reached a point where that  
24 gets triggered.

1 MR. URSO: You will know.

2 MS. MITZEN: I'm sure you'll tell us, but  
3 right now nothing that we're doing has ex-parte --

4 MR. URSO: You can talk about rules, for  
5 instance, to the guy sitting next to you, Terry. You can  
6 talk to him all day.

7 MS. MITZEN: Yeah, we talk about rules all  
8 the time.

9 MR. URSO: But once we get to the First Notice  
10 Period, the line is drawn.

11 MS. MITZEN: And you'll tell us when the line  
12 is drawn?

13 MR. URSO: Yes. And talking about lines, let  
14 me say this before I forget. It -- there is going to be a  
15 proposal, hopefully, in the statute, in the Health  
16 Facilities Planning Act to change the date by which this  
17 group needs to have rules promulgated. We passed that date  
18 already, and I -- the proposal is September of next year,  
19 and I need to tell you that the Legislator who communicated  
20 that to me said, "That's it". You need to get the rules  
21 done by September of next year, not that we have our  
22 proposal ready by then. They need to be law by September  
23 of next year. So, just to let you know, and I don't know  
24 how many meetings that is in between there.

1 MS. ALTMAN: Or what are they going to do to  
2 us?

3 (Laughter)

4 MR. URSO: There's got to be consequences  
5 somewhere.

6 CHAIRMAN WAXMAN: No lunch.

7 (Laughter)

8 MS. DEDERER: Working backwards, when do the  
9 rules have to be written in order for them to be --

10 MS. MITZEN: We need a time line. My  
11 question to Michael was really -- we've done a lot of work  
12 I can see that, and a lot of -- I think you'll find a lot  
13 of the things really do mesh quite well. So, I think  
14 there's -- but then what are the steps that we need to take  
15 to get to the rule-making process?

16 CHAIRMAN WAXMAN: Well, again, kind of  
17 thinking out loud, before the next meeting, we will hand  
18 you our summation of those four sheets of paper, divided  
19 into recommendations to the Health Facilities Board and  
20 those recommendations that need to become policy and rules  
21 from this group. It's those policies and rules that have  
22 to be done sometime before March to meet the September  
23 deadline to become law.

24 MR. FOLEY: I thought at the last meeting this

1 committee was supposed to receive the proposed rules that  
2 was put together by the associations.

3 MS. DEDERER: We did.

4 MR. FOLEY: And that was not discussed today,  
5 and I thought that was going to be our starting point in  
6 order to meet this March deadline.

7 CHAIRMAN WAXMAN: I think the starting point  
8 is what is currently in place. My opinion -- I think the  
9 information we got from Staff is the base line. The other  
10 document is suggestions and can be viewed as we come back  
11 to those items. That's my opinion. If anyone wants to  
12 disagree, please feel free.

13 MS. O'DEA EVANS: I did have a question about  
14 documents we got. I didn't see a lot of background on how  
15 that came to be or who was involved in it or -- I mean, we  
16 did get the actual information, but it didn't -- I didn't  
17 see that we got a lot of information about where that came  
18 from.

19 MS. DEDERER: Or the participants.

20 CHAIRMAN WAXMAN: Sure. Terry, you were one  
21 of the participants.

22 MR. SULLIVAN: At the time of the revised  
23 legislation and after all three of the associations, Life  
24 Services Network and Illinois Council on Long-Term Care and

1 Illinois Healthcare Association all appeared before the  
2 task force, we all -- and actually separately prepared very  
3 similar comments, we all perceived the same things. It  
4 became a matter of, you know, at the point that the State  
5 had a very fine deadline of when things had to happen. It  
6 was like, well, what is it that needs to be in the  
7 regulation based on the comments and based on what the task  
8 force put in the legislation? And so the three  
9 associations went through a giant process where, I think,  
10 we had nine -- seven people from each association,  
11 twenty-one people, a very similar group, all putting in  
12 their ideas. We then got down into a work group, taking  
13 all the ideas, probably similar to what was going on here,  
14 some very, very good discussions about what the changing  
15 marketplace is all like, and how things are very different  
16 from the existing rules which were formulated in the  
17 1970's, and we actually did start trying to work with the  
18 1970 rules and had a very difficult time. And so in a lot  
19 of ways, the suggestions we came up uses the outline that  
20 the Planning Board currently uses, but -- and a lot of the  
21 wording. But what came out of that were a lot of the  
22 discussions on just the ones we're having here: Is there a  
23 need for the bed-need formula? What is the consumer  
24 looking for? What's the marketplace providing? Should it

1 be based on beds or services? What about innovation? What  
2 about modernization? All of that were part of very lively  
3 discussions, and speaking on behalf of the three  
4 associations, I think it's sort of like the dinosaur --  
5 choice of change or die -- and there was a recognition that  
6 the marketplace is changing rapidly and we just can't have  
7 1970's regulations and 1970's structures and expectations  
8 for what this current senior marketplace is all about.

9 So, that was the basis of the development.  
10 I'd say we had about ten meetings all together that really  
11 focused on what these rules are all about.

12 MS. DEDERER: Eli, can you tell us --

13 MR. SULLIVAN: I'm sorry.

14 MS. DEDERER: I knew that. What happened in  
15 Texas? They got rid of the Certificate of Need process and  
16 then they took it back. Why, before we discuss that as a  
17 possibility?

18 MR. SULLIVAN: Again, the group that we had  
19 talked about that, too. Do you let the marketplace  
20 determine who can build anywhere and any time, and there  
21 are, I'm going to guess, about 25 states that have done  
22 away with the CON process.

23 MR. FOLEY: 34 states have it.

24 MR. SULLIVAN: 34 have it and the others allow

1 for free marketplace and don't have any CON. You build any  
2 time, anywhere, and don't care about the cost implications  
3 or what's being built or the havoc it causes in the  
4 marketplace.

5 MR. FOLEY: It's also dictated by the size of  
6 those states, also.

7 MR. SULLIVAN: Right. Smaller states, it's a  
8 different situation.

9 MS. O'DEA EVANS: Just had a follow-up  
10 question.

11 MR. SULLIVAN: And Texas was a big state, and  
12 they found it was far too disruptive and way over -- there  
13 was too much going on in one area.

14 MS. O'DEA EVANS: You had all of this stuff in  
15 the high financial areas.

16 I just had a follow-up question. After you  
17 guys went through this process -- because that seems like a  
18 daunting process and a lot of work, and no wonder you want  
19 us to look at it. Was there any -- did it go out to the  
20 membership of those groups for any feedback and comment as  
21 well?

22 MR. SULLIVAN: Um-hum.

23 MS. O'DEA EVANS: So, that was part of the  
24 process?

1 MR. SULLIVAN: It all went out to the  
2 membership.

3 MS. O'DEA EVANS: And the membership is  
4 composed primarily of individuals that work in the skilled  
5 side.

6 MR. SULLIVAN: No, no, not true.

7 MR. PHILLIPPE: L S N has members -- I forget  
8 how it was done, but there was opportunity for lots of  
9 people to --

10 MR. SULLIVAN: And Illinois Healthcare  
11 represents assisted living and supportive living also.

12 MS. DEDERER: And there was consensus among  
13 all of those individuals?

14 MR. SULLIVAN: There was consensus and coming  
15 together on these things.

16 MS. MITZEN: Just to get back to the CON and  
17 the states, you mentioned larger states continue to have  
18 CONS or they don't have?

19 MR. SULLIVAN: Most of the larger states do.

20 MR. SCAVOTTO: California, for example, it's  
21 been gone since the mid 80's.

22 MS. O'DEA EVANS: How is that working for them?

23 MR. SCAVOTTO: It works okay in California,  
24 because they have a very different delivery system.

1 MS. O'DEA EVANS: Not just that, but they have  
2 a lot of smaller care homes.

3 MR. FOLEY: It's interesting that the State of  
4 Ohio got rid of the CON Program for everything but  
5 long-term care. I thought that was very interesting. But  
6 they're also looking at -- the Governor from Ohio is in the  
7 process of looking -- bringing back CON for hospitals and  
8 surgery centers, because they are finding out that is  
9 costing the State a lot of money, I guess, by not having a  
10 review process.

11 MR. BIBO: When we talk about CON, we're not  
12 always talking about comparing apples to apples, and we're  
13 talking about other states, too. There are a lot of states  
14 that are looking at it as a purely need issue, and they  
15 leave licensure to deal with the operator background and  
16 all of that. I mean, is there a need? Yes or no? They  
17 don't get all involved in the whole issue as to who's  
18 proposing the project, which may be something we just need  
19 to be aware of, I mean when we're comparing to other  
20 states.

21 CHAIRMAN WAXMAN: Frank, what do you think  
22 the availability of the person who is ill that has the  
23 information on other states might be? Wow, what a great  
24 question?

1 MR. URSO: When is your next meeting?

2 CHAIRMAN WAXMAN: January 25th.

3 MR. URSO: I can check and see if she's  
4 available. If she can't be here, maybe we could get some  
5 of the information she has.

6 CHAIRMAN WAXMAN: I think that's a piece  
7 people are looking for.

8 And, Terry, I think you need to forgive me for  
9 saying the following statement, but I think the group needs  
10 to hear it. The work that you have already done -- which  
11 is really great work, and I've read it, and I know the  
12 groups very, very well. I think it's important that we use  
13 that as a tool but recognize that the people in this room  
14 represent a much broader perspective than the three groups.  
15 So, therefore, it's a base.

16 MR. SULLIVAN: Yeah, and we wanted to put  
17 something on the table.

18 MS. DEDERER: It's another base line.

19 CHAIRMAN WAXMAN: So, again, I think it  
20 becomes a tool after we finish with that.

21 MR. PHILLIPPE: Can I ask a question about the  
22 CON -- whether we have one or not -- process for long-term  
23 care? Is that even up for discussion by this group? I  
24 would assume it wouldn't be. That's the reason I'm asking.

1 MR. CONSTANTINO: My opinion, it's not.

2 MR. PHILLIPPE: It's at a higher level. As we  
3 talk about the CON and other state options, I'm just  
4 asking, is that really something we should spend time on,  
5 because can we actually change that process or is that  
6 handled higher?

7 MR. URSO: That's not the purpose of this  
8 committee, to decide whether CON was right for Illinois or  
9 not. That was debated for years in the legislative task  
10 force.

11 MR. PHILLIPPE: So, would that be the best use  
12 of our time if we have to have all of this done by March?

13 MS. ALTMAN: We weren't suggesting we should  
14 look at other states to figure out if we should get rid of  
15 CON. We were just wanting to look at if the use CON, what  
16 they do. We aren't saying get rid of it.

17 MS. MITZEN: I think we were concerned about  
18 the assumptions that are underlying, so we want to take a  
19 look at it and see if we can do it better.

20 MS. ALTMAN: What Eli said basically is that  
21 the Legislature has already decided that they want CON in  
22 Illinois, they want some sort of planning process, and so  
23 again that's a done deal.

24 MR. URSO: And that's the way I understood

1 what you needed, focusing in on long-term care in other  
2 states that have CON.

3 MS. ALTMAN: Exactly.

4 CHAIRMAN WAXMAN: Any other questions for  
5 Frank?

6 MS. DEDERER: You were talking about how you  
7 saw the starting point and how we were going to process  
8 through this between now and March. Are we going to finish  
9 that?

10 CHAIRMAN WAXMAN: Oh. Am I going to finish  
11 that? I think we have a meeting in -- we have a second  
12 meeting March 29th scheduled, so I think we have two  
13 meetings to work on it. I think if we get -- the best  
14 we're going to do, we get you this information before the  
15 meeting on the 25th and divided between recommendations and  
16 things that need policies and procedures, and then we work  
17 most of the 25th on writing the policies and regs and  
18 whether we do again a small group and bring it together and  
19 find the commonalities, or work as a group as a whole. We  
20 can decide that when we meet together. And then we have a  
21 second meeting -- then we have another meeting in March to  
22 tie it all together. I think we'll be fairly close.

23 MR. FOLEY: There's no February meeting?

24 CHAIRMAN WAXMAN: No. We're meeting every

1 other month.

2 MS. ALTMAN: I don't think that's possible.

3 MS. DEDERER: There are 28 pages.

4 MS. MITZEN: I'm overwhelmed.

5 MS. DEDERER: There is no way in a group  
6 process we're going to do that.

7 CHAIRMAN WAXMAN: Okay. I'm open for  
8 suggestions.

9 MS. ALTMAN: I think it would be impossible to  
10 in some three or four hour meeting to write something, even  
11 if you were taking a model that had already been written  
12 and commenting on it. I think, depending on whether it's  
13 the feeling of the group that we're going to start from  
14 scratch or it's the feeling of the group that we're going  
15 to look at what's been proposed would determine that.

16 CHAIRMAN WAXMAN: I don't know a lot of that  
17 yet.

18 MS. ALTMAN: Then we're going to have to work  
19 outside of this group to write drafts and send it back and  
20 forth.

21 CHAIRMAN WAXMAN: Obviously, we respect what  
22 the group has already done and what Terry represents, but I  
23 think we have to be open at this point to what we're going  
24 to represent.

1 MS. ALTMAN: Then I think that's a bigger task  
2 and I think we should divide it into groups that need to  
3 work on this before we get back together. We need sections  
4 that we are going to work on certain portions of it. How  
5 would we do it all together?

6 MS. DEDERER: How can you write it with no  
7 feedback from the Committee?

8 CHAIRMAN WAXMAN: We have a comment coming  
9 from the person behind me.

10 MR. FOLEY: I guess I was suggesting possibly  
11 that we look at the regulations that the associations had  
12 proposed and just go through that and make some  
13 modifications, minor modifications, because, you're right,  
14 there's no way that we could go through the whole thing,  
15 but I'm assuming after we get something done in March, this  
16 is still going to be a working sub-committee and we could  
17 then take a look at what has been submitted and further  
18 work on that document.

19 MS. ALTMAN: But I think that's what was  
20 suggested and people are saying no.

21 MS. DEDERER: Michael said no.

22 MR. URSO: Typically what I've seen -- and,  
23 Rick, you've worked a lot with rules and, Bill and Mike  
24 here. Typically what we see is you start with what we

1 currently have as a base. That's why we did this  
2 presentation today. And then you destroy that any way you  
3 want and add to it and amend it and revise it, and that's  
4 why the set that Terry and his group put together are  
5 important, because now you can see how that might fit in or  
6 not fit in, plus all of the things you talked about. But I  
7 think you have to utilize what we talked about today as  
8 your base. That's typically how we've seen revisions to  
9 rules, and I see a lot of people shaking their heads yes.  
10 Typically start with what you have. Maybe you're going to  
11 take a whole section or add a new section, but whatever it  
12 is, you start with that.

13 MS. ALTMAN: We're just talking about whether  
14 a group can do that in a four-hour meeting.

15 MS. MITZEN: And that's what this is. So  
16 we'll have this reconstituted for us as a working document.

17 MS. DEDERER: Maybe in the order of the  
18 current rules to facilitate discussions?

19 MS. MITZEN: Right, so that we can see it as  
20 rules. We have the document that Terry's group prepared as  
21 a potential model, but I think it's a -- but to me that  
22 seems to be information that we can use in our  
23 deliberation, but I just -- I don't see that as being the  
24 document that we would necessarily say we'll tweak it and

1 submit it. I see this as the basis of our work.

2 CHAIRMAN WAXMAN: I think the entire group  
3 needs to agree on the topics that are up there. I think  
4 after that, we could obviously break into some smaller  
5 groups and work independently and bring it back to the next  
6 meeting.

7 MR. BIBO: Given the amount of work we have to  
8 do and sort of the time frames we're working under, I think  
9 the schedule we have outlined is good, but it's not good  
10 for the first three months of 2011. I really would like to  
11 see us consider meeting the first part of January of 2011  
12 and maybe meeting on every two or three weeks basis until  
13 the March deadline where we have to get things filed.  
14 After that, we can meet every other month, but I think we  
15 have a volume of work, and I think -- I don't think it's  
16 going to be productive to sit here and try to think we're  
17 going to get this done with one meeting in the end of  
18 January and another meeting the end of March and March is  
19 where we're going to turn it over. I think there's a lot  
20 of good points brought up here, and as someone who is  
21 involved in writing -- at least providing input to the  
22 association, the long-term care association stuff, I think  
23 there's something there that is missing out of what we have  
24 and would be good to include.

1 CHAIRMAN WAXMAN: That's what I was hoping  
2 someone would say.

3 MR. BIBO: I'm not in favor of breaking this  
4 group into smaller work groups, because whenever you do  
5 that, you're always going to have people that say, "I  
6 should have had input." We have too many very good points.  
7 I think we all need to be here, but we need to be here  
8 every two or three weeks and make that commitment through  
9 March when we get it filed, and then we can --

10 CHAIRMAN WAXMAN: Is there any issue with  
11 Staff having more frequent meetings? Is that an issue for  
12 you guys?

13 MR. URSO: As long as it doesn't conflict with  
14 the full Board meetings, and we could work around it.

15 MR. DART: I think the minutes provide for  
16 teleconference and video, if you want to.

17 MS. HILLS: I think you could do  
18 teleconference.

19 CHAIRMAN WAXMAN: I personally am not in  
20 favor of anything other than face-to-face. I like  
21 face-to-face. I think more gets accomplished. I can read  
22 that you hate my guts and I can't see that on the phone.  
23 Or you --

24 MR. FOLEY: We can't see you anyway.

1 CHAIRMAN WAXMAN: That's the last time you'll  
2 sit behind me.

3 (Laughter)

4 MR. URSO: I think we need some rules for the  
5 gallery.

6 CHAIRMAN WAXMAN: Seriously, I think there's  
7 a lot to be said about understanding where people are at  
8 just by seeing their reactions and how they respond, and I  
9 didn't mean to make a personal statement out of it, but I  
10 think it really helps to meet face-to-face. I know some of  
11 you come far to get here, and I appreciate that.

12 If we look at the second week of January,  
13 because the first week is probably not a good week to play  
14 with -- if we look at the second week of January.

15 (Discussion held off the record.)

16 CHAIRMAN WAXMAN: So we'll use the 11th, and  
17 we'll put an e-mail out.

18 MS. ALTMAN: And we're going ten to three?

19 MS. DEDERER: No. I suggested if we have  
20 lunch, we could do ten to three.

21 CHAIRMAN WAXMAN: To summarize, we are going  
22 to have a meeting here, face-to-face, on January 11th --  
23 that's Tuesday -- from two to two. We're going to check to  
24 see if lunch can be provided, even if we have to pay for it

1 ourselves, and just work through lunch. We're going to see  
2 if the hotel can provide a phone for the room so that  
3 people can call in. Otherwise, I suppose we could use an  
4 open cell phone.

5 We'll also meet on the 25th, as already  
6 scheduled, under the same conditions, whatever they might  
7 be. And before the 11th, Staff and Eli and I will try to  
8 make all of that into a working document in your hands  
9 before the meeting that will talk about "These are the  
10 issues that we think are recommendations to the Health  
11 Facilities Board, and these are some issues that we think  
12 should be looked at in terms of policies, procedures", and  
13 I think someone already said that there are issues here  
14 that would be additional issues to what the nursing home  
15 groups have already done, and I think that's the way to  
16 look at this, is to see if we can make that document  
17 stronger.

18 Terry, are you okay with that?

19 MR. SULLIVAN: Yes. And just to clarify, the  
20 document that was distributed, our starting point was the  
21 existing regulations and mirrored the existing regulations  
22 in many ways. We kept as much statutory stuff in there.

23 MS. DEDERER: Does anybody have a side-by-side  
24 of yours and the original, by any chance, or a marked-out

1 version?

2 MR. SULLIVAN: Oh, my goodness.

3 MS. O'DEA EVANS: It looks like the changes are  
4 in italics.

5 MR. SULLIVAN: No, no. The italics means  
6 statutory language. Let me -- it would be a matter of  
7 taking the existing rules and putting them side by side. I  
8 can do a cross -- I'll do a cross walk.

9 MS. DEDERER: You really would do that?

10 MR. SULLIVAN: I would do that.

11 MS. DEDERER: You are the most wonderful  
12 person.

13 MR. SULLIVAN: I will do a topical cross walk,  
14 section to section. I don't think I have a red line.

15 MS. DEDERER: That's fine. But topical would  
16 be great.

17 MR. SULLIVAN: We had 87 versions that we  
18 worked on.

19 MS. DEDERER: That's great, side by side would  
20 be wonderful.

21 MS. MITZEN: So, if that could come out with  
22 this --

23 MS. DEDERER: If any of us are inclined to  
24 look at it.

1 MR. URSO: In your initial package, when we  
2 had our first meeting, you did receive the current Act, as  
3 well as the Rules, just so you know, in case you wanted to  
4 look back on that.

5 MS. DEDERER: Right.

6 CHAIRMAN WAXMAN: Okay. So we have -- I think  
7 we've reached a point where -- I guess we have to do  
8 adjournment. Thank you, Staff, for all of the work that  
9 they've done.

10 (Applause)

11 CHAIRMAN WAXMAN: Really appreciate the  
12 presentation and all of the work that went behind the  
13 presentation. I know it took a lot of time, and we do  
14 appreciate that.

15 Outside of that, I need a motion to adjourn.

16 MR. PHILLIPPE: So move.

17 MS. O'DEA EVANS: Second.

18 CHAIRMAN WAXMAN: I have a motion from Tim and  
19 a second from Pat. All in favor?

20 (Ayes were heard)

21 CHAIRMAN WAXMAN: And any opposed?

22 (No response)

23 CHAIRMAN WAXMAN: I'd like to thank all of you  
24 for coming today, and have a happy holiday, and I'll see

1 you in January.

2 END TIME: 1:49 P.M.

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CERTIFICATE OF REPORTER

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

\_\_\_\_\_

KAREN K. KEIM  
CRR, RPR, CSR-IL, CCR-MO

A				
<b>AARP</b> 4:21	54:1 86:19	<b>adult</b> 11:12 24:23 41:12,17,18	<b>already</b> 40:19 41:5 89:24 95:12 101:18 109:10 110:21 112:11,22 118:5,13,15	85:22 95:4,6 116:20
<b>ability</b> 26:18 122:6	<b>accounted</b> 17:15 86:15	<b>advisory</b> 1:9,12 84:10	101:18 109:10 110:21 112:11,22 118:5,13,15	<b>anyway</b> 7:13 46:19 65:8,8 116:24
<b>able</b> 19:11 38:20 64:2,4 72:6 76:15 80:4 81:7	<b>accurate</b> 23:23 28:3	<b>Advocates</b> 57:9	118:5,13,15	<b>anywhere</b> 13:4 14:14 105:20 106:2
<b>about</b> 8:1 10:6 11:24 12:8 13:3,5 13:22 14:17,22 16:21,21 17:14 24:18 26:15 28:23 31:2,16 34:2 38:11 40:24 42:19 43:16 45:20 49:17 52:19 54:17 56:22 56:23 61:8 62:19 63:1,3 65:2 69:8 73:22 74:3 75:1 79:11 80:14 81:4 81:24 82:1,6,11 83:13 84:15 85:8 85:9,17,19 86:12 87:2,7 88:2,13,21 89:2 90:16 91:11 91:13 92:1 93:20 94:24 95:10,11,14 95:16 96:8 97:7 97:12,16,19,21,22 98:1,4,7,20 99:2 99:23 100:6,12,15 101:4,7,13 103:13 103:17 104:14 105:1,2,8,10,11 105:19,21 106:2 108:11,12,13 109:21 110:3,17 111:6 114:6,7,13 117:7 118:9	<b>across</b> 38:2 67:16	<b>affect</b> 45:6	<b>alternative</b> 37:1 39:19 40:3,12	<b>apartment</b> 60:18 64:11,14
<b>above</b> 19:1	<b>act</b> 3:11,12 11:5,10 11:12,14 12:3,3,4 12:5,7,22 13:4,6 13:14,15,16,17 39:8,9,19 95:18 96:1,17 97:9,13 101:16 120:2	<b>affected</b> 63:24 64:2 67:22	<b>alternatives</b> 74:1	<b>apartments</b> 60:16 63:10,15
<b>above-entitled</b> 122:5	<b>action</b> 96:16 98:7	<b>affiliated</b> 66:14 67:22	<b>although</b> 39:23 52:13 92:4	<b>apologize</b> 20:19 41:22
<b>absence</b> 48:15	<b>activities</b> 3:8 98:9	<b>after</b> 52:8,22 58:2 68:11 84:1 96:9 96:19 103:23 106:16 109:20 113:15 115:4,14	<b>Altman</b> 2:6 52:15 57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>appeared</b> 104:1
<b>Absolutely</b> 15:4 26:13 53:22 94:13	<b>activity</b> 93:14	<b>again</b> 7:19 14:8 16:2 34:8,9,11,19 34:21 39:17 41:5 41:20 42:1,2 44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>Applause</b> 74:15 120:10
<b>accelerated</b> 36:24	<b>actual</b> 38:17 103:16	16:2 34:8,9,11,19 34:21 39:17 41:5 41:20 42:1,2 44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>apples</b> 108:12,12
<b>accept</b> 6:12	<b>actually</b> 21:10 30:22 45:22 48:1 49:19 50:1 51:6 51:10,19,20 76:3 85:7 87:6 90:22 91:8 92:2,8 93:2 93:22 96:24 104:2 104:17 110:5	41:20 42:1,2 44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>applicable</b> 14:12 39:14
<b>acceptable</b> 36:22 46:23 94:12,20	<b>acute</b> 30:20 80:4	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>applicant</b> 52:7 70:2
<b>accepted</b> 52:11,14	<b>add</b> 16:6 44:3 45:17 65:21 69:23 77:1 91:9 114:3,11	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>applicants</b> 71:2
<b>access</b> 43:6 48:14 48:17 60:2 75:1,8	<b>addition</b> 15:24 16:5 31:1	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>application</b> 11:8 42:23 73:7,8
<b>accommodate</b> 38:3 45:13	<b>additional</b> 36:18 57:19 69:4 91:9 118:14	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>applied</b> 61:18
<b>accomplished</b> 116:21	<b>address</b> 28:21 29:10 47:2 60:23 62:13 73:24 76:1 80:4 93:7	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>apply</b> 13:18 65:10
<b>account</b> 24:21 37:5 37:6 43:15,20	<b>addressed</b> 13:20 27:7 30:12 36:20	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>appreciate</b> 4:9 7:4 9:11 74:21 76:24 77:9 117:11 120:11,14
	<b>adds</b> 11:19	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>appropriate</b> 53:5
	<b>adequately</b> 83:9	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>approval</b> 3:3,4 6:7
	<b>adhere</b> 97:8	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>approvals</b> 84:13
	<b>adjourn</b> 120:15	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>approve</b> 5:21 43:24 92:12
	<b>adjournment</b> 3:15 120:8	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>approved</b> 6:6 18:6 84:6 89:4 92:7
	<b>adjust</b> 23:1,3,19 92:12	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>approximately</b> 11:18 16:18,19,20 17:12,13 35:9,15 69:14
	<b>adjusted</b> 32:2	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>April</b> 37:14 39:14
	<b>ADL's</b> 31:3	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>ARDC's</b> 87:13
	<b>Administrative</b> 18:17,19 96:17	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>area</b> 4:15 20:2,3 21:14 22:20,20 31:10,14 34:7,10 34:12 35:14,16 36:10 42:3,7 43:3 43:5 44:18,18,23 45:15 47:3,5,12 48:4,15,15,20,22 49:1 52:7 53:12 58:16 62:14 65:10 65:22 66:6,7,11 69:4 75:5 106:13
	<b>admission</b> 48:21,23 63:9	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	<b>areas</b> 18:22,23 19:6 19:9,9,18,18,23 19:23,23 20:1,10
	<b>admissions</b> 42:5	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	
	<b>admit</b> 61:2 64:2	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	
	<b>admitting</b> 65:14	44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	
		44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	
		44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	
		44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	
		44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	
		44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	
		44:12 45:18 48:17 48:24 50:22 58:1 62:19 64:15 68:21 74:21 75:15 76:1 76:5,20 78:13 80:23 85:2 102:16 105:18 109:19 110:23 111:18	57:7,8 66:21 67:21 79:3 86:3 87:11,13 88:18,24 89:22 90:10,18 91:2 100:9 102:1 110:13,20 111:3 112:2,9,18 113:1 113:19 114:13 117:18	
	</			

<p>20:18 21:20,22 34:8 35:19 40:5 41:9,12,13 45:2 46:10 49:2 74:6 85:11 86:13 87:1 88:16 91:22 93:4 106:15 <b>area's</b> 41:18 <b>arguably</b> 88:16 <b>argument</b> 96:15 <b>arms</b> 28:10 <b>around</b> 7:18 8:18 15:15 28:10 92:16 93:5 116:14 <b>arranged</b> 10:14 <b>artificially</b> 56:11 <b>aside</b> 41:6 <b>asked</b> 7:1 8:21 9:3,8 10:6 27:4,18 89:9 <b>asking</b> 25:15 47:10 59:22 73:12 89:5 109:24 110:4 <b>assemble</b> 76:20 <b>Assembly</b> 18:18 <b>assess</b> 92:7 <b>assessing</b> 91:21 <b>assessment</b> 87:24 <b>assisted</b> 11:15 12:8 24:23 27:24 28:10 28:13 79:14 107:11 <b>Associates</b> 5:6 <b>association</b> 9:20 104:1,10 115:22 115:22 <b>associations</b> 4:17 9:22 100:19 103:2 103:23 104:9 105:4 113:11 <b>assume</b> 92:24 109:24 <b>assuming</b> 54:2 64:18 67:5 113:15 <b>assumption</b> 14:11 25:3 <b>assumptions</b> 25:16 26:12 82:8 110:18 <b>assurance</b> 58:1 <b>asterisk</b> 45:19 65:21 <b>Attendees</b> 77:10 <b>attention</b> 29:6 <b>attest</b> 47:11 52:6 71:10 <b>attorney</b> 122:9 <b>attract</b> 43:17 <b>attractive</b> 54:16 <b>auspices</b> 39:23 <b>authority</b> 25:13</p>	<p>26:11 <b>authorized</b> 11:20 16:1 18:6,8 <b>availability</b> 68:23 70:8 79:16 108:22 <b>available</b> 10:16 38:4 45:4 51:13 70:2 70:10 109:4 <b>Avenue</b> 1:22 <b>average</b> 17:13 35:10 37:3 52:6 56:21 56:22 59:19 69:13 69:13 75:7 <b>aware</b> 22:14 108:19 <b>away</b> 105:22 <b>awfully</b> 42:14 <b>Ayes</b> 6:3,19 120:20 <b>A's</b> 87:9 <b>a.m</b> 1:14 4:1</p> <hr/> <p style="text-align: center;"><b>B</b></p> <hr/> <p><b>b</b> 3:12 21:20 <b>back</b> 9:18 10:3 15:2 19:15 20:6,8 24:17 31:13 37:22 39:19 45:8 58:5,6 64:13 68:13 74:24 75:23 76:15 77:8 77:12 83:15,17 88:22 89:1,4,21 89:23 90:4,12 92:4 94:8 95:7 103:10 105:16 107:16 108:7 112:19 113:3 115:5 120:4 <b>background</b> 74:1 103:14 108:15 <b>backgrounds</b> 93:15 <b>backwards</b> 102:8 <b>bad</b> 85:4 <b>Ballard</b> 4:24 <b>ballgame</b> 30:14 <b>bank</b> 70:9 <b>bare</b> 7:22 <b>base</b> 22:19 24:7,10 24:13 34:24 46:14 103:9 109:15,18 114:1,8 <b>based</b> 20:3,4 24:19 25:16,22 26:5,6 33:10,11,21 35:11 37:7 38:6 46:21 49:14 50:11,17,21 55:1,23 69:5 71:17,22 78:8 104:7,7 105:1 <b>basic</b> 82:8</p>	<p><b>basically</b> 21:1 24:17 81:3 84:9,10 85:21 86:10 110:20 <b>basing</b> 28:2 55:6 <b>basis</b> 50:22 51:17 84:7 97:17 105:9 115:1,12 <b>became</b> 62:5 104:4 <b>become</b> 94:4 102:20 102:23 <b>becomes</b> 109:20 <b>bed</b> 18:8 19:2,3,20 20:3 24:19 25:16 25:22 27:21 28:3 31:11 35:11 36:18 38:6,7 41:15,16 41:17,18 42:2,19 44:4 45:18 49:23 50:3,7 51:1 60:8 60:15,24 61:5,12 63:12 65:10 66:3 69:5,6 72:2 74:6 80:2 83:9 91:21 <b>beds</b> 11:19,20,20 14:1 15:24 16:1,5 16:6,9,10,18,20 16:22 18:5,6,10 18:10,12 28:11 30:20,21,24 33:19 33:20 35:12,16 41:20,23 42:3,9,9 42:10,24 43:2,5,6 43:7,9,22,24 44:3 45:3,17 48:15,19 49:14,19,23,24 50:4,4,7,11,12,17 50:24,24 51:2,4 51:11,20 52:5 54:5 57:21 59:14 62:14 65:2 68:19 68:21 69:3,4,23 75:5 80:3,5,7,12 82:1,2 86:18 88:4 88:4 91:22 93:3 105:1 <b>bed-need</b> 21:24 24:16 29:21 38:2 41:23 43:1 91:12 104:23 <b>before</b> 8:4,24 9:9 12:23 16:8 22:5 31:16 39:1 49:18 57:5 72:11 73:14 73:15,20 74:4 81:21 92:6 94:14 95:2,7 96:13 101:14 102:17,22</p>	<p>104:1 105:16 111:14 113:3 118:7,9 <b>begin</b> 40:19 94:4 <b>beginning</b> 1:13 <b>behalf</b> 4:10 105:3 <b>behind</b> 27:16 48:11 100:10 113:9 117:2 120:12 <b>being</b> 8:23 9:7 13:17 18:9 33:17 51:3,8,8,9 55:9,24 70:11 76:22 77:1 79:15 106:3 114:23 <b>belief</b> 83:14 <b>believe</b> 11:10 12:12 20:17 21:22 23:1 24:13 42:21 80:3 <b>below</b> 15:23 36:15 36:16 37:4 <b>benefit</b> 83:20 <b>best</b> 22:17 110:11 111:13 122:6 <b>bet</b> 54:8 <b>better</b> 10:9 38:2 43:18 80:8 92:11 92:13 110:19 <b>between</b> 18:5 33:7 33:15,16 49:22 55:12 56:19 64:3 69:11 86:17 87:18 87:21 88:8,14 93:23 95:20 101:24 111:8,15 <b>beyond</b> 91:21 <b>Bibo</b> 2:8 4:16,16 11:22,22 12:23 13:10 14:21 63:17 66:24 81:19 82:6 83:8,24 91:4 94:14 95:14 108:11 115:7 116:3 <b>big</b> 70:17 77:8 106:11 <b>bigger</b> 113:1 <b>biggest</b> 20:19 <b>Bill</b> 2:19 5:14 10:11 74:19 113:23 <b>Bill's</b> 23:2 <b>birth</b> 23:14 <b>births</b> 23:3,7,16,19 23:22 31:22 34:14 <b>bit</b> 46:16 75:21 91:24 <b>board</b> 1:2,12 5:4,19 12:15 14:4,24</p>	<p>16:15 18:7,7,20 19:19,22 26:19,24 27:5,14 28:22 29:3,4 37:20 39:24 71:7 73:14 73:15,20,23 76:3 77:5 84:10,11 89:14,15 92:7 94:3 98:18 102:19 104:20 116:14 118:11 <b>Board's</b> 78:7 96:16 <b>body</b> 40:18 100:23 <b>Bonnie</b> 2:20 5:16 74:19 <b>books</b> 80:6 <b>borrowing</b> 71:10 <b>both</b> 21:24 22:19 59:16 65:23 85:14 <b>boundaries</b> 66:5 <b>boxes</b> 21:2,7 <b>Boy</b> 72:19 <b>bracket</b> 32:5,7 35:2 <b>brackets</b> 34:9,21 35:4 <b>brand</b> 81:4 <b>break</b> 35:18 43:12 46:15 57:2,4 80:23 115:4 <b>breaking</b> 116:3 <b>briefly</b> 73:22 85:9 <b>bring</b> 8:13 15:2 27:1,5,13 111:18 115:5 <b>bringing</b> 108:7 <b>brings</b> 34:15 <b>broad</b> 91:24 <b>broadier</b> 82:12 109:14 <b>brought</b> 59:4 78:8 93:16 115:20 <b>Bud</b> 72:13,15 <b>budget</b> 78:7,10 <b>build</b> 38:18 54:3,7 105:20 106:1 <b>building</b> 54:3,4,7 55:19 56:1 59:21 69:19 81:4 <b>buildings</b> 52:20 54:14,16,20 <b>built</b> 46:2 64:3 72:6 72:19,21,22 95:6 106:3 <b>bullet</b> 77:22,23 <b>bunch</b> 87:9 <b>Burden</b> 2:2 5:3,3 29:2,6 66:19 89:17</p>
--	---	---	--	--

<p><b>business</b> 3:10 8:1 44:19 54:11 68:15 95:11 96:2 97:3,8 97:12,16,17,19 98:8,10,20 99:2 <b>buy</b> 93:2</p> <hr/> <p style="text-align: center;"><b>C</b></p> <hr/> <p><b>C</b> 21:20 <b>calculate</b> 19:20 25:22 32:5 34:18 42:2 <b>calculated</b> 27:21 32:3 35:11 41:17 42:24 60:8 69:5 74:6 <b>calculation</b> 30:18 35:17 69:5 <b>calculations</b> 21:24 38:17 42:20 <b>California</b> 107:20 107:23 <b>call</b> 3:2 4:3,8 7:10 18:10 66:5 73:10 94:18 118:3 <b>called</b> 33:11 49:24 61:11 <b>came</b> 9:15 19:16 41:21 76:10 79:6 79:10 86:9 89:13 91:17 103:15,17 104:19,21 <b>campus</b> 65:15,15 72:20 <b>capable</b> 51:2,8,12 <b>capacity</b> 16:1 19:3,4 22:6 <b>capital</b> 15:23 17:9 17:11,13,15 54:22 55:7 56:14 69:10 69:13 70:18 71:20 <b>capitalize</b> 41:5 <b>care</b> 1:9,12 4:16,19 5:13 9:22 10:22 11:4,11,12,14,17 11:21 12:5,7 13:16,17 15:22 16:13,19,20,21 17:2,10 19:2,3 22:1 24:18,20 30:16,20 31:11,20 38:6,7,11,13 39:4 39:12,21 41:9,15 42:21 43:5 44:13 46:1 47:10 48:24 53:12,24 60:5,6 60:12,19 63:12,20 64:12 65:1,23</p>	<p>69:15 72:11,17 73:2 79:19,20,24 80:4 81:6,21,22 81:24 82:2,3,4 83:19 84:20,21 87:5 88:8,15,17 88:19 90:9 91:19 96:2 97:17 98:10 98:16,18 103:24 106:2 108:2,5 109:23 111:1 115:22 <b>careful</b> 97:11 <b>Carolyn</b> 2:9 4:18 <b>carries</b> 6:22 <b>carry</b> 27:3 <b>case</b> 23:20 31:21,23 35:1,12 42:7 55:13 70:8,21 87:8 120:3 <b>cases</b> 13:15 <b>cash</b> 70:10 <b>casting</b> 41:6 <b>categories</b> 60:5 94:10 <b>category</b> 39:12,13 67:19 69:6 <b>Catholic</b> 67:23 <b>caught</b> 28:7 <b>cause</b> 53:8 122:5 <b>causes</b> 106:3 <b>CCRC</b> 63:6,13 64:1 83:14,18 <b>CCRCs</b> 64:1 65:7 <b>CCR-MO</b> 122:15 <b>cell</b> 7:20 118:4 <b>census</b> 35:10 47:6 51:20 <b>centers</b> 82:15,16 108:8 <b>certain</b> 26:18 44:22 45:2 64:3 113:4 <b>certainly</b> 8:2 93:9 93:14 <b>Certificate</b> 3:6 11:16 15:21 17:6 18:7 42:23 90:9 105:15 122:1 <b>Certified</b> 122:3 <b>certify</b> 122:5 <b>cetera</b> 91:23,23 93:4 <b>Chair</b> 26:23 99:9 <b>Chairman</b> 2:1 3:5 4:3 5:1,23 6:2,4,6 6:14,17,20,22 7:7 7:13 8:9,11,14,17 8:21 9:3,14,17</p>	<p>10:2,5,13,17 13:8 14:20 15:1 18:16 25:6 26:16 28:6 28:17,20 29:9 30:1,7,13 34:3 35:20 38:9,24 43:11,19 44:11 45:1 46:6,19 50:3 50:8,10,15,19 52:1 55:5,20 56:21 57:2,3,10 57:13,16 59:18 60:1 63:5 64:15 64:18,22 72:13,17 72:21,24 74:11,13 74:20 75:15,18 76:11,17,24 77:11 77:14,18,21 78:10 78:23 79:4 80:22 81:15,17 82:17,22 83:23 84:24 85:2 85:13,22,24 86:7 90:16 91:6 93:13 93:22 94:16,22 95:2 99:14,17,21 100:3 102:6,16 103:7,20 108:21 109:2,6,19 111:4 111:10,24 112:7 112:16,21 113:8 115:2 116:1,10,19 117:1,6,16,21 120:6,11,18,21,23 <b>challenges</b> 27:13 93:7 <b>challenging</b> 29:19 <b>chance</b> 118:24 <b>change</b> 12:14 15:22 16:7 25:23 29:14 36:22,23 101:16 105:5 110:5 <b>changed</b> 25:4 27:2 37:11,12,13 61:11 61:13 63:2,6 <b>changes</b> 65:13 68:5 119:3 <b>changing</b> 25:24 26:11 37:8 86:23 104:14 105:6 <b>characterize</b> 67:9 <b>charge</b> 86:14 <b>Charles</b> 2:21 9:24 19:15 <b>Charlie</b> 19:12,13 32:10 61:15 62:10 <b>chart</b> 46:11 <b>check</b> 90:3 109:3 117:23</p>	<p><b>checking</b> 88:22 <b>Chicago</b> 1:23 21:11 36:5 39:15,16 71:23 72:2 84:18 84:19 85:10 <b>children</b> 11:13 39:12 40:5 41:11 41:16 <b>children's</b> 39:15 <b>chime</b> 86:6 <b>choice</b> 44:23 83:3 105:5 <b>choices</b> 87:4,23 <b>choose</b> 64:22 68:1 82:23,24 <b>Christian</b> 5:7 <b>Chronic</b> 41:9 <b>Chuck</b> 72:4 <b>churches</b> 81:5 <b>CILA</b> 87:14 <b>Circle</b> 66:19 <b>citations</b> 53:20 <b>cite</b> 53:13 <b>City</b> 21:11 <b>clarification</b> 13:9 38:5 92:16 <b>clarify</b> 3:11 29:2 95:17 118:19 <b>Claritas</b> 47:6 <b>classes</b> 60:10 <b>clear</b> 80:11 81:23 82:5 <b>clearly</b> 64:12 <b>clique</b> 7:10 <b>close</b> 98:22 111:22 <b>closer</b> 29:21 <b>closes</b> 73:21 <b>closing</b> 98:24 <b>code</b> 18:17,18 <b>coincide</b> 31:22 <b>COLA</b> 56:6 <b>COLAs</b> 56:11,12,13 <b>collar</b> 84:18,19 <b>collect</b> 17:6,9 24:2 25:12 <b>collected</b> 31:19 40:20 <b>collecting</b> 40:1 89:24 <b>combine</b> 41:13 94:9 <b>come</b> 9:4,10 10:6 23:4 29:18 31:5 38:2 46:12,20 47:5 48:1,4 59:7 59:11,14 66:12,16 66:21 67:5 75:23 77:8 94:8 103:10 117:11 119:21</p>	<p><b>comes</b> 96:11 100:3 100:11 <b>comfortable</b> 7:15 <b>coming</b> 36:12 46:9 69:17 80:18 107:14 113:8 120:24 <b>comment</b> 24:16 37:19 41:1 45:7 50:22 62:21 63:3 73:15,16,20 75:1 81:20 106:20 113:8 <b>commenting</b> 12:16 82:10 112:12 <b>comments</b> 42:15 73:17,18 104:3,7 <b>Commerce</b> 22:24 23:18 35:7 <b>commitment</b> 116:8 <b>committee</b> 7:3 9:7 9:15 13:2 15:3 26:10 27:20 46:7 76:8,19 97:5 98:10,19 103:1 110:8 113:7 <b>committees</b> 85:18 <b>commonalities</b> 111:19 <b>commonality</b> 78:1 <b>communicated</b> 96:18 101:19 <b>communication</b> 96:6,14 <b>community</b> 24:22 58:11,12 60:22 61:2 63:11,19,21 64:2 <b>community-base</b> 79:16 <b>community-related</b> 57:23 58:8 68:22 <b>compare</b> 30:24 75:6 <b>comparing</b> 108:12 108:19 <b>compile</b> 11:9 <b>complains</b> 98:17,21 <b>complete</b> 7:24 23:22 24:14 73:11 <b>completed</b> 58:21 <b>completely</b> 14:23 <b>completeness</b> 73:8 <b>completion</b> 52:8 58:2 <b>complex</b> 60:15 <b>component</b> 54:22 55:17 56:15 60:13 <b>composed</b> 107:4</p>
--	---	--	---	---

<p><b>comprehensive</b> 30:10 62:24  <b>compress</b> 37:17  <b>comprised</b> 22:22  <b>computed</b> 61:5,12 66:3  <b>CON</b> 11:5 26:19,23 27:5,14 28:22 29:3 44:3 69:17 72:21 76:3 78:7 89:14 92:7 105:22 106:1 107:16 108:4,7,11 109:22 110:3,8,15,15,21 111:2  <b>conceivably</b> 43:23  <b>concept</b> 91:11,17 92:15  <b>concern</b> 45:11  <b>concerned</b> 52:19 110:17  <b>concerning</b> 96:16  <b>conclusion</b> 36:18 79:7  <b>conditions</b> 44:13 64:12 118:6  <b>conference</b> 94:18  <b>confirmed</b> 44:1  <b>conflict</b> 116:13  <b>Confused</b> 17:23  <b>connotation</b> 92:5  <b>CONS</b> 107:18  <b>consensus</b> 107:12 107:14  <b>consequences</b> 44:19 102:4  <b>consider</b> 18:7 40:10 40:18 75:6,7 78:7 82:3 93:10 115:11  <b>considered</b> 21:14 52:9 60:8 74:1 79:15  <b>considering</b> 14:4  <b>consistency</b> 77:6 84:2,2,12  <b>consistent</b> 69:1  <b>CONSTANTINO</b> 10:11,20 11:3 12:20 15:20 16:7 16:9,12 17:1,3,5,9 17:18,21 18:2,21 19:7 20:9,14,17 21:4,8,11,16,19 22:4,8,11,14 23:16 24:5,8,11 25:10,19 26:1,6 30:9,19,23 31:4,9 32:14,16,23 33:2</p>	<p>33:6,9,12,18 34:6 34:14 35:22 37:10 37:14 38:12,20 39:3,11 40:10 41:8 42:13,15,18 43:13 47:1,16 48:2,7,10,13 49:11,13,15,21 52:2,21 57:1,14 57:19 58:5,10,14 58:18,22 59:11,14 60:4,23 61:3,9,14 61:19,23 62:2,5,9 62:15,18 63:7,22 65:4 66:1,17,20 67:3,7,13 68:17 69:20,23 71:1 72:9 73:7 74:18 75:4,11 110:1  <b>construction</b> 17:17 72:1 95:12  <b>consultant</b> 9:24  <b>consumer</b> 104:23  <b>consumers</b> 46:5  <b>contact</b> 7:2  <b>contained</b> 67:18  <b>context</b> 79:15  <b>continue</b> 14:22 29:24 39:1 46:24 53:18 57:17 95:13 107:17  <b>continues</b> 13:15  <b>continuing</b> 65:1  <b>continuum</b> 60:5,12 65:23 82:3  <b>contract</b> 89:19  <b>conversation</b> 65:22  <b>conversations</b> 98:8  <b>converted</b> 51:24  <b>convinced</b> 10:23  <b>Cook</b> 4:15 21:3,4,4 21:12,13 84:18,19  <b>cool</b> 7:7 77:2 95:8  <b>cooler</b> 7:10  <b>coordinate</b> 78:21  <b>coordinated</b> 15:13  <b>coordination</b> 87:8  <b>copies</b> 47:7  <b>correct</b> 21:2 25:9 33:10 47:18 49:21 62:15 64:9 66:20  <b>correctly</b> 14:24 26:2 60:21  <b>correlate</b> 23:8,13 24:1,6  <b>correspondence</b> 68:24  <b>cost</b> 55:6,12 56:24</p>	<p>71:17,20,22 79:20 106:2  <b>costing</b> 108:9  <b>costly</b> 71:10  <b>costs</b> 55:1 56:20 71:19  <b>cost-based</b> 56:4  <b>council</b> 58:16 103:24  <b>counsel</b> 2:18 5:19 5:19 122:7,10  <b>count</b> 77:10 91:21  <b>counter</b> 36:14  <b>counties</b> 20:10 21:2 21:5,7 31:15 34:15,17 84:18,19 88:17  <b>county</b> 4:15 16:2 21:12,13 31:10,12 34:7,8,10,12,16 34:16 35:14 36:1 36:2 42:8  <b>couple</b> 8:22 88:17 93:23  <b>course</b> 39:14 98:9  <b>Court</b> 122:3  <b>cover</b> 78:12  <b>covered</b> 61:7  <b>creative</b> 30:6 93:6  <b>creativity</b> 91:18  <b>criteria</b> 57:20 65:24  <b>criterion</b> 65:24  <b>critical</b> 51:22  <b>cross</b> 119:8,8,13  <b>crossed</b> 98:1  <b>CRR</b> 1:21 122:3,15  <b>CRR-MO</b> 1:21  <b>crunch</b> 93:19  <b>CSR-IL</b> 1:21 122:15  <b>curious</b> 46:3  <b>current</b> 3:6 11:5,6 16:12 18:3 23:5,6 24:20 26:5 27:13 27:22 30:9 44:9 44:17 51:23 60:9 61:6 93:19 105:8 114:18 120:2  <b>currently</b> 10:7 30:3 35:14 73:12 86:11 87:20 91:12 103:8 104:20 114:1  <b>cut</b> 95:3</p>	<p>26:13 77:20 100:8 116:15  <b>data</b> 23:8,10,11,23 23:24 24:1 25:12 27:22 31:3,24 35:6 37:7 40:1,2 40:15,20 47:6,7 58:24 59:5,9 71:17,22,23 75:10 88:22 89:23  <b>date</b> 101:16,17  <b>Dates</b> 3:14  <b>daunting</b> 106:18  <b>Dave</b> 2:4,5 4:20 76:14  <b>day</b> 11:1 47:20 101:6  <b>daycare</b> 24:23  <b>days</b> 31:18,19,21 32:4,22 33:6,7 34:9,19 35:8,9 38:16,17 42:4 71:19,20 73:14,15 73:18,20 78:15  <b>DD</b> 14:12 16:21 41:11,12,16,17 42:6  <b>deadline</b> 102:23 103:6 104:5 115:13  <b>deal</b> 108:15 110:23  <b>dealing</b> 78:2  <b>dealt</b> 29:3  <b>death</b> 23:14  <b>deaths</b> 23:4,7,16,19 23:22 31:23 34:13 34:14  <b>debate</b> 14:8  <b>debated</b> 91:15 110:9  <b>debating</b> 11:24  <b>debt</b> 71:9,13,14  <b>decades</b> 37:9  <b>December</b> 16:23  <b>decide</b> 27:1 94:1 110:8 111:20  <b>decided</b> 13:17 88:10 91:20 110:21  <b>decision</b> 92:12 95:20  <b>decisions</b> 51:15 80:16,17  <b>decrease</b> 13:24  <b>Dederer</b> 2:16 5:11 5:11 7:12 8:6,10 8:12,16,20 12:18 15:5,11,11,17 16:4,8,11,24 17:2</p>	<p>17:4,8 20:23 22:2 22:5,9,12 25:21 26:5 38:15,22 43:15,21 44:5,7 47:15,17,22 49:22 50:6,9,13 53:11 53:18,23 54:13 56:2,11,17 63:8 63:14 64:10,17 75:17 76:15 78:6 78:16,20 87:12 89:13,18 94:13 97:15 98:3,13 99:4,9,12,16,23 100:1,6 102:8 103:3,19 105:12 105:14 107:12 109:18 111:6 112:3,5 113:6,21 114:17 117:19 118:23 119:9,11 119:15,19,23 120:5  <b>Dees</b> 2:14 5:12,12  <b>Deficiency</b> 13:16  <b>define</b> 66:5 81:1,24 82:2,7  <b>defined</b> 11:12 26:17 60:6 65:24 66:2,4 66:8,13,14,15 67:1,24 68:13 96:12  <b>defining</b> 83:14  <b>definitely</b> 15:9,9 79:6  <b>definition</b> 82:5 96:19  <b>definitions</b> 21:21  <b>deliberating</b> 26:9  <b>deliberation</b> 114:23  <b>delivery</b> 107:24  <b>demand</b> 43:4 44:15 45:5 47:9  <b>demands</b> 44:17  <b>demo</b> 39:21  <b>demographics</b> 47:6  <b>demonstrate</b> 93:15  <b>demonstration</b> 39:18,24  <b>Department</b> 5:10 5:12,14,16 12:21 13:14,15 22:24 23:2,18 35:6 40:1 50:23 51:4 53:4  <b>Department's</b> 12:11  <b>dependent</b> 50:13  <b>depending</b> 112:12  <b>describe</b> 86:10 87:3</p>
--	--	---	--	--

<p><b>described</b> 87:1  <b>description</b> 86:19  <b>designate</b> 75:22  <b>destroy</b> 114:2  <b>detail</b> 13:11 20:5  <b>deter</b> 45:16  <b>determine</b> 22:19  33:19 34:22 41:19  105:20 112:15  <b>determining</b> 91:24  <b>develop</b> 76:4 84:4  94:2  <b>developed</b> 37:22  48:11 98:6  <b>development</b> 24:22  37:1 70:15 105:9  <b>Developmental</b>  15:6  <b>developmentally</b>  14:7 41:19  <b>DHS</b> 5:11 15:7  68:24  <b>Dialysis</b> 88:18  <b>Diane</b> 2:15 5:9  <b>dictate</b> 25:16  <b>dictated</b> 106:5  <b>die</b> 105:5  <b>difference</b> 18:5  33:15,16 49:22  86:17  <b>differences</b> 85:10  85:12  <b>different</b> 13:24  28:11 30:5 34:17  36:2 46:2 66:6  82:21 83:11 88:5  93:3,3 104:15  106:8 107:24  <b>differently</b> 27:8  <b>difficult</b> 86:22  104:18  <b>dim</b> 57:17  <b>diminishing</b> 44:19  <b>dinosaur</b> 105:4  <b>direct</b> 71:18  <b>directed</b> 30:4  <b>directions</b> 28:12  <b>directly</b> 66:13  <b>Disabilities</b> 15:7  <b>Disability</b> 57:8  <b>disabled</b> 14:7 41:19  <b>disagree</b> 12:2,3  103:12  <b>disagreement</b> 14:17  <b>disapproved</b> 84:6  <b>discharge</b> 87:10,15  <b>discontinuation</b>  15:21</p>	<p><b>discuss</b> 11:3 29:18  55:11 97:2 105:16  <b>discussed</b> 26:17  88:4 90:7 91:15  103:4  <b>discussing</b> 96:2  <b>discussion</b> 3:6,8  15:7 78:22 79:8  80:2,11 81:13  109:23 117:15  <b>discussions</b> 12:20  12:21 95:13  104:14,22 105:3  114:18  <b>dispute</b> 13:3  <b>disruptive</b> 106:12  <b>dissect</b> 29:16  <b>distinct</b> 18:10  <b>distinction</b> 88:14  <b>distinctions</b> 88:7  <b>distributed</b> 118:20  <b>diversity</b> 93:15  <b>divide</b> 18:24 31:16  35:10 46:8 75:19  94:9 113:2  <b>divided</b> 18:21 19:6  19:17 42:11  102:18 111:15  <b>dividing</b> 32:3 34:19  41:18  <b>division</b> 15:6 23:2  <b>divorce</b> 56:19  <b>document</b> 20:21  100:16 103:10  113:18 114:16,20  114:24 118:8,16  118:20  <b>documentation</b>  47:2,3,9 48:14,23  52:2 57:20 60:17  68:22  <b>documented</b> 100:20  <b>documents</b> 103:14  <b>Dodgin</b> 2:4 4:20  <b>doing</b> 30:3,5,8 35:4  45:17 51:6 68:15  69:21 83:10,11  84:23 87:18 90:8  93:5 101:3  <b>dollars</b> 11:19 15:24  69:12  <b>done</b> 7:14 10:7  13:14 19:9 27:11  38:15,23 40:13  41:6 46:8 56:5  83:17 95:5 101:21  102:11,22 105:21  107:8 109:10</p>	<p>110:12,23 112:22  113:15 115:17  118:15 120:9  <b>door</b> 7:16,16,17,17  <b>doubt</b> 28:12  <b>down</b> 7:22 18:1  34:15 35:18 68:20  77:19 85:5 98:19  104:12  <b>downstate</b> 85:11  <b>Dr</b> 5:3 29:2,6 66:19  89:17  <b>drafted</b> 45:12  <b>drafts</b> 112:19  <b>drawn</b> 101:10,12  <b>drive</b> 1:15 88:17  <b>due</b> 48:17  <b>DuPage</b> 21:13  <b>duplication</b> 43:7  52:3  <b>during</b> 45:9 73:9  <b>duties</b> 26:22  <b>dynamic</b> 29:24  <b>dynamics</b> 37:8</p> <hr/> <p style="text-align: center;"><b>E</b></p> <p><b>each</b> 20:12 21:2  30:16 32:5,7  38:18 46:9 75:20  75:24 77:23 93:14  104:10  <b>earlier</b> 4:6 12:9  45:8 52:18  <b>easier</b> 20:1 54:6  89:15  <b>easy</b> 60:2 86:22  <b>economic</b> 23:1,18  35:7 74:9  <b>economically</b> 70:3  71:8  <b>Eden</b> 82:15  <b>effect</b> 19:16 44:15  69:18 71:19  <b>effective</b> 39:13 62:5  80:1 92:8  <b>eight</b> 41:13 76:6  85:19  <b>eight-plus</b> 69:11  <b>either</b> 66:3 76:4  <b>elements</b> 36:20  <b>Eli</b> 2:13 4:24 6:14  7:3,4,8 37:23  63:22 86:3 87:5  88:12 90:10 94:17  105:12 110:20  118:7  <b>eliminated</b> 61:14,22  61:24 62:1,8</p>	<p><b>emerging</b> 88:7  <b>employed</b> 122:8,10  <b>employee</b> 122:9  <b>encourage</b> 91:18  <b>encouraging</b> 92:1  <b>end</b> 4:5,6 7:24 8:1  16:23 17:11 25:1  30:18 36:1 85:8  115:17,18 121:2  <b>endorsements</b>  57:22  <b>ends</b> 73:15  <b>enjoy</b> 7:21  <b>enjoyable</b> 97:22  <b>enough</b> 28:8 56:3  <b>entire</b> 14:2 28:10  45:9 115:2  <b>entirety</b> 23:20  <b>entities</b> 25:11 70:6  71:4  <b>entity</b> 70:8  <b>environment</b> 39:21  <b>envisioned</b> 46:7  <b>envisioning</b> 77:22  <b>equation</b> 33:24  <b>equations</b> 92:22  <b>equipment</b> 51:11  <b>equivalent</b> 71:19,20  <b>especially</b> 51:22  <b>essentially</b> 22:18  25:18 42:22 70:1  78:16  <b>establish</b> 11:17  39:24 64:20  <b>established</b> 27:9  37:6 39:19 70:6  71:6,6  <b>establishing</b> 46:14  <b>Establishment</b> 69:3  <b>estate</b> 70:7  <b>estimate</b> 22:19,21  23:4,6 30:19  34:11  <b>estimated</b> 23:9 32:1  32:2,4 34:20  47:13  <b>estimates</b> 22:23  <b>et</b> 91:23,23 93:4  <b>Ethics</b> 5:19  <b>ethnic</b> 66:4 67:2  68:13  <b>evaluating</b> 40:12  <b>evaluation</b> 40:3  <b>Evans</b> 2:7 9:12,13  21:1,6,9 28:19  31:6 47:20 49:9  63:24 64:6,20  68:10 79:1 80:24</p>	<p>83:2,4 103:13  106:9,14,23 107:3  107:22 108:1  119:3 120:17  <b>even</b> 7:9 14:4 18:6  25:4 36:15,18  45:6,15 78:18  80:13 84:5 109:23  112:10 117:24  <b>events</b> 79:9  <b>ever</b> 38:15 72:5,5  <b>every</b> 11:1 21:24  24:8 36:1 59:12  59:15 60:15 71:18  111:24 115:12,14  116:8  <b>everybody</b> 15:7,15  18:14 57:11 87:6  95:8  <b>everyone</b> 14:11  82:17  <b>everything</b> 14:6  27:23 93:20,20  97:24 100:7 108:4  <b>evidence</b> 60:9 61:4  61:5,20 62:20  <b>evidence-based</b>  41:1  <b>exactly</b> 9:6 53:10  111:3  <b>example</b> 22:22 23:9  23:12,21 58:16  88:15 107:20  <b>exceed</b> 49:5 57:21  <b>excellent</b> 27:18  29:23  <b>except</b> 21:2,10 87:6  <b>exception</b> 63:18  84:19  <b>exceptions</b> 16:2  88:4  <b>excess</b> 11:18,19  31:1 42:9 49:8  62:14  <b>excluded</b> 92:18,18  <b>exclusions</b> 79:11  <b>exclusion/inclusion</b>  80:10  <b>exempt</b> 12:7,9  <b>exempted</b> 60:21  <b>exist</b> 44:14 66:9  <b>existence</b> 32:10  60:10 100:4  <b>existing</b> 30:24 42:9  47:11 52:19 54:14  64:1 66:10 104:16  118:21,21 119:7  <b>exists</b> 61:20</p>
--	---	---	--	--

<p><b>expand</b> 37:18 84:21  <b>expect</b> 50:1  <b>expectations</b> 105:7  <b>expend</b> 84:4  <b>expenditure</b> 15:23  17:10,13,16 69:10  <b>expenditures</b> 17:12  69:13  <b>expert</b> 91:2  <b>expertise</b> 27:5 77:2  <b>explain</b> 19:5  <b>explicit</b> 62:23  <b>exploring</b> 93:5  <b>ex-parte</b> 95:18,20  95:20 96:8,8,11  96:12,19 98:4,23  99:6,16,23,24  100:10,14,15,17  100:22 101:3  <b>e-mail</b> 6:11 20:20  20:21 117:17</p> <hr/> <p style="text-align: center;"><b>F</b></p> <hr/> <p><b>face</b> 44:18  <b>face-to-face</b> 116:20  116:21 117:10,22  <b>facilitate</b> 114:18  <b>facilities</b> 1:2,11 5:18  7:15 11:4,4,10,11  13:23 16:3,14  17:10,12,15 18:12  18:20 26:4 29:4  31:20 34:10 37:20  39:5 41:10 42:2  44:21 45:14,15  47:10,11 48:22  49:7,18 51:16  52:4,23 53:19  54:10,11 55:17  58:21 60:6,7,11  60:16 63:16 64:1  65:1 66:11,16  68:14,18 69:16,16  81:7 82:7 89:15  92:2,17,21 93:3  95:13 101:16  102:19 118:11  <b>facility</b> 3:11 11:17  11:21,21 14:6  15:22,22 17:14  19:3 39:6,18  45:16 47:8 48:1  49:6,7,19 51:3  54:6 57:21,24  58:2,6,6 60:12,13  63:16,20 64:19,23  66:2,2,12 68:20  70:14 72:6,10,18</p>	<p>83:5 89:20,23,24  92:22,23 98:18  <b>facility's</b> 92:6  <b>fact</b> 19:17 43:16  45:12 74:5 85:18  86:23 97:9 98:14  100:15  <b>factored</b> 67:11  88:10,13,20  <b>facts</b> 98:22  <b>fairly</b> 111:22  <b>fall</b> 65:1  <b>falling</b> 54:2  <b>familiar</b> 100:22  <b>family</b> 64:22 84:16  <b>far</b> 106:12 117:11  <b>fashion</b> 86:16,20  88:20 90:6  <b>fault</b> 30:2  <b>favor</b> 6:2,18 116:3  116:20 120:19  <b>favorably</b> 75:7  <b>feasibility</b> 74:9  <b>feasible</b> 70:3 71:9  <b>February</b> 62:6  111:23  <b>fed</b> 22:6  <b>federal</b> 22:10 52:20  55:21  <b>feds</b> 22:13 55:22  <b>feed</b> 89:5  <b>feedback</b> 106:20  113:7  <b>feel</b> 7:17 28:3 46:20  92:5 103:12  <b>feeling</b> 112:13,14  <b>feels</b> 83:7  <b>feet</b> 71:24  <b>felt</b> 9:5 91:14  <b>few</b> 39:5,22 40:14  46:9 59:20 90:22  95:19  <b>fewer</b> 41:18 68:14  68:14  <b>field</b> 45:23 50:15  54:18 65:13  <b>fifth</b> 40:7 92:15  <b>figure</b> 48:5 110:14  <b>file</b> 90:23  <b>filed</b> 63:5 115:13  116:9  <b>fill</b> 52:12 59:21  <b>final</b> 64:10 78:1  <b>finally</b> 43:9 49:3  <b>financial</b> 11:7 52:24  70:1 71:3 72:5  74:9 79:17 106:15  <b>financially</b> 70:2</p>	<p>71:2 122:10  <b>financials</b> 70:24  <b>financing</b> 70:14  71:9,13,14  <b>find</b> 13:3,6 16:13  18:3,18 19:10  21:21 30:2 60:9  61:3,5,19 62:19  75:20,20 77:6  85:5 102:12  111:19  <b>finding</b> 75:9 108:8  <b>fine</b> 43:13 51:18  76:21 94:16 97:2  104:5 119:15  <b>finger</b> 30:8  <b>finish</b> 34:4 109:20  111:8,10  <b>firm</b> 92:19  <b>first</b> 10:20 26:16  28:8 31:11 33:23  77:14,15,15,15  79:5 86:9,12  90:17 91:17 94:24  95:11 96:9,10,12  96:19 101:9  115:10,11 117:13  120:2  <b>fit</b> 65:13 114:5,6  <b>fits</b> 80:9  <b>five</b> 40:5 46:10  60:15 66:16 83:23  95:22 96:1,24  97:1,3  <b>five-minute</b> 43:12  <b>five-year</b> 37:11  65:20  <b>fixed</b> 56:5  <b>floor</b> 1:3 10:14  <b>flow</b> 85:5  <b>flowing</b> 87:23  <b>focused</b> 105:11  <b>focusing</b> 111:1  <b>Foley</b> 2:21 9:24,24  19:12,14,15 20:8  27:17 28:16 36:6  37:19 45:7 61:10  61:16,21 62:7,12  62:16,21 63:1  65:9,21 102:24  103:4 105:23  106:5 108:3  111:23 113:10  116:24  <b>folks</b> 15:6 87:4  <b>follow</b> 35:23  <b>followed</b> 22:15  <b>following</b> 109:9</p>	<p><b>follow-up</b> 106:9,16  <b>food</b> 8:13  <b>foot</b> 72:2 81:8  <b>force</b> 104:2,8  110:10  <b>forces</b> 55:14  <b>forget</b> 40:7 74:19  101:14 107:7  <b>forgive</b> 109:8  <b>form</b> 95:3  <b>formed</b> 9:7  <b>formula</b> 24:16,20  25:20 37:5,21,22  38:1,2,3,6 41:16  41:23 43:1 55:23  79:11,23 83:8  86:10,23 87:1  88:3,11 89:3  91:12 104:23  <b>formulas</b> 29:21  32:13  <b>formulated</b> 104:16  <b>forth</b> 112:20  <b>forum</b> 14:19 99:3  <b>forward</b> 14:24  36:24 92:19  <b>found</b> 106:12  <b>four</b> 46:8 73:18  75:19 77:23 83:13  102:18 112:10  <b>fourth</b> 88:21 91:7  <b>four's</b> 77:10  <b>four-hour</b> 114:14  <b>frame</b> 36:23 37:18  64:3  <b>frames</b> 115:8  <b>Frank</b> 2:18 5:18  10:11 11:24 12:1  12:21,23 28:8,24  29:2,9 34:16  62:19,21 74:19  76:22 94:22 95:2  95:7 108:21 111:5  <b>frankly</b> 78:18  <b>fraternal</b> 66:4 67:2  <b>free</b> 7:17 43:16  103:12 106:1  <b>freely</b> 100:6  <b>freeze</b> 56:7  <b>frequent</b> 116:11  <b>fresh</b> 41:7  <b>from</b> 9:19 15:6  18:10,13 19:19  24:18 31:19 34:21  34:23 35:6 36:12  36:24 40:9,11  41:21 47:10 48:4  54:9 55:21 56:10</p>	<p>57:22 58:11,19  61:2,22 64:2  65:14 66:12 68:24  70:9 71:18 74:18  74:21 75:24 77:4  77:23 79:10 80:18  81:15 85:22 90:1  90:19,19 91:18  93:3,8 98:17 99:1  102:21 103:9,18  104:10,16 108:6  112:13 113:7,9  117:23 120:18,19  <b>front-door</b> 68:8  <b>frozen</b> 55:7 56:16  <b>fulfill</b> 96:4  <b>full</b> 47:18,20,21  116:14  <b>fun</b> 7:8 77:12  <b>function</b> 30:10 89:6  <b>functions</b> 57:23  58:8 68:22  <b>funded</b> 30:11 70:11  <b>funding</b> 30:14  <b>funds</b> 53:3 55:18  70:2,9  <b>furniture</b> 51:11,12  <b>further</b> 20:5 45:20  91:15 113:17  122:8  <b>future</b> 3:8 10:9 20:2  46:22 89:6 92:14  92:24 98:7</p> <hr/> <p style="text-align: center;"><b>G</b></p> <hr/> <p><b>gallery</b> 117:5  <b>game</b> 25:1  <b>gardening</b> 82:23  <b>gave</b> 27:18  <b>gawd</b> 10:23  <b>geared</b> 82:18  <b>general</b> 5:19 18:18  20:10  <b>generally</b> 20:9  23:11 36:2 48:7  48:15 49:11 67:8  70:4,6 71:2  <b>gentleman</b> 76:10  <b>geographic</b> 20:2,3  66:6,11 85:10  <b>gets</b> 15:2 82:10 84:6  84:6 100:14,24  116:21  <b>getting</b> 13:10 50:4  53:3 54:4 56:23  56:23 59:8 75:2  75:11,14 90:5  92:16 96:24 97:10</p>
--	--	---	---	---

<p>99:1,5  <b>ghost</b> 80:3  <b>giant</b> 104:9  <b>give</b> 22:16,21 25:13  26:14 64:23 95:18  <b>given</b> 23:7,19 74:5  115:7  <b>giving</b> 10:24  <b>glad</b> 29:19  <b>go</b> 4:12 14:9 15:18  20:6 31:6,13  44:23 46:13,22  50:11 53:13 54:6  58:5 63:16,17,20  64:13 65:8,16  68:2,18 77:11  81:18 83:15 84:3  90:1,3 91:9 94:1  94:20 95:7 106:19  113:12,14  <b>goals</b> 69:1 79:8  <b>goes</b> 45:8  <b>going</b> 4:6 7:10 8:7  10:3 12:14,24  13:12 19:14 20:5  22:16 24:20 28:13  36:3 37:19 46:15  46:16 49:9 50:12  52:20 53:1,3,21  54:11 55:18 59:20  62:24 64:13 69:22  72:22 73:6 76:6,6  76:17 78:11 81:10  82:8 84:22 87:24  92:19,23 93:21  95:13 97:4,5,20  98:6 101:14 102:1  103:5 104:13  105:21 106:13  111:7,8,10,14  112:6,13,14,18,23  113:4,16 114:10  115:16,17,19  116:5 117:18,21  117:23 118:1  <b>golden</b> 4:4 7:23  <b>gone</b> 10:24 14:12  55:1 58:6 107:21  <b>good</b> 8:20 39:10  45:17,21 58:17  59:3 84:1,24 85:2  87:7 104:14 115:9  115:9,20,24 116:6  117:13  <b>goodness</b> 119:2  <b>gotten</b> 90:11  <b>govern</b> 14:5  <b>governed</b> 17:3,5</p>	<p><b>government</b> 49:2  70:12  <b>Governor</b> 108:6  <b>Governor's</b> 15:18  <b>gratitude</b> 75:15  <b>gray</b> 98:15  <b>great</b> 10:19 37:23  57:14 75:17 95:5  108:23 109:11  119:16,19  <b>greater</b> 68:19 99:18  <b>Greatly</b> 9:11  <b>Greek</b> 67:17  <b>Greeks</b> 67:16  <b>Greg</b> 2:5 76:13  <b>gross</b> 71:24 72:1  <b>group</b> 3:8 4:23 12:2  13:1 30:2 46:8,13  46:21,22,22 66:4  68:2 75:20,22,24  77:1,2,4,7,8,14,15  77:23 78:17 79:5  80:18,21,23 81:2  81:15,18,19,22,23  82:6 85:4,22,24  86:1,3 87:6 89:7,9  89:13 93:11,16,18  95:22 96:9 101:17  102:21 104:11,12  105:18 109:9,23  111:18,19 112:5  112:13,14,19,22  114:4,14,20 115:2  116:4  <b>groups</b> 19:1 31:17  34:12 46:9,15  75:19 76:21 77:13  93:14 96:23 99:1  100:8 106:20  109:12,14 113:2  115:5 116:4  118:15  <b>group's</b> 26:23 46:21  91:7  <b>growth</b> 81:12  <b>GSA</b> 66:9,9  <b>guess</b> 13:8 28:20  33:1 37:15 47:24  48:5 49:9 53:14  55:11 70:12 88:9  88:23 93:23  105:21 108:9  113:10 120:7  <b>guidance</b> 26:20  <b>Guild</b> 2:23 9:19,19  <b>guts</b> 116:22  <b>guy</b> 101:5  <b>guys</b> 9:17 10:13</p>	<p>20:22 32:17 75:20  77:11 89:16  106:17 116:12</p> <hr/> <p><b>H</b></p> <p><b>H</b> 66:6  <b>half</b> 11:19 15:24  33:23 52:6 69:11  99:18  <b>hand</b> 84:1 102:17  <b>handed</b> 10:17,18  <b>handle</b> 38:23 80:8  <b>handled</b> 110:6  <b>Handler</b> 2:9 4:18,18  33:23 67:17 89:20  91:8  <b>hands</b> 118:8  <b>hang</b> 75:21  <b>happen</b> 9:6 104:5  <b>happened</b> 24:21  62:10 105:14  <b>happening</b> 40:2  88:8  <b>happens</b> 58:4 68:4  73:13 86:11  100:18,20  <b>happy</b> 7:2 20:20,21  25:12 120:24  <b>hard</b> 54:5 60:2  78:14  <b>hate</b> 8:6 28:13  116:22  <b>having</b> 36:1,21,24  45:2 78:7 84:20  90:18 92:17 97:11  104:22 108:9  116:11  <b>havoc</b> 106:3  <b>head</b> 59:19  <b>heading</b> 78:5  <b>heads</b> 114:9  <b>health</b> 1:2,11 4:22  5:13,15,17,18  9:23 16:14 18:20  18:22,23 19:8,9  19:15,17,18 20:7  20:9,18 22:20,20  23:2 24:23 29:4  30:10 37:20 38:15  40:1 41:11 42:3  49:1,2 53:4,13  54:9 57:8 66:7  74:5 80:3 89:14  90:2 98:18 101:15  102:19 118:10  <b>healthcare</b> 5:4  39:19 40:3,13  60:13 76:14 83:5</p>	<p>84:16 104:1  107:10  <b>hear</b> 109:10  <b>heard</b> 6:3,19 56:22  90:1 120:20  <b>hearing</b> 73:10 85:19  87:20  <b>heavy</b> 8:4  <b>held</b> 1:13 78:22  117:15  <b>help</b> 19:7 40:12  41:21 74:18  100:13  <b>helpful</b> 32:19 59:1  74:16 75:16  100:21  <b>helping</b> 100:19  <b>helps</b> 117:10  <b>hesitate</b> 85:6  <b>HFS</b> 3:12 68:24  84:16 90:1,1  <b>HFS's</b> 84:15  <b>Hi</b> 9:12  <b>high</b> 36:8,11,16,19  45:13,14 106:15  <b>higher</b> 36:4 80:15  110:2,6  <b>Highland</b> 72:7 73:2  <b>Hills</b> 2:20 5:16,16  6:11 76:9 78:13  116:17  <b>him</b> 39:1 101:6  <b>hint</b> 80:22  <b>historic</b> 33:12,13  41:4  <b>historical</b> 19:10  71:3  <b>historically</b> 12:12  13:5,12 52:11,13  88:10  <b>hit</b> 8:4 76:5 97:14  <b>holiday</b> 120:24  <b>home</b> 5:11 11:12  12:5,7 13:16,17  24:22 43:22,24  50:11 54:5 56:23  68:14 79:16 82:1  82:2,19,19 86:18  118:14  <b>homes</b> 5:8 16:3,3  24:18 25:1 36:3,8  36:10 43:16,18,23  45:3 53:13,21  54:1 68:13 82:11  85:14 88:7 108:2  <b>honor</b> 6:23  <b>hope</b> 46:23 97:19  <b>hopefully</b> 46:16</p>	<p>95:17 101:15  <b>hoping</b> 116:1  <b>Hospice</b> 4:19  <b>hospital</b> 9:20 39:21  47:13,17 49:23  87:9,15  <b>hospitals</b> 22:1 38:7  38:8,13 39:15,16  47:11 75:9 80:5  108:7  <b>hotel</b> 75:21 118:2  <b>hour</b> 1:14 112:10  <b>hours</b> 8:23  <b>housekeeping</b> 7:14  7:19  <b>houses</b> 81:5  <b>housing</b> 60:14 70:15  <b>HSA</b> 19:21,23 21:14  21:19 31:12 34:22  43:22 66:7  <b>HSA's</b> 18:24 19:19  <b>HSA-3</b> 31:13 34:15  34:17 42:7,8  <b>HUD</b> 70:11,17  <b>hundred</b> 27:12 32:7  32:8 68:19 71:24  <b>hundred-some-odd</b>  35:16  <b>husband</b> 63:21</p> <hr/> <p><b>I</b></p> <p><b>IAC</b> 18:3,14 42:21  70:22  <b>IADL's</b> 31:3  <b>ICF/DD</b> 11:12,17  11:21 12:13 13:6  14:1 15:22 39:5,6  41:17 42:2 68:18  69:3,7  <b>ICF/DD's</b> 12:3,4,5  13:22  <b>idea</b> 19:12 79:14  85:4 87:17 89:22  <b>ideal</b> 46:1  <b>ideals</b> 88:11  <b>ideas</b> 85:6 87:7  104:12,13  <b>identified</b> 18:11  19:24 49:2 57:11  91:16  <b>identifies</b> 83:9  <b>identify</b> 9:10 47:7  57:6 66:7  <b>IDPH</b> 2:19,20 32:2  <b>IHDA</b> 70:16  <b>IL</b> 1:23  <b>ILCS</b> 14:13  <b>ill</b> 90:21 108:22</p>
---	--	--	---	--

<p><b>illinois</b> 1:1,4,11,15 4:21 7:6 9:19 16:3 16:14 18:17 19:17 19:20 68:21 70:15 90:17 91:20 93:19 103:24 104:1 107:10 110:8,22 122:4</p> <p><b>illness</b> 41:10</p> <p><b>impact</b> 26:9 43:10 52:16 65:18 79:21 84:15,22 85:9 92:9 93:20</p> <p><b>impacts</b> 79:17</p> <p><b>impaired</b> 81:9</p> <p><b>imparts</b> 96:15</p> <p><b>implication</b> 61:16 63:1</p> <p><b>implications</b> 63:4 79:18 106:2</p> <p><b>important</b> 27:19 29:12 45:9 46:10 51:15,21 65:22 93:18 95:19,24 96:7 109:12 114:5</p> <p><b>impose</b> 83:20</p> <p><b>impossible</b> 112:9</p> <p><b>impressed</b> 93:13</p> <p><b>improve</b> 43:6</p> <p><b>improvement</b> 82:14</p> <p><b>inadequate</b> 86:11</p> <p><b>Incapable</b> 51:11</p> <p><b>inclined</b> 119:23</p> <p><b>include</b> 15:21 40:5 94:17,19 115:24</p> <p><b>included</b> 67:13,14 79:12</p> <p><b>includes</b> 34:17</p> <p><b>including</b> 27:22 82:11 84:21</p> <p><b>incorporated</b> 37:2 90:6</p> <p><b>incorporating</b> 92:21</p> <p><b>increase</b> 14:1 86:24</p> <p><b>incredible</b> 95:6</p> <p><b>independent</b> 60:16 63:10,15</p> <p><b>independently</b> 115:5</p> <p><b>indicate</b> 64:13</p> <p><b>indicated</b> 27:24 37:21</p> <p><b>indicating</b> 4:11,12 7:16,17 31:14 34:19</p> <p><b>individual</b> 35:19 77:13 81:11 98:14</p>	<p><b>individuals</b> 13:22 47:7 66:8 107:4 107:13</p> <p><b>industry</b> 10:22 52:12 98:16</p> <p><b>Infinity</b> 5:2</p> <p><b>influence</b> 53:20 55:15 100:12</p> <p><b>inform</b> 59:5</p> <p><b>information</b> 16:14 17:6,7,10 19:10 24:14 27:14 39:4 65:3,5 71:4 87:3,7 90:5,14,21 92:13 96:15 97:24 103:9 103:16,17 108:23 109:5 111:14 114:22</p> <p><b>informative</b> 74:17</p> <p><b>informed</b> 15:17</p> <p><b>infrastructure</b> 54:15 81:12</p> <p><b>initial</b> 120:1</p> <p><b>initiatives</b> 13:24</p> <p><b>innovation</b> 46:4 91:18 105:1</p> <p><b>innovations</b> 82:14</p> <p><b>input</b> 115:21 116:6</p> <p><b>inputs</b> 22:18</p> <p><b>instance</b> 101:5</p> <p><b>instead</b> 13:1 83:5</p> <p><b>instituted</b> 66:10</p> <p><b>integrated</b> 84:20</p> <p><b>integrity</b> 53:1</p> <p><b>interest</b> 50:6 71:14</p> <p><b>interested</b> 7:1 58:23 70:21 122:11</p> <p><b>interesting</b> 80:21 108:3,5</p> <p><b>intermediate</b> 11:11 16:21</p> <p><b>interruptions</b> 7:22</p> <p><b>introduce</b> 4:7 9:18</p> <p><b>invariably</b> 71:5</p> <p><b>inventory</b> 18:13 22:22 23:22 24:12 32:17 51:5</p> <p><b>invest</b> 54:1</p> <p><b>invested</b> 53:2 54:14 54:19</p> <p><b>investment</b> 54:18</p> <p><b>involve</b> 15:6</p> <p><b>involved</b> 103:15 108:17 115:21</p> <p><b>issue</b> 8:18 13:3,20 13:21 25:15 28:21 30:4 51:21,22 53:11 68:9 76:22</p>	<p>80:9 83:18 95:17 100:22 108:14,17 116:10,11</p> <p><b>issues</b> 8:4 26:8,14 27:7 29:17 44:13 65:16 76:1,2,3 94:2,4 100:14 118:10,11,13,14</p> <p><b>italics</b> 119:4,5</p> <p><b>item</b> 92:3</p> <p><b>items</b> 71:21 94:22 103:11</p> <hr/> <p style="text-align: center;"><b>J</b></p> <hr/> <p><b>James</b> 2:2 5:3</p> <p><b>January</b> 79:1 109:2 115:11,18 117:12 117:14,22 121:1</p> <p><b>Jefferson</b> 1:3</p> <p><b>Jimmy</b> 78:8</p> <p><b>job</b> 45:17</p> <p><b>John</b> 34:1 81:21</p> <p><b>Johns</b> 78:8</p> <p><b>Johnson</b> 2:15 5:10</p> <p><b>joined</b> 57:11</p> <p><b>Joliet</b> 1:15</p> <p><b>Jonathan</b> 2:3 4:14</p> <p><b>July</b> 12:12 79:2</p> <p><b>June</b> 37:15 62:4</p> <p><b>jurisdiction</b> 25:11</p> <p><b>just</b> 7:6 8:7,13 9:17 11:23 13:11 14:9 15:12 16:15 19:14 22:7 24:16 26:21 29:11 30:21 33:15 37:19 38:5,19 40:23 41:6,11 45:7 46:3,6 47:1 49:4 54:2 55:9 56:5 59:18,20 60:15 61:10 62:24 66:18,24 67:1,4 67:22,23,24 68:18 69:14,18,21 73:22 74:24 75:19,19 77:21 81:20 82:10 82:11 85:4 86:11 86:17,22 87:14 90:11 92:24 95:18 95:21 96:13,19 98:24 101:23 104:22 105:6 106:9,16 107:16 108:1,18 110:3,15 113:12 114:13,23 117:8 118:1,19 120:3</p>	<p style="text-align: center;"><b>K</b></p> <hr/> <p><b>K</b> 1:21 122:3,14</p> <p><b>Karen</b> 1:21 4:9 122:3,14</p> <p><b>keep</b> 7:21 54:6,15 73:6</p> <p><b>keeping</b> 50:7</p> <p><b>Keim</b> 1:21 122:3,14</p> <p><b>kept</b> 118:22</p> <p><b>kicks</b> 9:17</p> <p><b>kind</b> 16:16 19:20 28:8,11 46:4 50:1 59:5,6 61:10 67:4 76:5 78:3,4 79:21 80:24 85:3 86:11 87:21 88:4,7 93:6 94:1 100:20 102:16</p> <p><b>kinds</b> 92:10</p> <p><b>knew</b> 105:14</p> <p><b>know</b> 7:1 8:11,12 9:6 15:12 18:14 26:20 27:9 30:11 32:9 38:21 39:20 39:21 40:14,16 41:20 44:20 45:3 45:4,10 48:10 50:16 51:15 53:23 54:19 56:3 58:20 59:2 61:19 62:9 63:22,23 64:4 66:17 68:19 73:3 73:13 80:12,13 81:7 82:17 85:14 86:7,13,14,17,18 86:24 87:8 88:2,5 88:8,16 89:18 98:16 100:23 101:1,23,23 104:4 109:11 112:16 117:10 120:3,13</p> <p><b>known</b> 7:7 12:15</p> <p><b>knows</b> 47:17</p> <hr/> <p style="text-align: center;"><b>L</b></p> <hr/> <p><b>L</b> 107:7</p> <p><b>lag</b> 36:21,21 59:15</p> <p><b>land</b> 29:15</p> <p><b>language</b> 61:22 62:23 94:5 119:6</p> <p><b>large</b> 12:2 19:21,21</p> <p><b>larger</b> 20:3 46:22 65:15 79:15 107:17,19</p> <p><b>last</b> 6:24 7:14 8:9 9:10 11:1 18:11 27:11 39:6 40:20</p>	<p>61:11 65:7 68:19 69:12 84:14 85:16 85:19 90:7 92:3 92:20 102:24 117:1</p> <p><b>late</b> 9:15</p> <p><b>later</b> 12:24</p> <p><b>Laughter</b> 10:4 11:2 17:24 29:8 42:17 46:18 52:10 91:5 102:3,7 117:3</p> <p><b>Lavin</b> 2:3 4:14,14 19:5 20:6 21:13 21:17 30:15,21 31:2,5,8 32:20,24 33:5,7 47:23 48:3 48:9,12 58:20 59:1 64:24 67:15 67:18 68:4,8 70:15 77:17 79:6 80:21 81:3 85:1 93:17</p> <p><b>law</b> 19:16 101:22 102:23</p> <p><b>lay</b> 29:15</p> <p><b>lead</b> 36:17</p> <p><b>learn</b> 93:7</p> <p><b>least</b> 13:24 15:17 18:1 26:8 38:10 90:24 115:21</p> <p><b>leave</b> 86:4 108:15</p> <p><b>led</b> 79:14</p> <p><b>left</b> 71:4</p> <p><b>Legal</b> 2:18</p> <p><b>legislation</b> 27:2 103:23 104:8</p> <p><b>legislative</b> 110:9</p> <p><b>Legislator</b> 101:19</p> <p><b>legislators</b> 28:23</p> <p><b>Legislature</b> 110:21</p> <p><b>length</b> 71:14</p> <p><b>less</b> 15:24 16:2 35:3 42:3 47:24 71:10 88:3</p> <p><b>let</b> 7:1 34:3 46:6 76:17 85:5 95:7 95:18 101:13,23 105:19 119:6</p> <p><b>letters</b> 47:10 57:22 58:10,19</p> <p><b>letting</b> 78:14</p> <p><b>let's</b> 40:20 41:5 44:9 57:3</p> <p><b>level</b> 16:5 53:5 54:16 55:21 56:16 110:2</p> <p><b>levels</b> 51:10 56:14</p> <p><b>licensed</b> 12:5,6</p>
--	---	---	---	--

<p>16:18 17:2,4 18:5 18:9,10,13 19:3 49:14,19 50:3,7 50:11,12,17,24 51:1,16,20 <b>licensing</b> 50:21 90:11 <b>licensure</b> 108:15 <b>lie</b> 52:9 <b>Life</b> 103:23 <b>lights</b> 57:17 <b>like</b> 7:6 11:3 13:19 20:22 31:9 32:17 36:4 39:11 42:18 43:11,18 46:8 47:1,5 51:18 57:16 58:16 62:7 67:15,23,23 75:18 77:19 78:19 82:19 82:22 85:5,18 87:18 88:4 89:4 89:10 98:19 104:6 104:15 105:4 106:17 115:10 116:20 119:3 120:23 <b>likely</b> 36:3 <b>limit</b> 58:15 <b>limitation</b> 75:8 <b>limitations</b> 48:14,17 75:2 <b>limited</b> 63:9 66:24 73:17 <b>line</b> 32:14 46:14 51:2 54:2 59:11 59:15 98:2 101:10 101:11 102:10 103:9 109:18 119:14 <b>lines</b> 101:13 <b>list</b> 43:22 44:1 46:13 52:3 54:9 59:7 93:16 94:1,8 98:6 <b>listed</b> 60:10 61:4 <b>listening</b> 14:10 <b>lists</b> 53:19 94:7 <b>Litigation</b> 1:22 <b>little</b> 42:15 46:16 55:14 59:7 75:21 84:8 91:23 <b>live</b> 27:10 <b>lively</b> 105:2 <b>lives</b> 7:9 <b>living</b> 11:15,15 12:8 13:22 24:23,24 27:24 28:1,10,14 60:16 63:10,15,19 79:14,15 107:11</p>	<p>107:11 <b>LLC's</b> 70:6 <b>loan</b> 71:15 <b>located</b> 18:23 31:13 69:4 <b>locations</b> 3:14 <b>long</b> 24:10 56:3 85:18 88:14 116:13 <b>longer</b> 12:13 39:8 51:2,12 62:23 <b>long-care</b> 63:9 <b>long-term</b> 1:9,12 4:16 5:13 9:22 11:4,17,21 16:13 17:10 19:2,3 21:24 26:4 30:20 31:11,20 38:6,7 38:11,13 39:4,12 39:20 41:9,15 42:21 43:4 47:9 60:6,19 63:11,20 64:12 69:1,15 70:4 81:6,21,22 81:24 82:2,3,4 83:19 84:21 87:5 90:9 91:19 96:2 97:16 98:10,16,18 103:24 108:5 109:22 111:1 115:22 <b>look</b> 8:18 26:24 27:24 28:1,1 29:14,21 30:5 31:12 33:12,20 34:7 36:14 40:20 45:9,19 46:11 49:16 52:3,5,15 59:16 62:22 65:23 68:17 75:7 82:12 82:19 86:15 88:5 89:1 90:8 92:4,6 92:21 98:22 106:19 110:14,15 110:19 112:15 113:11,17 117:12 117:14 118:16 119:24 120:4 <b>looked</b> 40:4 44:8 79:12 80:5 90:17 118:12 <b>looking</b> 24:13 32:23 40:22 43:23 45:12 51:19 70:9 75:4 75:23 77:21 84:23 86:16 87:17,17,21 87:22 89:4 104:24 108:6,7,14 109:7</p>	<p><b>looks</b> 17:22 62:18 83:6 98:19 119:3 <b>Lorena</b> 2:4 4:20 <b>lose</b> 60:18 <b>losing</b> 64:11 <b>lost</b> 73:5 84:1 <b>lot</b> 7:8 13:11 19:8 26:8 34:13,14 59:4 67:6,10,21 68:12 74:18 80:3 84:3 85:17 88:12 91:9 98:15 102:11 102:12,12 103:14 103:17 104:18,20 104:21 106:18 108:2,9,13 112:16 113:23 114:9 115:19 117:7 120:13 <b>lots</b> 13:19 43:22,23 87:13 97:16 107:8 <b>loud</b> 102:17 <b>low</b> 36:22 45:16 48:5 54:5 55:18 <b>lower</b> 37:4,4 52:7 53:9 <b>Lowitski</b> 2:5 76:14 <b>lunch</b> 8:7 78:7,14 78:19 79:7 97:11 102:6 117:20,24 118:1 <b>lunches</b> 78:21 <b>Lutheran</b> 67:23 <b>luxury</b> 89:11</p> <hr/> <p style="text-align: center;"><b>M</b></p> <hr/> <p><b>made</b> 74:24 83:17 92:12 <b>mail</b> 79:3 <b>maintain</b> 51:1 54:13 <b>maintained</b> 44:22 <b>maintaining</b> 45:14 53:1 <b>majority</b> 99:20 <b>make</b> 6:12,23 8:8 9:6 10:8 12:15 13:21 14:5 26:11 26:18 28:22 29:16 37:19 51:16 52:24 76:2 79:23 81:11 81:20,23 82:4,18 88:10 93:8,8 113:12 116:8 117:9 118:8,16 <b>makes</b> 96:15 <b>making</b> 53:4 83:4 87:4,23 92:18 96:17 100:16</p>	<p><b>maldistribution</b> 43:8 <b>managed</b> 84:20 <b>Management</b> 5:5 <b>Manak</b> 9:23,23 <b>Manor</b> 72:11,17 73:2 <b>many</b> 13:15 24:19 33:19 49:18 53:2 58:20 65:14 66:15 69:9 74:5 80:12 101:24 116:6 118:22 <b>map</b> 20:18 31:13 <b>March</b> 79:1 102:22 103:6 110:12 111:8,12,21 113:15 115:13,18 115:18 116:9 <b>marked-out</b> 118:24 <b>market</b> 37:8 43:16 44:12,14,18 47:5 51:23 55:14,14 90:11 <b>marketable</b> 71:12 <b>marketplace</b> 92:9 104:15,24 105:6,8 105:19 106:1,4 <b>markets</b> 44:21 71:11 <b>marking</b> 29:20 <b>massive</b> 87:18 <b>master</b> 46:12 <b>match</b> 55:22 <b>matched</b> 38:16 <b>matching</b> 55:22 <b>material</b> 90:24 96:15,15 <b>materials</b> 73:24 <b>math</b> 38:16 <b>Mathematically</b> 38:23 <b>matter</b> 29:13 83:6 104:4 119:6 <b>max</b> 33:1,4 <b>maximum</b> 32:6,7 34:21 35:3 <b>may</b> 8:19 16:4 20:20 26:7 27:7,7 43:16 47:7,15 49:18 51:12 53:9 59:21,23,23 65:21 79:1 88:15 90:24 93:6 96:23 108:18 <b>maybe</b> 15:1 19:11 30:4 31:6,8 38:17 40:17 44:22 51:19 53:24 58:7 75:24</p>	<p>77:24 83:15,15 90:18 94:17 109:4 114:10,17 115:12 <b>mayor</b> 58:19 <b>ma'am</b> 15:10 <b>McDonald</b> 1:14 <b>MCO's</b> 84:15 <b>meals</b> 83:1 <b>mean</b> 12:16 22:21 32:21 33:5 44:8 54:2,3 58:9 64:17 66:21 85:4,21 86:16 95:3 97:16 100:17 103:15 108:16,19 117:9 <b>meaning</b> 66:22 79:21 94:7 <b>means</b> 18:15 51:11 52:15 63:10,14 64:15,18 71:17,22 71:23 82:22 119:5 <b>mechanism</b> 87:19 89:10 <b>Medicaid</b> 48:18,19 54:21,22 55:17,18 55:24 56:23 75:5 84:15 85:1 <b>medical</b> 39:12 48:24 53:12,24 64:12 82:14 <b>Medicare</b> 14:2 48:18,19 55:20 75:5 <b>Medicine</b> 4:23 <b>meet</b> 49:5 69:22 71:5 75:6 77:13 102:22 103:6 111:20 115:14 117:10 118:5 <b>meeting</b> 1:10,11 4:3 6:24 7:21 12:24 26:17,21,24 28:8 44:14,17 46:17 57:8 73:14,16,20 78:2 81:10 90:17 91:19 94:8,11,15 95:21,23,24 96:3 96:4,5,6 97:2,4,5 97:7,8,23 98:2,5 98:21 99:3,6,22 100:9 102:17,24 109:1 111:11,12 111:15,21,21,23 111:24 112:10 114:14 115:6,11 115:12,17,18 117:22 118:9 120:2</p>
--	---	--	---	--

<p><b>meetings</b> 3:12,14 46:23 78:9,23 95:18,20 96:1,23 97:9,13 98:5 101:24 105:10 111:13 116:11,14 <b>member</b> 5:4 76:8 <b>members</b> 13:2 96:18 99:7,15,18 107:7 <b>membership</b> 106:20 107:2,3 <b>member's</b> 100:12 <b>mental</b> 41:9 <b>mention</b> 12:4 39:11 55:10 <b>mentioned</b> 12:9 14:14 25:12 45:24 52:18 86:17 87:14 90:10 96:13 107:17 <b>mentions</b> 12:4 <b>Mercy</b> 66:18,18,19 <b>mesh</b> 102:13 <b>met</b> 74:2 <b>method</b> 40:19 56:4 <b>methodology</b> 22:15 22:17 83:9 <b>MI</b> 41:16 <b>Michael</b> 2:1,8,11 5:5 27:16 28:5 32:12 34:4 35:20 39:1,17 42:11 43:11 46:7,24 57:13,17 59:8 60:20 66:15,24 69:18 72:4 74:11 74:13 102:11 113:21 <b>Michigan</b> 1:22 <b>mid</b> 39:20 107:21 <b>middle</b> 79:7 <b>Midwest</b> 1:22 <b>might</b> 15:18 19:11 43:24 46:2 58:16 59:5,6,6 87:7 88:5 90:1 108:23 114:5 118:6 <b>Mike</b> 4:16 5:1 10:10 11:22 12:19 14:16 14:21 18:14 43:13 61:10 74:23 89:17 95:14 113:23 <b>million</b> 11:19 15:24 69:11,11 <b>mind</b> 10:23 20:24 28:9,12 57:1 59:5 <b>minimum</b> 7:22</p>	<p>15:23 32:5,6,24 33:1,2 34:21 35:3 <b>minor</b> 113:13 <b>minute</b> 42:18 69:8 <b>minutely</b> 38:19 <b>minutes</b> 3:4 6:7,9 6:13 8:23 46:9 49:6,7 52:4 57:13 77:3,12 116:15 <b>mirrored</b> 118:21 <b>Misacordia</b> 39:7,8 <b>miss</b> 80:19 93:11 <b>missed</b> 62:11 80:24 81:13 93:21 <b>missing</b> 79:18 83:23 115:23 <b>Missouri</b> 122:4 <b>mistakes</b> 93:8 <b>Mitzen</b> 2:10 4:22,22 10:15,19 20:12,15 23:14 24:4 25:3 25:14 26:7 33:10 33:14,21 34:1,5 36:12 38:5,10,14 40:23 58:4,8,12 58:15 59:3 61:7 67:4,11 74:16 78:12,18 81:20 82:20 83:6 85:7 85:15 90:22 100:21 101:2,7,11 102:10 107:16 110:17 112:4 114:15,19 119:21 <b>mix</b> 46:16 <b>mixed</b> 46:17 <b>model</b> 70:5 112:11 114:21 <b>models</b> 40:4,13,21 41:1 <b>modern</b> 80:1 <b>modernization</b> 11:18 17:19 69:9 69:15 79:22 92:1 105:2 <b>modernize</b> 69:16 <b>modifications</b> 113:13,13 <b>money</b> 52:20 73:6 84:4 108:9 <b>month</b> 112:1 115:14 <b>months</b> 47:12,14 52:8,12 58:2 59:9 115:10 <b>more</b> 13:24 28:3 29:6 30:6 35:2 36:2,10 37:9 43:17,24 54:12</p>	<p>55:12,14,15 56:2 62:24 68:12 80:15 82:19,20 84:8,12 88:3,9,9 91:21,24 95:23 96:1,24 97:3,14 99:1,14 99:16 116:11,21 <b>mortgage</b> 50:13 <b>most</b> 16:12 23:5,6 23:23 24:14 31:22 36:3 46:10,17 70:5,10 107:19 111:17 119:11 <b>motion</b> 5:21,23 6:8 6:12,22 120:15,18 <b>move</b> 14:24 29:22 51:23 120:16 <b>moved</b> 5:22 39:24 56:13 <b>moving</b> 8:3 28:11 45:24 <b>MR/ICFDD</b> 3:11 95:12 <b>much</b> 19:7 37:8 41:21 49:10 65:15 73:5 74:14 79:19 88:22 89:17 91:6 106:13 109:14 118:22 <b>multi-county</b> 21:10 <b>must</b> 47:4 48:4 66:12 69:3 <b>myself</b> 94:7</p> <hr/> <p style="text-align: center;"><b>N</b></p> <hr/> <p><b>N</b> 1:22 107:7 <b>name</b> 15:10,10 72:9 72:14,24 73:1 <b>narrow</b> 85:5 <b>national</b> 91:2 <b>nationwide</b> 19:17 <b>natural</b> 44:15 <b>nature</b> 97:23 <b>navigating</b> 87:4 <b>necessarily</b> 14:11 15:13 68:2 92:23 100:17 114:24 <b>need</b> 3:6 5:20,23 6:7 6:15 7:15,18 11:6 11:16 12:1 15:21 17:6 18:7 19:20 20:3 24:19,20 25:16,22 27:7,21 27:24 28:1,1,3,14 29:14,14,16,16,17 29:21,24 30:4,16 31:3,11 33:11 34:3 35:11,15</p>	<p>36:10,18 37:17 38:6,7 41:15,16 41:17 42:2,19,20 42:22,23,24 44:4 45:18 46:5,11,13 57:20 60:8,16,24 61:5,12 65:10,15 65:22,23 66:3 68:22,23 69:4,5,6 70:22 74:4,6 76:1 76:2,3 77:4 79:7 80:2,14 81:23,24 83:9,17 84:2,8,14 86:10,15,19 88:6 90:9 91:21,24 97:11 100:13 101:19,20,22 102:10,14,20 104:23 105:15 108:14,16,18 109:8 111:16 113:2,3 116:7,7 117:4 120:15 <b>needed</b> 9:6 30:20 31:1 33:8,15,19 33:20 35:12 42:9 91:23 111:1 <b>needs</b> 15:8 33:17 36:20 38:3 44:8 44:14 46:22 53:24 54:1 79:12 81:2 82:7,12 84:11 88:3 91:14,19 97:8 101:17 104:6 109:9 115:3 <b>negative</b> 43:10 52:16 92:5,9 <b>neither</b> 122:7 <b>Network</b> 103:24 <b>never</b> 18:12 29:3 37:20 58:5,6 63:2 64:13 72:23 <b>new</b> 9:4 17:17,19 29:22 30:13 53:8 54:7,9 59:10,21 59:22 61:9 63:24 65:7 66:22,23 67:5 70:5,23 71:4 71:24 81:4 82:7 93:8 114:11 <b>next</b> 20:17 34:6 47:14,21 71:1 78:2,24 79:17 94:8,11,14,22 99:6 101:5,18,21 101:23 102:17 109:1 115:5 <b>Neyna</b> 2:15 5:10</p>	<p><b>nice</b> 15:14 20:23 22:7 80:21 <b>nine</b> 41:14 104:10 <b>nineteen</b> 99:15,18 <b>nobody</b> 64:6 80:6 <b>Nonetheless</b> 44:7 <b>Non-elderly</b> 87:12 <b>non-Greeks</b> 68:5 <b>non-state</b> 78:17 <b>noon</b> 8:10,18 <b>north</b> 7:9,10 <b>note</b> 4:8 71:11 74:24 98:24 <b>notes</b> 29:17 77:19 <b>notetaker</b> 77:8 <b>nothing</b> 31:2 38:1,8 40:2 68:6,7 89:4 101:3 <b>notice</b> 13:16 73:9 96:9,10,12,19 101:9 <b>noticed</b> 54:24 65:6 <b>November</b> 1:13 79:2 <b>number</b> 14:1 19:24 22:7,16 30:16,16 30:20,21,23,24 31:15 32:10 33:2 34:17 35:13 40:19 40:21 41:20,21 43:2 47:13 48:1 49:23,24 50:23 52:13 64:24 65:2 65:2 66:8 69:12 75:1,4,19 76:5 82:13 83:8,13,21 83:21 96:22 97:10 97:14 99:21 <b>numbers</b> 19:21 25:4 34:22 42:14 95:19 <b>nursing</b> 10:22 11:11 11:12 12:5,6 13:15,17 15:21 16:2,19 24:17 25:1 36:3,8,10 43:16,18,21,23,24 50:11 53:13,19,21 54:1,5 56:15,16 56:22 82:1,2,11 82:19 86:18 88:7 118:14</p> <hr/> <p style="text-align: center;"><b>O</b></p> <hr/> <p><b>OASAC</b> 3:13 <b>objection</b> 76:18 <b>objectives</b> 79:9 <b>obligation</b> 51:3 52:24</p>
--	--	---	---	---

<p><b>observation</b> 36:19  <b>obviously</b> 19:16  20:2 27:3 37:22  92:11 112:21  115:4  <b>occupancies</b> 89:3  <b>occupancy</b> 16:23  19:2 20:4 35:12  35:21 36:15,16  44:19 45:13,14,16  49:5,8 50:18 58:3  59:9,10,17,19  80:16 85:17,20  88:22 92:8  <b>occupied</b> 50:4 51:14  <b>occurred</b> 33:16  <b>occurs</b> 96:6  <b>off</b> 7:19 51:2 59:18  77:10 78:22 79:10  84:1 95:3 117:15  <b>office</b> 15:18  <b>official</b> 4:8  <b>often</b> 17:22 24:7  44:5  <b>Oh</b> 10:23 20:8,15  32:14 99:12  111:10 119:2  <b>Ohio</b> 108:4,6  <b>okay</b> 5:20 6:23 7:13  9:3 10:2,5,13 17:8  17:20 18:2 20:16  23:24 24:4 29:17  29:20 47:22 48:12  50:9 53:23 54:4  56:17 77:16 79:5  81:17 83:24 85:15  97:10 98:11,15  100:14 107:23  112:7 118:18  120:6  <b>old</b> 21:14 44:22  52:13 54:10 56:3  68:14 72:19 85:3  <b>older</b> 64:1  <b>ombuds</b> 87:11  <b>Ombudsman</b> 5:9  <b>once</b> 59:11,14 94:15  96:3,9,11 97:13  101:9  <b>one</b> 4:4 7:2 16:24  20:12 21:14,16  22:2 26:22 27:12  27:13 28:7 29:17  31:10 34:7,16  36:20 40:18,19  43:21 45:10,11,16  45:23 47:20 49:12  52:5,17 53:1</p>	<p>54:12 56:2 60:15  64:8,10 66:17,22  66:23 67:5,5,15  68:19 70:6,17  72:7 73:3 75:22  76:21 78:24 80:24  84:1,5,6 85:8  87:14,20 88:3,5,7  89:22 90:14 92:6  93:17,24 95:1  97:4 103:20  106:13 109:22  115:17  <b>ones</b> 64:3 67:21  83:20 93:9 104:22  <b>only</b> 12:4 24:18  28:21 39:14 49:15  54:18 56:11 59:8  60:14 61:2 62:13  64:2 65:9 67:5  83:24 85:1,13  99:11 100:3  <b>onward</b> 88:20  <b>open</b> 3:12 8:14  14:17 72:6 76:4  95:18,20,21,23,24  96:5 97:5,9,13  98:2,5,21 99:3,22  100:9 112:7,23  118:4  <b>opened</b> 54:9  <b>opening</b> 53:8  <b>operate</b> 18:8  <b>operating</b> 53:5 70:8  71:19  <b>operation</b> 58:1  <b>operational</b> 51:1,3  51:5,9,9,15 60:17  <b>operationalized</b>  91:12  <b>operator</b> 108:15  <b>operators</b> 44:16  52:19  <b>opinion</b> 12:22 44:11  87:19 103:8,11  110:1  <b>opportunity</b> 23:1,18  35:7 73:10 92:6  107:8  <b>opposed</b> 6:4,20 34:1  120:21  <b>opposite</b> 36:17  37:17  <b>option</b> 24:18  <b>options</b> 4:14 28:2  83:10 90:17 110:3  <b>oral</b> 96:14  <b>order</b> 3:2 4:4 9:6</p>	<p>19:20 38:3 102:9  103:6 114:17  <b>orders</b> 78:9  <b>organization</b> 53:2  58:13 100:14  <b>organizations</b> 58:11  68:15 87:22  <b>original</b> 118:24  <b>originally</b> 55:11  <b>ostensibly</b> 89:24  <b>other</b> 8:24 12:9  13:21 16:24 23:6  25:11 27:1,8 28:1  37:7,24 38:4,24  43:10,22,23 45:15  49:6 52:7 59:9  66:1,2 67:8 70:7  70:12 76:20 78:4  80:16 83:10,15,20  85:7 86:13,24  87:14 88:15 90:5  90:8,13,19 93:5,6  95:14,16 96:7,23  103:9 110:13,19  108:23 108:3,14  111:1,4 112:1  115:14 116:20  <b>others</b> 43:17,18  67:7 82:3 105:24  <b>otherwise</b> 4:5 21:6  69:21 118:3  122:11  <b>ought</b> 83:15 93:4  <b>ourselves</b> 118:1  <b>out</b> 9:24 10:17,18  14:18 24:11 26:2  26:3 27:3,20 28:2  29:13 35:15 39:8  44:19 45:12 51:5  52:15 54:11 56:19  58:21 72:22 75:21  78:2 79:3,22  80:12 83:10 84:21  85:6 86:11,24  91:17 93:10 99:17  100:5 102:17  104:21 106:19  107:1 108:8  110:14 115:23  117:9,17 119:21  <b>outcome</b> 122:11  <b>outcomes</b> 80:14  <b>outline</b> 104:19  <b>outlined</b> 115:9  <b>outside</b> 7:16,17  54:20 83:18  112:19 120:15  <b>over</b> 8:24 14:3,4,13</p>	<p>25:11 31:18 36:13  40:20 41:4,24  56:8 59:23 61:18  65:6 67:5 106:12  115:19  <b>overall</b> 56:7  <b>oversight</b> 83:16  <b>overview</b> 11:7 14:9  16:16  <b>overwhelmed</b> 112:4  <b>over-bedded</b> 88:16  <b>own</b> 65:15 70:7 86:8  93:8  <b>owned</b> 66:13  <b>Owners</b> 54:4  <b>ownership</b> 15:22  <b>o'clock</b> 8:2  <b>O'dea</b> 2:7 9:12,12  21:1,6,9 28:19  31:6 47:20 49:9  63:24 64:6,20  68:10 79:1 80:24  83:2,4 103:13  106:9,14,23 107:3  107:22 108:1  119:3 120:17</p> <hr/> <p style="text-align: center;"><b>P</b></p> <p><b>package</b> 120:1  <b>page</b> 15:8 18:19,20  20:17  <b>pages</b> 112:3  <b>Palliative</b> 4:19  <b>paper</b> 102:18  <b>parent</b> 26:19 94:3  <b>Park</b> 72:8 73:3  <b>part</b> 8:4 21:20 23:2  30:12 34:6,6  39:18 40:21 76:21  76:22 79:13,13,13  79:23 80:11 81:13  105:2 106:23  115:11  <b>participants</b> 103:19  103:21  <b>participate</b> 76:8,16  <b>participating</b> 39:22  <b>particular</b> 91:22  <b>particularly</b> 36:24  81:23 88:12  <b>parties</b> 122:8,10  <b>parts</b> 41:17 56:9  <b>party</b> 100:11,11  <b>passage</b> 100:5  <b>passed</b> 101:17  <b>passively</b> 12:15  <b>past</b> 3:6 10:7 24:21  27:9 36:21 47:12</p>	<p>56:22 66:16  <b>Pat</b> 67:15 120:19  <b>patient</b> 31:18,19,21  32:4 34:9,19 35:8  35:9 42:4 47:4  48:4 71:19,20  <b>patients</b> 47:13  55:24  <b>Patricia</b> 2:7 9:12  <b>patterns</b> 98:15  <b>pause</b> 9:2,16 39:2  57:18 74:12 78:6  80:20 81:16 85:23  94:21 95:9  <b>pay</b> 29:6 78:20  117:24  <b>paying</b> 79:19  <b>payor</b> 48:17 75:2  <b>pediatric</b> 13:23  <b>pediatrics</b> 12:6,13  13:7  <b>people</b> 9:10 12:2  13:12 14:3,10  27:2,6,8 28:14  30:3,16 36:12  43:18 44:23 47:23  48:1 50:1 51:6  53:21 64:24 76:15  82:1,23,24 84:3  87:4,5,9,23 90:15  95:14,21,23 96:1  96:22,24 97:1,6  97:10,11 98:16,17  99:2,13,24 104:10  104:11 107:9  109:7,13 113:20  114:9 116:5 117:7  118:3  <b>per</b> 17:14 31:21  71:24 72:1,2  98:10  <b>perceived</b> 104:3  <b>percent</b> 11:20 16:1  16:9 17:15 19:2  22:6 32:6,7 33:2,3  33:4 35:11,21  37:3 44:2,3 47:4  47:23 48:3,6 49:5  49:8,20 51:20  55:22 56:22,24  58:3,21 59:19,23  66:12 68:5 69:24  85:17,20,20 91:14  <b>percentage</b> 16:23  25:22 50:18 55:24  <b>percentages</b> 16:22  <b>perfect</b> 37:21  <b>Performance</b> 5:6</p>
--	--	---	--	---

<p><b>perhaps</b> 29:20 53:23</p> <p><b>period</b> 73:9,11,12 73:15,17,20 96:9 96:10,12,20 101:10</p> <p><b>periods</b> 56:8</p> <p><b>permissible</b> 99:3</p> <p><b>permitted</b> 18:10,12</p> <p><b>person</b> 83:7 96:14 108:22 113:9 119:12</p> <p><b>personal</b> 117:9</p> <p><b>personally</b> 116:19</p> <p><b>person-centered</b> 82:16</p> <p><b>perspective</b> 91:19 91:24 109:14</p> <p><b>pet</b> 82:23</p> <p><b>Phillippe</b> 2:12 5:7,7 6:16 44:20 45:21 49:12,14,17 51:8 51:18 54:17,24 55:9 62:1 65:6,12 83:3 107:7 109:21 110:2,11 120:16</p> <p><b>phone</b> 116:22 118:2 118:4</p> <p><b>phones</b> 7:20</p> <p><b>phonetic</b> 2:4 4:20</p> <p><b>Phyllis</b> 2:10 4:22 27:18 86:17</p> <p><b>pick</b> 2:13 4:24,24 5:22 6:9,12 7:3,6 17:17,20 24:7,10 32:12,15,19 36:14 37:13,16 39:10,17 40:15 41:3 42:11 42:14 44:2,6 50:17,21 51:10,22 52:9,11,17,22 53:10,16,22 54:22 55:4,16,21 59:8 59:13,16,21 60:20 61:1 62:4 63:13 63:18 65:19 67:9 67:20 68:1,6 69:18,21 70:13,16 70:18 72:7,11,16 72:19,23 73:2,5 74:17 79:20</p> <p><b>picture</b> 20:19 27:23</p> <p><b>piece</b> 10:24 109:6</p> <p><b>pieces</b> 59:4</p> <p><b>Pioneer</b> 82:14</p> <p><b>place</b> 4:20 5:10 9:7 10:7 13:14 16:5 22:15 40:19 88:16</p>	<p>93:2,7 96:11 100:17 103:8</p> <p><b>places</b> 94:4</p> <p><b>plan</b> 20:1 34:23 38:16 40:22 49:10 79:13</p> <p><b>planned</b> 35:7,8,9,11</p> <p><b>planners</b> 87:10,15</p> <p><b>planning</b> 5:15 11:6 14:4 17:22 18:3 18:23 19:9,16,18 19:22,22,23 20:1 20:7,10 21:21 22:20 27:23 29:4 30:10 31:10 34:7 34:8,10,12 35:14 35:16,19 37:2,7 37:20 39:24 40:9 40:11 41:8,12,18 42:7,16 43:3,5 45:10 47:3,5,12 48:4,14,20,22 49:1,1 53:12 62:14 65:10 66:7 68:10,11 69:4 74:6 75:5 79:13 79:15,21 85:4 89:6,15 92:11,14 93:3 101:16 104:20 110:22</p> <p><b>plans</b> 82:15</p> <p><b>platform</b> 92:10</p> <p><b>play</b> 94:18 117:13</p> <p><b>please</b> 6:8 7:20 9:10 46:24 60:3 75:21 85:6 86:6 103:12</p> <p><b>pleasure</b> 28:6</p> <p><b>plus</b> 114:6</p> <p><b>point</b> 8:4 10:15 11:23 13:8 19:19 26:20 28:21 45:10 45:11 51:18 55:10 55:16 56:4,19 68:10,11 76:20 79:17 92:3 94:11 100:1,23 103:5,7 104:4 111:7 112:23 118:20 120:7</p> <p><b>pointed</b> 56:18 79:22</p> <p><b>pointing</b> 30:8</p> <p><b>points</b> 59:9 77:22 77:23 79:10 93:21 115:20 116:6</p> <p><b>policies</b> 3:9 18:3 27:4 48:21,23 60:17 76:4 102:21 111:16,17 118:12</p>	<p><b>policy</b> 4:23 5:15 23:3 64:21 94:5 102:20</p> <p><b>politics</b> 7:6</p> <p><b>poll</b> 58:24</p> <p><b>polling</b> 87:19</p> <p><b>poorly-performing</b> 92:21,22,23</p> <p><b>population</b> 14:3 18:24 20:4,5 22:19,23,23 23:3 23:5,10,17 25:2 25:23 31:17 32:1 32:2,4 34:11,20 35:5 41:19 42:6 44:17 52:5 60:6 65:24 66:2,5,8,13 66:14,16 67:1,24 68:5 81:1,12 84:15</p> <p><b>populations</b> 83:14</p> <p><b>portion</b> 14:6</p> <p><b>portions</b> 113:4</p> <p><b>position</b> 14:23</p> <p><b>possibility</b> 90:4 105:17</p> <p><b>possible</b> 32:12 47:6 78:6 80:1 112:2</p> <p><b>possibly</b> 43:17 113:10</p> <p><b>post</b> 73:9</p> <p><b>potential</b> 96:16 114:21</p> <p><b>potentially</b> 87:9</p> <p><b>Power</b> 10:15</p> <p><b>practice</b> 44:21 51:19</p> <p><b>practices</b> 82:15</p> <p><b>predict</b> 84:7</p> <p><b>predictability</b> 84:3 84:9</p> <p><b>predominantly</b> 96:8</p> <p><b>preferences</b> 81:11</p> <p><b>premature</b> 26:7</p> <p><b>prepare</b> 8:22 100:19</p> <p><b>prepared</b> 104:2 114:20</p> <p><b>present</b> 2:1,18 9:1 71:24</p> <p><b>presentation</b> 10:12 10:14 12:10 26:14 31:7 74:21 90:18 95:6 114:2 120:12 120:13</p> <p><b>presentations</b> 8:22 10:10 26:21</p> <p><b>presumption</b> 53:7</p>	<p><b>pretty</b> 51:21</p> <p><b>previous</b> 57:7 78:8</p> <p><b>Previously</b> 37:10</p> <p><b>primarily</b> 107:4</p> <p><b>prior</b> 9:7 37:9</p> <p><b>private</b> 51:23 70:18 80:15 97:7</p> <p><b>privilege</b> 6:23</p> <p><b>probably</b> 19:12 36:22 37:17 38:18 58:22,24 67:22 85:12 90:20 91:20 104:13 117:13</p> <p><b>problem</b> 27:20 65:12 97:6,8</p> <p><b>problematic</b> 97:13</p> <p><b>problems</b> 48:24 53:12,24</p> <p><b>procedures</b> 76:4 96:17 111:16 118:12</p> <p><b>proceeding</b> 122:11</p> <p><b>proceedings</b> 122:5</p> <p><b>process</b> 8:15 11:6,8 24:12 27:15 37:2 45:10 53:4 65:8 73:8 82:13 84:3 88:22 91:14 102:15 104:9 105:15,22 106:17 106:18,24 108:7 108:10 109:22 110:5,22 111:7 112:6</p> <p><b>productive</b> 115:16</p> <p><b>program</b> 5:13 70:12 84:5,5,16,17 108:4</p> <p><b>programmatically</b> 88:6</p> <p><b>programs</b> 68:23</p> <p><b>progressing</b> 29:23</p> <p><b>prohibited</b> 100:18</p> <p><b>project</b> 11:19 39:18 39:23 40:16 52:8 53:8 58:2 60:14 70:3 71:8,16,20 71:22 73:10 74:1 74:2 84:6 92:6,12 108:18</p> <p><b>projected</b> 24:11,19 30:24 35:5 41:18 42:6 47:4 48:3 52:17 71:5,5</p> <p><b>projecting</b> 24:24 26:3</p> <p><b>projection</b> 26:2 37:11 65:17,20</p>	<p><b>projections</b> 67:12</p> <p><b>projects</b> 11:5,16,18 15:20,23 39:5 59:10 69:9,15 70:5</p> <p><b>promulgated</b> 101:17</p> <p><b>proper</b> 14:18</p> <p><b>proposal</b> 101:15,18 101:22</p> <p><b>proposals</b> 9:4 84:12</p> <p><b>propose</b> 84:5</p> <p><b>proposed</b> 45:11 47:8 49:6,7 66:11 74:4 96:10 103:1 112:15 113:12</p> <p><b>proposing</b> 29:22 108:18</p> <p><b>protect</b> 44:9</p> <p><b>protecting</b> 44:16</p> <p><b>Provena</b> 9:23</p> <p><b>provide</b> 43:2 46:4 57:22 73:23 116:15 118:2</p> <p><b>provided</b> 22:24 23:17 35:23 79:24 117:24</p> <p><b>provider</b> 44:14</p> <p><b>providers</b> 4:17 43:10 44:9 52:8</p> <p><b>providing</b> 53:6,6 75:10 104:24 115:21</p> <p><b>provision</b> 13:7</p> <p><b>proxy</b> 76:13</p> <p><b>public</b> 5:12,14,16 23:2 38:15 52:23 53:2,13 54:9 55:18 73:10 80:3 87:19,20 90:2 96:3,3 97:1,4,24</p> <p><b>published</b> 16:16 73:16</p> <p><b>pull</b> 29:13 39:10 60:2</p> <p><b>punting</b> 89:12</p> <p><b>purely</b> 108:14</p> <p><b>purpose</b> 62:12 73:24 100:10 110:7</p> <p><b>Pursuant</b> 13:17</p> <p><b>put</b> 7:20 10:12 26:22 35:13 39:3 42:1 74:24 76:9 77:5,23 83:17,18 84:3 85:6 93:6 98:6 103:2 104:8 109:16 114:4</p>
---	---	--	---	--

117:17 <b>putting</b> 52:22 74:22 104:11 119:7 <b>P.M</b> 121:2	<b>rather</b> 37:18 41:4,6 83:9 <b>ratio</b> 23:14 52:5 71:3 <b>ratios</b> 71:5,6 <b>reach</b> 81:9 92:8 <b>reached</b> 100:23 120:7 <b>reactions</b> 117:8 <b>read</b> 10:22 109:11 116:21 <b>reading</b> 24:9 60:7 <b>ready</b> 101:22 <b>real</b> 70:7 79:8 85:11 <b>realistic</b> 87:24 <b>really</b> 7:4 15:12,13 29:12 45:23 46:1 46:4 55:13 68:8 69:19 75:16,16 79:11 80:9 81:8 81:22 82:21 84:7 85:21 86:20 89:4 91:16,17 93:4,19 95:5 100:21 102:11,13 105:10 109:11 110:4 115:10 117:10 119:9 120:11 <b>realm</b> 98:2 <b>reason</b> 12:8 40:17 41:3 48:10 54:12 62:7 90:12 109:24 <b>reasonableness</b> 71:9,16,22 <b>recalculate</b> 28:2 <b>recall</b> 96:21 <b>receive</b> 71:17 73:18 103:1 120:2 <b>recent</b> 31:22 37:16 66:18 <b>recently</b> 40:4 <b>Recess</b> 57:15 <b>recognition</b> 95:24 105:5 <b>recognize</b> 27:20 85:10 109:13 <b>recognizing</b> 85:12 <b>recommendation</b> 27:15 94:2 <b>recommendations</b> 26:11 28:22,23 29:18 76:2 94:3 102:19,20 111:15 118:10 <b>reconstituted</b> 114:16 <b>reconvene</b> 57:16 <b>record</b> 13:2 14:10	28:18 57:6 76:9 78:22 117:15 <b>recorder</b> 75:22 <b>red</b> 119:14 <b>redefine</b> 82:8 <b>redesigning</b> 82:9 <b>reduced</b> 122:7 <b>reduction</b> 38:18,19 <b>refer</b> 47:14 <b>reference</b> 14:14 <b>referencing</b> 53:17 53:17 <b>referral</b> 47:10 75:10 <b>referrals</b> 47:11,18 <b>referred</b> 19:18 81:21,22 <b>refers</b> 48:18 49:1 <b>reflected</b> 37:2 <b>reflects</b> 25:23 <b>refrain</b> 99:1 <b>regard</b> 19:8 <b>regarding</b> 8:7 17:6 39:4 42:15,22 68:24 96:16 <b>regardless</b> 44:4,10 <b>regions</b> 70:8 <b>region</b> 33:8 47:24 <b>Regional</b> 5:9 <b>regions</b> 20:6 30:17 <b>regs</b> 111:17 <b>regularly</b> 67:22 <b>regulation</b> 94:5 104:7 <b>regulations</b> 9:5 96:10 105:7 113:11 118:21,21 <b>regurgitate</b> 99:5 <b>Rehab</b> 5:2 15:12 <b>Rehabilitation</b> 4:24 <b>reimbursed</b> 50:4 54:20 <b>reimbursement</b> 54:5 55:12,23 93:19 <b>reinstated</b> 73:13 <b>reinvent</b> 93:9 <b>reiteration</b> 96:13 <b>relate</b> 40:8 <b>related</b> 73:19 74:8 122:8 <b>relates</b> 90:9 <b>relationship</b> 10:21 <b>relative</b> 122:9 <b>relatively</b> 51:13 <b>religious</b> 66:3 67:1 67:8 68:13 <b>remember</b> 72:14 73:1	<b>removal</b> 71:11,11 <b>removed</b> 18:13 39:13 <b>reopens</b> 73:17 <b>replace</b> 11:17 <b>replacement</b> 68:20 69:19 <b>report</b> 50:23 51:4 59:12,15 73:19 84:10 89:20 100:16 <b>reported</b> 1:20 17:11 <b>Reporter</b> 122:1,4 <b>reporting</b> 51:16 59:10 89:23 <b>reports</b> 11:9 55:6 73:16,22 <b>represent</b> 32:21 109:14 112:24 <b>representative</b> 26:23 <b>representing</b> 15:12 <b>represents</b> 10:21 107:11 112:22 <b>request</b> 47:2 90:2 <b>Require</b> 89:20 <b>required</b> 21:23 26:3 50:23 <b>requirement</b> 40:16 96:4 <b>requirements</b> 11:6 11:7 83:19 95:22 <b>requires</b> 30:9 <b>requiring</b> 11:5,16 15:20 <b>Research</b> 4:23 <b>residence</b> 83:4 <b>resident</b> 56:23 60:18 64:11 82:15 <b>residential</b> 14:7 <b>residents</b> 43:3,17 47:4 54:20 60:14 63:9,15 66:12 <b>residing</b> 63:21 <b>resolution</b> 15:2 <b>resolved</b> 13:9 15:2,8 <b>resources</b> 52:23 <b>respect</b> 112:21 <b>respond</b> 117:8 <b>response</b> 6:5,21 27:19 28:5 57:12 120:22 <b>restricted</b> 61:1 <b>restrictive</b> 48:21 <b>result</b> 43:7 <b>results</b> 80:17 <b>retired</b> 5:3 <b>retrospectively</b>	38:16 92:11 <b>return</b> 77:13 <b>revenue</b> 50:20 <b>review</b> 1:2,12 3:12 5:19 11:8 16:15 18:20 40:4,23 42:23 73:9,11,12 92:17 98:18 108:10 <b>reviewed</b> 13:11 96:22 <b>revise</b> 21:23 114:3 <b>revised</b> 103:22 <b>revisions</b> 114:8 <b>Rick</b> 2:14 5:12 76:7 76:7 113:23 <b>rid</b> 90:11 105:15 108:4 110:14,16 <b>right</b> 7:16 16:17,22 22:22 25:5 28:24 29:12,16 31:14 38:14 49:15 50:8 50:19,21 52:1 53:10 54:4 58:18 63:13 67:3,23 69:23 72:16 81:3 81:3 90:21 98:11 101:3 106:7 110:8 113:13 114:19 120:5 <b>Road</b> 36:5,9 <b>role</b> 26:17 27:3 40:9 <b>roles</b> 27:13 <b>roll</b> 4:8 <b>room</b> 10:3 12:1 19:11 27:6,6 82:3 109:13 118:2 <b>rooms</b> 51:13 80:15 <b>Rose</b> 72:13,13,15,24 <b>RPR</b> 1:21 122:3,15 <b>RSMeans</b> 71:18 <b>rule</b> 7:23 22:8,9,10 35:22 44:3 48:11 63:2,6 65:13 69:24 96:17 100:13,15 <b>rules</b> 3:7,8 4:5 9:5 18:19 27:4 29:22 32:9,15,18 35:23 42:20 45:12 60:9 61:6,11 62:5,20 70:21,22,23 100:4 100:7,19 101:4,7 101:17,20 102:9 102:20,21 103:1 104:16,18 105:11 113:23 114:9,18 114:20 117:4
<b>Q</b>				
<b>quality</b> 44:10 79:24 <b>quarter</b> 71:18 <b>question</b> 13:9 16:4 16:24 22:2 25:7,9 25:17 26:2,8 27:16,18 28:4,10 30:15 39:17 45:23 47:15 49:4,12 50:2 51:7 53:11 54:17 56:2 63:8 64:10 67:4 71:1 74:7,23 84:24 85:21 96:21 97:15 98:3 99:5 102:11 103:13 106:10,16 108:24 109:21 <b>questioning</b> 25:20 <b>questions</b> 8:3,24 26:21,24 30:12 38:24 42:22 45:22 47:3 70:1 74:3,8 74:10,11,20 95:17 111:4 <b>quickly</b> 51:14 91:10 <b>quite</b> 22:15 27:8 45:24 78:18 102:13 <b>quorum</b> 4:4 10:3 99:18,19,20				
<b>R</b>				
<b>Rainbow</b> 4:18 <b>raise</b> 26:24 27:7 40:17 41:3 <b>raised</b> 26:15 <b>raising</b> 26:8 30:4 <b>random</b> 76:5 <b>range</b> 86:18,19 88:6 <b>rapidly</b> 37:9 45:24 105:6 <b>rare</b> 70:19 <b>rate</b> 3:12 32:3,6 33:3,3,4 34:18,23 35:1,8 36:2,3,8,11 36:15,16,19,22,23 45:14,16 54:23 55:1 56:4,9,14 56:15 85:17,20 <b>rates</b> 34:20 36:16 50:13 55:6,7 56:5 56:8,20 71:14 80:16				

<p>119:7 120:3  <b>rule-making</b> 102:15  <b>run</b> 47:1 58:23  67:22 72:22  <b>rural</b> 85:11</p> <hr/> <p style="text-align: center;"><b>S</b></p> <p><b>S</b> 107:7  <b>sale</b> 71:11  <b>same</b> 12:7 15:8 34:7  35:4 51:9 60:13  76:19 77:1 80:23  93:8 98:22 104:3  118:6  <b>Sangamon</b> 31:10,12  31:15 34:8,10,11  34:16 35:14 42:8  <b>SAR</b> 73:17  <b>sat</b> 98:5  <b>satisfy</b> 60:22  <b>saw</b> 98:17 111:7  <b>saying</b> 10:23 24:5  30:8 36:10 43:21  44:9 45:8 62:16  85:3 109:9 110:16  113:20  <b>says</b> 13:4,16 63:8  <b>scale</b> 97:23  <b>Scavotto</b> 2:11 5:5,5  6:1 53:7 54:8 55:3  72:15 74:23 75:9  75:13 107:20,23  <b>schedule</b> 115:9  <b>scheduled</b> 78:24  111:12 118:6  <b>school</b> 58:13  <b>schools</b> 81:6  <b>scope</b> 82:12  <b>Scout</b> 72:19  <b>scratch</b> 112:14  <b>SDS</b> 89:23 90:4  <b>se</b> 98:11  <b>second</b> 5:24 6:1,15  6:16 7:19 58:1  87:2 91:16 111:11  111:21 117:12,14  120:17,19  <b>secondarily</b> 53:3  <b>secret</b> 54:8  <b>secretary</b> 75:22  <b>section</b> 42:20 70:20  70:23 114:11,11  119:14,14  <b>sections</b> 18:18 113:3  <b>securities</b> 71:12  <b>see</b> 6:9 8:17 15:10  17:14 19:24 27:2  27:8 35:3 38:5,16</p>	<p>39:5 46:11,19  47:5 48:8,22 50:1  52:16 58:18,18  60:17 69:9 70:5  77:6,24 79:23  80:15 87:22 94:15  102:12 103:14,17  109:3 110:19  113:24 114:5,9,19  114:23 115:1,11  116:22,24 117:24  118:1,16 120:24  <b>seeing</b> 27:9,23  58:23 69:14 70:4  70:11 117:8  <b>seeking</b> 37:4  <b>seem</b> 79:18,20  <b>seemed</b> 42:14  <b>seems</b> 33:14 40:2  51:18 68:11 89:10  106:17 114:22  <b>seen</b> 69:13 113:22  114:8  <b>segregate</b> 94:9  <b>SEIU</b> 76:14  <b>selection</b> 3:5 6:24  <b>self</b> 83:20  <b>sell</b> 50:11,12  <b>semi-private</b> 51:24  <b>send</b> 32:17 112:19  <b>sending</b> 47:18  <b>senior</b> 24:18 25:1  70:13 105:8  <b>seniors</b> 24:19  <b>sense</b> 11:24 13:21  14:5 83:17 90:3  <b>sent</b> 6:11 79:4  <b>separate</b> 10:2 40:10  60:10  <b>separately</b> 104:2  <b>September</b> 3:4 6:7  6:13 79:2 101:18  101:21,22 102:22  <b>serious</b> 27:20 65:23  <b>Seriously</b> 117:6  <b>serve</b> 60:14 68:1  81:9  <b>served</b> 55:24  <b>serves</b> 14:7  <b>service</b> 16:15 18:22  19:8,18 20:18  22:20 39:12,13  41:11 42:3 43:2,4  43:8,8,10 44:9,10  44:18 47:3 66:6  66:11 74:4 79:16  81:1 86:13,24  91:22</p>	<p><b>services</b> 1:2,12,22  5:4,11,19 18:20  24:22 28:15 37:1  37:7,24 38:4 46:1  46:4 49:3,4 52:3  53:6,17 66:9,10  81:7 84:16,20  86:18,20 98:18  103:24 105:1  <b>servicing</b> 76:13  <b>session</b> 96:4  <b>set</b> 12:10 22:6,8  28:8 49:19 51:13  56:12 68:14 78:23  114:4  <b>sets</b> 85:14  <b>setting</b> 56:4  <b>set-up</b> 50:24  <b>seven</b> 41:13 76:6  83:21 85:19  104:10  <b>several</b> 45:3  <b>shaking</b> 114:9  <b>shape</b> 95:3  <b>share</b> 14:23  <b>shared</b> 93:1  <b>shed</b> 54:10  <b>sheer</b> 97:9  <b>sheets</b> 77:24 102:18  <b>shelter</b> 16:21 17:2  <b>sheltered</b> 11:14  <b>Sheridan</b> 36:4,9  <b>Shiner</b> 2:15 5:9  <b>short</b> 11:7,8 57:1,4  <b>shortage</b> 49:2 53:17  <b>shortly</b> 68:18  <b>show</b> 29:15  <b>Shower</b> 83:2  <b>shown</b> 42:17  <b>shut</b> 31:8  <b>side</b> 107:5 119:7,7  119:19,19  <b>side-by-side</b> 118:23  <b>significant</b> 56:19  <b>significantly</b> 55:1  <b>sill</b> 14:2  <b>similar</b> 104:3,11,13  <b>simple</b> 30:15 81:17  <b>since</b> 13:14 38:18  40:18 56:6 57:11  63:6 78:16 107:21  <b>single</b> 25:1  <b>sit</b> 115:16 117:2  <b>site</b> 6:10 16:14,15  53:19 60:13  <b>sites</b> 39:22  <b>sitting</b> 14:10 18:1  98:19 101:5</p>	<p><b>situation</b> 96:11  106:8  <b>situations</b> 45:6  <b>six</b> 11:18 15:23  41:13 42:22 47:2  69:11 74:3 75:24  76:5 83:21,21,24  94:18 96:24 97:6  97:11,14 98:17  99:1,14,20,22  <b>sixty</b> 32:6,7,8,9 33:3  <b>size</b> 57:21 74:1,2  106:5  <b>skilled</b> 11:11 12:6  12:13 13:7,23  16:20 28:11,14  46:1 82:18 107:4  <b>skip</b> 8:13  <b>slide</b> 10:20 12:14  42:17 75:1  <b>slowly</b> 55:4  <b>small</b> 10:12 14:6  20:1 42:14 46:21  75:24 100:8  111:18  <b>smaller</b> 20:2,4  106:7 108:2 115:4  116:4  <b>sold</b> 73:4,5  <b>sole</b> 53:8  <b>solution</b> 40:22  91:18 92:2  <b>solutions</b> 93:6  <b>some</b> 9:4 19:10,20  21:9 29:18 30:11  38:12,17 39:4  40:13,21 41:4,5  43:16,17,18 44:13  44:21 45:5 46:3  46:16,20 53:24  54:9 55:10 56:4  56:13 62:7 64:1  64:12 70:18 77:6  77:19,24 78:4  79:8 82:1 83:16  85:11 86:14,15,20  87:18 88:13,20  90:1,3,6,12,23,23  92:16,17 93:1,5,7  95:17 104:14  109:4 110:22  112:10 113:12  115:4 117:4,10  118:11  <b>somebody</b> 7:8 28:9  33:17 63:11 88:11  90:19 98:17,20  <b>someone</b> 19:11</p>	<p>25:12 38:1 57:17  77:5,7,18 78:3,21  115:20 116:2  118:13  <b>something</b> 28:23  36:4 40:24 44:8  45:18,19 53:15  54:15 78:8,19  81:13 87:18,21  88:9 89:2 90:24  91:1 93:10,12  98:3 108:18  109:17 110:4  112:10 113:15  115:23  <b>sometime</b> 102:22  <b>sometimes</b> 10:21  <b>somewhat</b> 87:24  <b>somewhere</b> 44:24  86:23 102:5  <b>sorry</b> 15:11 17:18  21:1 22:3 34:5  36:7 37:14 48:2  56:2,17 57:7  76:11 81:14  105:13  <b>sort</b> 12:11 26:19  83:16 87:18 89:23  90:1,13 105:4  110:22 115:8  <b>source</b> 50:20 70:16  <b>southern</b> 68:21  <b>so-called</b> 20:1  <b>speak</b> 19:13 30:1  <b>speaking</b> 77:17  105:3  <b>specialized</b> 39:4,20  41:9,15 88:15,19  <b>specific</b> 40:5 49:4  68:1 96:21  <b>specifically</b> 18:4  73:19 91:13 92:1  <b>spend</b> 46:9 110:4  <b>split</b> 21:6,7  <b>spokesman</b> 77:4  <b>spokesperson</b> 75:23  77:16 86:2 91:7  <b>sponsored</b> 66:14  <b>spot</b> 75:21  <b>spouse</b> 63:19,19  <b>Springfield</b> 1:4 7:9  7:11 10:1 31:15  72:1,3  <b>square</b> 71:24 72:2  <b>staff</b> 2:19,20 8:21  8:24 9:8 10:6  14:24 17:22 84:10  94:7 99:8 103:9</p>
--	---	---	--	---

<p>116:11 118:7 120:8 <b>staffing</b> 57:21 89:14 89:16 <b>Staff's</b> 95:6 <b>stand</b> 92:19 <b>standard</b> 52:11 71:21 <b>standards</b> 71:6 74:2 <b>standing</b> 100:5 <b>standpoint</b> 40:9 <b>stands</b> 40:14 <b>start</b> 4:1,5,6,11 7:23 51:19 58:7 59:4 78:2 81:21 91:1 91:21 95:2 97:12 104:17 112:13 113:24 114:10,12 <b>started</b> 24:17 92:20 <b>starting</b> 41:4,7 94:11 103:5,7 111:7 118:20 <b>starts</b> 96:12 <b>state</b> 1:1,11 11:9 13:23 14:1 16:3 16:19 17:22 18:7 18:9,21 20:15 22:7,9 34:8 41:10 45:2 50:6 51:17 52:6,18,20 54:1 54:19 55:21,23 73:16,19 75:7 79:20 81:4 100:19 104:4 106:11 108:3,9 110:3 <b>stated</b> 93:17 <b>statement</b> 11:23 20:11 25:6,8 70:9 109:9 117:9 <b>states</b> 90:8,13,19 93:1,5,6 105:21 105:23 106:6,7 107:17,17,19 108:13,13,20,23 110:14 111:2 122:4 <b>state-wide</b> 37:3 84:22 <b>static</b> 25:21 <b>statistics</b> 5:15 16:13 23:3 <b>stats</b> 20:5 <b>status</b> 48:17 57:23 75:2 <b>statute</b> 21:23 24:9 26:3 30:9 37:11 37:12,13 101:15 <b>statutorily</b> 37:6</p>	<p><b>statutory</b> 95:12 118:22 119:6 <b>stay</b> 88:14 <b>stayed</b> 56:14 88:12 <b>steady</b> 38:19 <b>step</b> 99:6 <b>Stephanie</b> 2:6 57:5 57:8 86:1 87:5 <b>Stephanie's</b> 86:1 <b>stepping</b> 7:5 <b>steps</b> 102:14 <b>still</b> 12:22 13:13 24:24 37:7 39:22 40:15 45:5 54:4 55:5 60:9 61:17 86:5,8 113:16 <b>stop</b> 47:18 <b>stopped</b> 8:10 56:4 76:7 <b>stopping</b> 64:7,8 <b>storage</b> 51:13 <b>straight</b> 28:9 <b>strategic</b> 85:3 <b>strategy</b> 49:20 <b>street</b> 1:3 67:16 <b>stronger</b> 118:17 <b>structures</b> 105:7 <b>student</b> 90:23 <b>study</b> 47:6 <b>stuff</b> 41:5 74:22 85:2 86:21 88:20 98:6 100:20 106:14 115:22 118:22 <b>sub</b> 21:20 <b>SUBCOMITTEE</b> 1:9 <b>Subcommittee</b> 1:13 <b>subdivided</b> 18:22 19:22 <b>subject</b> 11:5,10,14 12:3,22 29:13 39:8 98:5 <b>submit</b> 115:1 <b>Submittal</b> 73:8 <b>submitted</b> 73:24 113:17 <b>submitting</b> 40:15 <b>subsequent</b> 3:14 78:9 <b>subsequently</b> 39:7 <b>suburban</b> 4:15 21:4 21:12,13 <b>sub-acute</b> 39:21 40:6 <b>sub-areas</b> 19:6 21:17 <b>sub-committee</b> 96:2</p>	<p>96:18 97:2,7,12 97:15,17,18,19 98:8,20 99:2 100:12 113:16 <b>sub-regions</b> 30:17 <b>sufficient</b> 48:19 70:10 <b>suggest</b> 15:5 59:16 <b>suggested</b> 94:5 113:20 117:19 <b>suggesting</b> 8:15 110:13 113:10 <b>suggestion</b> 89:14 <b>suggestions</b> 26:19 78:4 89:8,11 103:10 104:19 112:8 <b>Sullivan</b> 2:22 9:21 9:21 24:15,15 25:5,8,18 35:24 35:24 36:7 55:7 56:7,13,18 64:4,8 66:15,23 68:7,12 70:17 72:4 73:4 103:22 105:13,18 105:24 106:7,11 106:22 107:1,6,10 107:14,19 109:16 118:19 119:2,5,10 119:13,17 <b>summarize</b> 77:6 117:21 <b>summation</b> 102:18 <b>supply</b> 44:15 45:5 <b>support</b> 56:9,14 57:22 58:11 68:23 81:6 <b>supportive</b> 11:15 24:23 28:1 79:14 107:11 <b>supports</b> 13:6 <b>suppose</b> 93:9 118:3 <b>supposed</b> 86:10 103:1 <b>sure</b> 8:22 15:9 17:1 22:4 32:14 43:19 47:16 50:5 52:24 53:4 60:4 76:7 79:23 81:11 82:4 92:18 101:2 103:20 <b>surgery</b> 40:6 108:8 <b>surprised</b> 10:24 62:10 <b>survey</b> 53:4 87:19 <b>surveys</b> 24:2 31:19 <b>suspect</b> 59:20 <b>system</b> 87:5 93:2</p>	<p>107:24 <b>Systems</b> 20:7 <hr/><b>T</b><hr/><b>table</b> 14:18 15:16 109:17 <b>tacit</b> 8:1 <b>take</b> 22:23 23:5,17 24:20 26:21 29:14 30:23 31:18 32:1 34:21 35:5 37:6 37:24 42:8 43:15 44:13 53:24 57:1 57:3 62:22,24 65:22 69:8 77:19 81:8 90:8 92:6 94:7 98:22 102:14 110:18 113:17 114:11 <b>taken</b> 29:21 43:20 51:5 55:16 122:6 <b>taker</b> 4:9 <b>takes</b> 31:14 34:15 52:12 <b>taking</b> 29:15 37:5 104:12 112:11 119:7 <b>talk</b> 10:6 12:8,24 14:17,22 29:12 42:18 45:19 62:19 69:8 73:22 79:11 80:14 82:6 84:14 93:20 95:16 97:7 97:16 98:1,4 99:2 100:6 101:4,6,7 108:11 110:3 118:9 <b>talked</b> 11:23 12:23 31:16 40:24 49:17 74:3 83:13 85:8,9 85:17 86:12 87:2 88:21 90:16 91:11 91:13 92:1 94:24 95:11 97:18 105:19 114:6,7 <b>talking</b> 13:4,5,22 29:7 34:2 38:10 61:8 65:2 81:4,24 82:1,11 95:10 96:8 97:12,21,22 98:7,20 100:15 101:13 108:12,13 111:6 114:13 <b>target</b> 19:1 22:5 36:15,16,17 37:4 37:4 49:5,8 91:14 <b>targeting</b> 47:23 <b>targets</b> 92:9</p>	<p><b>task</b> 7:19 9:4 37:23 78:1 104:2,7 110:9 113:1 <b>tax</b> 49:23,24 50:3,7 <b>Team</b> 80:19 <b>tear</b> 54:10 <b>technicalities</b> 86:21 <b>technique</b> 97:22 <b>teleconference</b> 116:16,18 <b>tell</b> 4:12 46:6 62:10 76:11 101:2,11,19 105:12 <b>tells</b> 16:22 <b>ten</b> 11:20 15:24 16:9,9,9 37:12 73:20 99:18 105:10 117:18,20 <b>Teri</b> 2:16 5:11 15:11 <b>term</b> 62:20 88:24 92:4 <b>terms</b> 9:5 24:22 71:13,14 72:5 80:4,5 81:10 82:18 91:19 118:12 <b>Terry</b> 2:22 9:21 24:15 25:6,15 27:24 35:24 45:11 55:17 91:4 93:1 101:5 103:20 109:8 112:22 114:4 118:18 <b>Terry's</b> 114:20 <b>Texas</b> 90:10 105:15 106:11 <b>thank</b> 5:20 6:14,17 7:4 8:20 10:19 15:19 16:11 17:8 27:17 28:4,4,16 43:13 47:22 56:17 74:13 84:1 85:24 91:6 120:8,23 <b>their</b> 26:22 28:10 44:17,18 52:4 60:17 61:2 63:20 65:15 66:5 68:4 69:16 71:4 81:10 83:1 90:9 92:8 104:12 114:9 117:8 <b>themselves</b> 9:10 <b>therapy</b> 82:23,23 <b>thereto</b> 122:10 <b>they'd</b> 7:1 <b>thing</b> 31:11 49:15 58:19 60:2 80:11</p>
---	--	---	---	---

<p>80:24 84:14 85:16 86:9 87:2 88:2,21 89:5,10 90:7 91:16 93:17 95:11 95:16 98:22 113:14 <b>things</b> 10:8,9 12:4,9 13:19 15:12 26:18 27:8,9 28:7 29:13 46:14 52:18,24 53:14,20 61:8 77:5 82:16,22 83:14,15 85:6,8 91:9 92:10 93:23 94:6 97:23 102:13 104:3,5,15 107:15 111:16 114:6 115:13 <b>think</b> 7:14 10:17,21 12:1 13:11,12,13 13:20,20 14:8,18 14:20 18:11 25:14 25:15 26:9,13,16 27:10,12,17,19 28:7,11,20 29:13 29:19,22,23 30:1 30:2,7 34:3 35:14 35:20 36:20 37:23 40:17,24 44:7,12 44:16,16 45:5,7,8 45:18,21 46:8,10 49:17 52:17 54:12 55:10,11,16 56:21 59:3,4,6 61:16 64:15 75:13 76:1 76:7,18 77:3 78:1 78:11 79:22 80:7 80:10 82:4,20 87:6,16 93:15,18 94:5 95:5,11 97:21 98:1 102:12 102:13 103:7,8 104:9 105:4 108:21 109:6,8,9 109:12,19 110:17 111:11,12,13,22 112:2,9,12,23 113:1,2,19 114:7 114:21 115:2,3,8 115:14,15,15,16 115:19,22 116:7 116:15,17,21 117:4,6,10 118:10 118:11,13,15 119:14 120:6 <b>thinking</b> 12:11 26:15 85:4 93:24 94:6 100:12</p>	<p>102:17 <b>third</b> 51:14 56:15 88:2 92:3 100:11 100:11 <b>though</b> 9:9 18:6 21:2 25:4,11 36:15,19 45:15 63:1 81:21 <b>thought</b> 40:13 53:18 62:11 63:19 88:2 93:4 99:12 102:24 103:5 108:5 <b>thoughts</b> 8:7 93:24 95:19 <b>thousand</b> 32:4 42:12 <b>three</b> 18:24 31:17 33:1 34:20 51:10 70:1 71:3 74:8 83:8 103:23 104:8 105:3 109:14 112:10 115:10,12 116:8 117:18,20 <b>threshold</b> 69:10,22 <b>through</b> 8:8 27:10 28:13 31:6,10 47:1 65:8 68:2,18 70:11 75:2,19 78:14 87:23 89:14 89:16 91:9 93:21 94:1 104:9 106:17 111:8 113:12,14 116:8 118:1 <b>tie</b> 13:1 55:12 111:22 <b>Tim</b> 5:7 56:18 120:18 <b>time</b> 4:1,5,5,6 6:24 7:14,24,24 8:1,4,9 8:18,23 19:19,22 23:8,21 29:15 36:21,23 37:18,22 39:6 45:10,11 56:5,9 59:10 64:3 70:5 99:17 100:18 101:8 102:10 103:22 104:18 105:20 106:2 110:4,12 115:8 117:1 120:13 121:2 <b>times</b> 18:9 32:4 35:7 52:6 <b>Timothy</b> 2:12 6:17 <b>Tim's</b> 50:22 <b>tips</b> 97:23 <b>today</b> 5:21 10:8 11:4 46:1 55:13</p>	<p>78:1 83:10,12 92:22 103:4 114:2 114:7 120:24 <b>together</b> 10:12 12:1 12:24 74:22 77:24 95:15 97:7,10 98:7 99:5 103:2 105:10 107:15 111:18,20,22 113:3,5 114:4 <b>Tom</b> 9:23 <b>tool</b> 109:13,20 <b>top</b> 59:18 75:24 <b>topical</b> 119:13,15 <b>topics</b> 78:3 97:4 115:3 <b>torn</b> 93:23 <b>total</b> 11:20 16:1 17:11,15 20:15 27:23 35:9 41:20 <b>totally</b> 7:15 8:14 83:11 <b>track</b> 65:4 84:1 <b>transcript</b> 29:20 96:22 <b>transferred</b> 60:18 64:11 <b>transitional</b> 88:8 <b>translate</b> 36:9 <b>traveled</b> 45:2 <b>trend</b> 65:6 <b>tricky</b> 89:10 <b>tried</b> 19:10 20:19 <b>triggered</b> 41:2 95:21,22 100:24 <b>triggers</b> 95:23 97:13 99:22 <b>Triple</b> 87:8 <b>trouble</b> 75:11,13 <b>true</b> 28:19 45:4 51:17 93:22 107:6 <b>try</b> 8:8 15:15 22:16 23:5 24:6 30:19 73:23 77:11,20 78:13,15 79:23 84:4 99:1 100:11 115:16 118:7 <b>trying</b> 33:18,19 81:9 82:18 84:17 87:3 104:17 <b>Tuesday</b> 117:23 <b>turn</b> 7:19 8:24 115:19 <b>turned</b> 35:15 <b>tweak</b> 114:24 <b>tweaked</b> 38:3 <b>twenty</b> 11:1,20 16:1 16:6 44:3 68:5</p>	<p>73:14 <b>twenty-one</b> 104:11 <b>twenty-two</b> 33:1 <b>two</b> 8:1 13:24 18:11 21:24 23:13 24:8 34:6 39:15,15 40:21 41:17 44:6 52:15,24 58:21 60:5 70:6 71:23 82:13 85:7 88:3 93:24 94:6,10,22 95:21 99:11,12,16 99:24 111:12 115:12 116:8 117:23,23 <b>type</b> 14:5 17:7 31:3 40:11 58:19 95:24 <b>types</b> 46:1 80:16 82:15 88:15 <b>typewriting</b> 122:7 <b>typically</b> 113:22,24 114:8,10</p> <hr/> <p style="text-align: center;"><b>U</b></p> <hr/> <p><b>ultimately</b> 91:20 93:1 <b>Um-hum</b> 106:22 <b>under</b> 12:5,6,13 13:7 16:20 18:19 39:19,23 54:2 69:24 83:15 90:1 96:17 115:8 118:6 <b>underlying</b> 110:18 <b>understand</b> 4:4 10:8 12:10 14:22 26:1 60:1,20 78:10 81:8 84:9 <b>understanding</b> 117:7 <b>understood</b> 110:24 <b>unfinished</b> 3:10 95:10 <b>unfortunately</b> 25:10 35:13 <b>unfrozen</b> 56:9,10 <b>unit</b> 60:19 63:9 64:12 <b>units</b> 38:13 63:10 87:8 <b>unless</b> 38:1 78:3 99:2 <b>unnecessary</b> 52:3 <b>until</b> 100:7 115:12 <b>updated</b> 24:7 56:10 <b>updating</b> 24:12 <b>urologist</b> 5:4 <b>Urso</b> 2:18 5:18,18 14:16,21 15:4,9</p>	<p>15:15,19 18:1,14 18:17 29:1,5,11 30:6 34:13 45:8 58:7 62:22 63:3 65:17,20 70:20 76:23 89:7 90:14 90:20 94:24 95:10 97:21 98:12,14 99:7,11,20,24 100:10 101:1,4,9 101:13 102:4 109:1,3 110:7,24 113:22 116:13 117:4 120:1 <b>usable</b> 54:16 <b>USDA</b> 70:12 <b>use</b> 7:15 19:21 23:10,12,24 24:1 24:3 25:22 27:22 31:4 32:3,6,8 33:3 33:3,4,10,11 34:18,20,22,23 35:1,1,7 36:2,3,8 36:11,16,19 37:10 47:7 59:5 63:11 65:7 88:24 92:4 92:13 94:10 109:12 110:11,15 114:22 117:16 118:3 <b>used</b> 25:20 31:23 33:8,15,17,22 37:10 60:7 61:4 61:11 65:14,20 89:3 90:3 <b>uses</b> 104:19,20 <b>using</b> 23:9 33:21 35:21 40:24 55:5 92:10 <b>usually</b> 67:23 <b>utilization</b> 17:7 23:8 23:10,11 24:1 26:5,6 33:13,13 52:4,7 53:9 89:3 <b>utilize</b> 114:7</p> <hr/> <p style="text-align: center;"><b>V</b></p> <hr/> <p><b>validity</b> 91:13 <b>value</b> 50:10 <b>variance</b> 45:13 61:17,20,21,23 62:13,20 65:7,11 66:3 68:3 69:6 80:9,10,12 83:16 83:18 <b>variances</b> 60:8 61:4 61:12 83:13 92:16 <b>various</b> 53:14,14</p>
---	--	---	--	--

56:8 <b>vehicle</b> 46:3 <b>vehicles</b> 40:18 <b>version</b> 119:1 <b>versions</b> 119:17 <b>versus</b> 32:20 33:17 50:24 51:12 81:1 82:2 85:10 <b>very</b> 7:2 27:19 36:8 39:5 45:9,14,15 46:2 55:4 59:20 64:12 70:19,19 74:13,14,17 80:21 82:21 91:6 104:2 104:5,11,14,14,15 104:18 105:2 107:24 108:5 109:12,12 116:6 <b>veteran's</b> 16:3 <b>via</b> 56:11 <b>viability</b> 72:5 74:9 <b>viable</b> 70:2 71:2 72:23 <b>vibrate</b> 7:20 <b>Vice</b> 3:5 <b>Vice-Chair</b> 6:24 7:3 94:17 99:10 100:2 <b>video</b> 116:16 <b>view</b> 81:8 <b>viewed</b> 103:10 <b>Vinkler</b> 2:4 4:21 <b>virtue</b> 97:9 <b>volume</b> 47:4 48:4 115:15 <b>volunteer</b> 77:7 <b>voting</b> 99:7	<b>wanted</b> 8:12 26:14 29:11 82:6 109:16 120:3 <b>wanting</b> 65:7 110:15 <b>wants</b> 77:7,15 95:4 100:11 103:11 <b>wasn't</b> 19:11 61:10 62:4 88:10 97:22 98:21 <b>Waxman</b> 2:1 4:3 5:1,1,20,23 6:2,4 6:6,14,17,20,22 7:7,13 8:9,11,14 8:17,21 9:3,14,17 10:2,5,13,17 13:8 14:20 15:1 18:16 25:6 26:16 28:6 28:17,20 29:9 30:1,13 34:3 35:20 38:9,24 43:11,19 44:11 45:1 46:6,19 50:3 50:8,10,15,19 52:1 55:5,20 56:21 57:3,10,13 57:16 59:18 60:1 63:5 64:15,18,22 72:13,17,21,24 74:11,13,20 75:15 75:18 76:11,17,24 77:11,14,18,21 78:10,23 79:4 80:22 81:15,17 82:17,22 83:23 84:24 85:2,13,22 85:24 86:7 90:16 91:6 93:13,22 94:16,22 95:2 99:14,17,21 100:3 102:6,16 103:7,20 108:21 109:2,6,19 111:4,10,24 112:7 112:16,21 113:8 115:2 116:1,10,19 117:1,6,16,21 120:6,11,18,21,23 <b>way</b> 4:11,12 20:8 24:9 27:11,11 28:21 29:19 30:5 38:22 61:18 62:18 65:19 70:21 75:20 86:12 88:13 91:11 94:20 95:3 106:12 110:24 112:5 113:14 114:2 118:15 <b>ways</b> 87:13 88:5	104:19 118:22 <b>web</b> 6:10 16:14,15 53:19 <b>week</b> 117:12,13,13 117:14 <b>weeks</b> 115:12 116:8 <b>Welcome</b> 4:9 <b>well</b> 8:11 18:19 19:7 19:14 27:17 50:19 55:4,16 64:6 65:13,24 79:16 81:11 87:9,14 96:24 99:24 100:12 102:13,16 104:6 106:21 109:12 120:3 <b>went</b> 83:21,24 90:11 90:12 104:9 106:17 107:1 120:12 <b>were</b> 18:12 24:18,19 55:7 56:5 62:13 63:21 64:3 68:12 70:22 81:4,4,7,8 85:7 87:14 92:8 98:19 103:20 104:16,21 105:2 110:15,17 111:6,7 112:11 120:20 122:6 <b>weren't</b> 110:13 <b>West</b> 1:3 <b>we'll</b> 4:12 15:15 46:11,12 55:11 59:7 77:23 78:2 81:17,18 85:5 94:10 111:22 114:16,24 117:16 117:17 118:5 <b>we're</b> 10:23 12:24 14:17 16:16 18:1 18:22 23:9 24:9 24:12,13 26:3,8 27:4,23 28:11 29:15,19 30:17 33:18,19,21 35:4 36:23 37:4,7 38:10 39:20 40:11 40:12,15 44:16 47:10 49:9 50:23 53:1 54:20 55:5,6 55:9 62:24 65:2 69:14,21 70:4,9 71:4 73:12 75:4 75:23 77:21 81:24 82:8 83:10,11,23 84:23 86:16 87:2 95:13 96:8 99:7,7	100:15 101:3 104:22 108:11,12 108:19 111:14,24 112:6,13,14,18,23 114:13 115:8,16 115:19 117:18,23 118:1 <b>we've</b> 8:21 9:8 10:5 12:20 29:3 53:2 54:14 56:5 57:11 58:6 61:8 69:13 85:19 90:1 95:5 98:21 102:11 114:8 120:7 <b>wheel</b> 93:9 <b>Wheeling</b> 67:15 <b>whichever</b> 16:2 <b>white</b> 52:9 <b>whole</b> 13:1 27:10 30:13 65:8 70:23 80:11 81:13 86:18 91:11,14 92:15 100:22 108:17 111:19 113:14 114:11 <b>wife</b> 63:21 <b>willing</b> 77:5 <b>wing</b> 69:22 <b>Wingate</b> 1:14 <b>wonder</b> 59:3 106:18 <b>wonderful</b> 119:11 119:20 <b>wondering</b> 90:13 <b>word</b> 20:21 27:22 61:21 62:8 <b>wording</b> 61:10,12 104:21 <b>words</b> 23:6 49:6 96:7 <b>work</b> 4:9 19:8 40:13 40:23 41:4 59:5 95:5 102:11 104:12,17 106:18 107:4 109:10,11 111:13,16,19 112:18 113:3,4,18 115:1,5,7,15 116:4,14 118:1 120:8,12 <b>worked</b> 113:23 119:18 <b>Workgroup</b> 3:13 <b>working</b> 78:13 102:8 107:22 113:16 114:16 115:8 118:8 <b>works</b> 44:21 107:23 <b>world</b> 25:4 27:10	<b>wouldn't</b> 20:24 67:9 109:24 <b>Wow</b> 108:23 <b>wrap</b> 28:9 <b>write</b> 94:4 112:10 112:19 113:6 <b>writing</b> 111:17 115:21 <b>written</b> 39:8 96:14 100:4 102:9 112:11 <b>wrong</b> 30:8 38:1 <b>Wyndham</b> 1:14
				<b>X</b>
				<b>X</b> 97:19
				<b>Y</b>
				<b>Y</b> 97:19
				<b>yeah</b> 10:11 25:19 30:7 31:4,8 32:16 35:22 60:2,23 61:3,16 72:17 79:6 88:19 94:16 101:7 109:16
				<b>year</b> 18:11 22:19 23:7,19 24:6,13 25:23,23 31:21,22 34:24 38:18 55:5 58:1 59:12,15,15 101:18,21,23
				<b>years</b> 7:8 11:1 19:9 21:24 22:16 24:9 24:21 25:20 26:2 26:3 27:12 32:11 34:23 36:21 37:12 40:14,21 44:6 46:3 52:15 54:3 54:18 58:21 61:18 65:7 66:16 67:6 69:12 71:3 85:19 90:22 110:9
				<b>yell</b> 76:6,7
				<b>Z</b>
				<b>Z</b> 97:19
				<b>zip</b> 47:7
				<b>zoning</b> 57:24
				<b>\$</b>
				<b>\$173</b> 72:1
				<b>\$187,000</b> 69:14
				<b>\$200</b> 71:24
				<b>\$211,000,000</b> 17:13
				<b>\$6</b> 78:19
				<b>0</b>

<p><b>0</b> 19:1 31:17 35:2  <b>09</b> 62:4,6</p> <hr/> <p><b>1</b></p> <p><b>1</b> 3:2,3 75:19 81:15  <b>1st</b> 12:12  <b>1,100</b> 17:12  <b>1,395</b> 35:12  <b>1:49</b> 121:2  <b>10</b> 26:2,3 34:23 44:2  44:3 54:18 57:13  69:24  <b>10-day</b> 73:8  <b>10-year</b> 36:21 65:17  67:12  <b>10:00</b> 1:14  <b>10:02</b> 4:1  <b>101</b> 1:14  <b>1010</b> 70:22  <b>103,000</b> 16:19  <b>11</b> 18:21,23 19:6,17  20:6,12,16 21:16  41:11 75:1  <b>11th</b> 117:16,22  118:7  <b>1100</b> 18:4 21:22  <b>1110</b> 42:21  <b>1120</b> 70:22,23  <b>113,000</b> 16:18  <b>12</b> 47:12 59:13  <b>12-month</b> 59:17,22  59:23  <b>120-day</b> 73:12  <b>14</b> 73:15  <b>14,000</b> 14:3  <b>15</b> 40:21  <b>150</b> 49:20  <b>16</b> 41:18,23 42:3  <b>160</b> 33:4  <b>17</b> 42:17  <b>1730</b> 42:21  <b>1970</b> 104:18  <b>1970's</b> 24:17 104:17  105:7,7  <b>198,000</b> 17:14  <b>1994</b> 55:8 56:8,14</p> <hr/> <p><b>2</b></p> <p><b>2</b> 3:4 81:18,19 82:6  85:22,24  <b>2nd</b> 1:3  <b>20</b> 14:13 77:3,12  <b>200</b> 49:18  <b>2000</b> 36:24  <b>2004</b> 56:10  <b>2005</b> 22:22 23:4,9  23:10,12,15,17,20  23:24 24:1,10</p>	<p>26:6 31:21,24  32:3 33:13 34:11  34:24 37:7 42:4,4  <b>2006</b> 23:23 68:20  <b>2007</b> 23:23 24:3  39:6  <b>2008</b> 23:11 24:3,13  <b>2009</b> 16:23 17:11,16  37:14,15,15 69:14  <b>2010</b> 1:13 3:4 12:12  39:14  <b>2011</b> 37:8 115:10,11  <b>2015</b> 24:12 34:23  35:6  <b>21.4</b> 41:19,21  <b>217-782-3516</b> 1:5  <b>22</b> 16:20  <b>22,000</b> 32:20 33:7  <b>24</b> 47:14 52:8,12  58:2 59:9,13,24  <b>24th</b> 79:2  <b>24-month</b> 59:17  <b>25</b> 105:21  <b>25th</b> 79:1 109:2  111:15,17 118:5  <b>250</b> 57:21  <b>252.50</b> 35:2  <b>26th</b> 79:2  <b>27th</b> 79:2  <b>28</b> 3:4 112:3  <b>28th</b> 6:7  <b>29th</b> 79:1,2 111:12</p> <hr/> <p><b>3</b></p> <p><b>3</b> 3:5 21:19 42:3  <b>3,700</b> 16:21  <b>3/916</b> 14:13  <b>30</b> 1:13 52:4  <b>30,000</b> 81:8  <b>34</b> 17:14 105:23,24  <b>35</b> 24:21  <b>365</b> 35:10  <b>37,520</b> 33:3</p> <hr/> <p><b>4</b></p> <p><b>4</b> 3:6 75:19  <b>401</b> 1:22  <b>41</b> 72:16  <b>423</b> 42:3  <b>45</b> 49:5,7  <b>458,000</b> 35:9</p> <hr/> <p><b>5</b></p> <p><b>5</b> 3:8  <b>50</b> 45:3 46:2 47:4,23  48:3,9 54:3 55:22  <b>51</b> 17:15  <b>525</b> 1:3</p>	<hr/> <p><b>6</b></p> <p><b>6</b> 3:10 21:10,11 62:6  <b>6,300</b> 16:21  <b>6-A</b> 36:6,7  <b>6-J</b> 36:4  <b>60</b> 33:2  <b>60,000</b> 32:21 33:7  <b>60,032</b> 33:4  <b>60-day</b> 73:11  <b>60611</b> 1:23  <b>62761</b> 1:4  <b>64</b> 19:1 31:17 35:2  <b>65</b> 19:1 31:17  <b>660</b> 18:4 21:22,22  <b>6800</b> 13:22</p> <hr/> <p><b>7</b></p> <p><b>7</b> 3:14 21:11,19  <b>7-A</b> 21:20  <b>70</b> 48:5  <b>70's</b> 19:15 68:13  <b>72</b> 85:19  <b>74</b> 19:1 31:17  <b>75</b> 19:1 31:18  <b>75-plus</b> 32:24  <b>77</b> 18:3 42:21 70:22  <b>78</b> 37:3 56:22,24  59:19 85:20  <b>78,500</b> 72:3</p> <hr/> <p><b>8</b></p> <p><b>8</b> 3:15  <b>80</b> 48:6  <b>80's</b> 107:21  <b>85</b> 66:11  <b>87</b> 119:17</p> <hr/> <p><b>9</b></p> <p><b>90</b> 19:2 22:6 35:11  35:21 49:5,8,20  51:20 58:3,21  59:20,23 85:17,20  91:13  <b>90's</b> 39:20  <b>90,500</b> 72:2  <b>900</b> 16:20  <b>93</b> 68:21  <b>93-641</b> 19:16  <b>94</b> 56:10  <b>95</b> 18:22 19:6 20:10  20:13 21:14,20  34:8  <b>99</b> 56:10,10,16</p>		
---	--	--	--	--