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**STATE OF ILLINOIS  
HEALTH FACILITIES AND SERVICES REVIEW BOARD**

**LONG-TERM CARE ADVISORY SUBCOMMITTEE**

**MEETING**

**MAY 24, 2011**

**ORIGINAL**

**NATIONWIDE SCHEDULING**

OFFICES: MISSOURI Springfield Jefferson City Kansas City Columbia Rolla Cape Girardeau ■ KANSAS Overland Park ■ ILLINOIS Springfield

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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 May 24, 2011, scheduled to begin at the hour of 10:30 a.m., at the Holiday Inn, 411 South Larkin Avenue, Joliet, Illinois.

1 PRESENT:

Michael Waxman - Chairman

2

Eli Pick - Vice-Chair

3

Greg Will (for Dave Lowitzki)

4

Timothy Phillippe

5

Patricia Odea Evans

6

Terry Sullivan (for Mike Bibo)

7

Michael Scavotto

8

Nenya Johnson

9

Rick Dees

10

PRESENT VIA TELEPHONE (at various times):

11

Stephanie Altman

Teri Dederer

12

Laurinda Dodgen

13

ALSO PRESENT:

Frank Urso - HFSRB Legal Counsel

14

Courtney Avery - HFSRB Administrator

15

Cathy Clarke - Assistant to the Administrator

16

Michael Constantino - HFSRB Staff

17

Bill Dart - HFSRB Staff

18

Claire Berman - HFSRB Staff (via telephone)

19

Charles Foley

20

Jason Speaks (via telephone)

21

Reported by:

Karen K. Keim

22

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AGENDA

CALL TO ORDER

1. Roll Call
2. Approval of Agenda
3. Approval of April 11, 2011 Minutes
4. Public Participation and Comment
5. Ethics Training -- Frank Urso
6. Survey Results -- Mike Constantino
7. Comparison of CON States Discussion -- Clare Berman
8. Strategies for Next Steps -- Group
9. Next Meeting
10. Adjournment

1 START TIME: 10:30 a.m.

2

3 CHAIRMAN WAXMAN: I'd like to call the meeting  
4 to order. May we call roll.

5 MR. CONSTANTINO: Shall we just go around the  
6 room?

7 CHAIRMAN WAXMAN: That will work for me. I  
8 forgot that's how we do this. Mike, we'll start with you.

9 MR. SCAVOTTO: Mike Scavotto.

10 MR. PHILLIPPE: Tim Phillippe.

11 MS. JOHNSON: Nanya Johnson.

12 MR. SULLIVAN: Terry Sullivan, substituting  
13 for Mike Bibo.

14 MS. AVERY: Courtney Avery.

15 MR. URSO: Frank Urso.

16 CHAIRMAN WAXMAN: Mike Waxman.

17 MR. PICK: Eli Pick.

18 MS. O'DEA EVANS: Patricia O'Dea Evans.

19 MR. DART: Bill Dart.

20 MR. WILL: Greg Will, proxy for Dave Lowitzki.

21 MR. DEES: Rick Dees.

22 CHAIRMAN WAXMAN: Do we have a quorum, Mike?

23 (Pause)

24 MR. CONSTANTINO: We've got seven here and

1 Stephanie on the phone and Laurinda. Nine.

2 CHAIRMAN WAXMAN: So we can go down the agenda  
3 without voting. We can carry on business, unless somebody  
4 objects to that process, correct? All right. Everyone  
5 okay with moving forward? We just can't have an official  
6 vote until we get a quorum number.

7 Okay. We'll assume that the agenda is okay  
8 with people. We'll approve the minutes later. I don't  
9 see -- the only public person I see is Mr. Foley.

10 Frank, can you do your ethics training?

11 MR. URSO: I can. I've handed out a cover  
12 letter and packet of ethic training material to everyone  
13 that's present. The people that are not here that are part  
14 of the Committee, including the people on the telephone,  
15 we'll be sending materials out to them so that they could  
16 take the ethics training, and anyone at the table who wants  
17 to complete the ethics training, you know, during breaks  
18 and whatnot while we're here and sign the participation  
19 form, I'll be glad to collect them back today. If not,  
20 please let me know and we'll work out other arrangements so  
21 you can get the acknowledgement form back to us. In fact,  
22 we have some envelopes that are self-addressed,  
23 self-stamped. So, if you're not planning on completing it  
24 today, please let me know. It is due back by Friday, June

1 24th. That's for everybody on the phone as well as people  
2 around the table. If there are any questions, please don't  
3 hesitate to call me. This is material directed toward  
4 appointees to State boards. So, even if you've taken the  
5 ethics training at an agency, this material needs to be  
6 completed. So, if you have any questions, don't hesitate  
7 to call me and I'll be glad to answer them.

8 Any thoughts or questions now?

9 MS. O'DEA EVANS: You know, another committee  
10 that I'm on, we submit time sheets, but I have noticed that  
11 we don't really do that on this Board. Are we supposed to  
12 be submitting time sheets?

13 MR. URSO: There is a requirement in the  
14 Ethics Act, but that also brings me to the point -- you're  
15 correct, we probably should be. We also talked about  
16 absences and whatnot as an amendment to the bylaws, and I  
17 don't think we received any action on that at this point.  
18 So, those, I think, run hand-in-hand. But the attendance  
19 sheets, we technically call them the minutes, because we  
20 know who's here.

21 MS. O'DEA EVANS: Okay. We have a record.

22 MR. URSO: We have a transcript of every  
23 meeting, so if the Ethics Commission wanted to know what  
24 we're doing in terms of time --

1 MS. O'DEA EVANS: -- that justifies it.

2 MS. AVERY: I just asked Mike, should we  
3 create the same type of sign-in sheet that we use for the  
4 Board, where we circulate it and people can sign it?

5 MR. URSO: That would be fine. I thought we  
6 were doing that.

7 Can we just verify who is on the phone again,  
8 Mike?

9 MR. CONSTANTINO: Can the individuals on the  
10 phone tell us who is there?

11 MS. BERMAN: Claire Berman.

12 MR. SPEAKS: Jason Speaks.

13 MS. DODGEN: Laurinda Dodgen.

14 CHAIRMAN WAXMAN: Any other questions for  
15 Frank?

16 MR. FOLEY: Mr. Waxman, I talked earlier today  
17 with Teri Dederer. She indicated to me that she wouldn't  
18 be able to make it. I did send her the call-in number that  
19 Mike shared, so I was hoping she would call in.

20 CHAIRMAN WAXMAN: Thank you, sir.

21 Since we're still waiting for a quorum, Mike,  
22 I guess we're up to you on your survey results.

23 MR. CONSTANTINO: If you recall, we sent a  
24 survey out I think on April 12th to all of the Committee

1 members, asking them where and when they would like to hold  
2 these meetings and how, and the general consensus was to  
3 hold the meetings by video conference call-in,  
4 approximately once every two months. The video conference  
5 would be in Springfield and in the Chicago area. We can  
6 always get that finalized, but that was the general  
7 consensus of all of the Committee members. I know we've  
8 discussed, until we get these rules done, to hold more  
9 frequent meetings, and we don't know how that would play  
10 into everyone's schedules. Other than that, I really don't  
11 have much else to say about the survey.

12 MR. URSO: Did you enjoy doing it?

13 MR. CONSTANTINO: Oh, yes.

14 CHAIRMAN WAXMAN: Do we have another meeting  
15 scheduled? Is our next meeting scheduled? Do we have  
16 another meeting scheduled, or do we have to do that today?

17 MR. CONSTANTINO: I believe we have to do that  
18 today.

19 CHAIRMAN WAXMAN: How much time does it take  
20 to create video conferencing? As much as I personally  
21 don't like video conferencing, I think I've been out-voted,  
22 and in the process of making sure we have quorum and our  
23 meetings are as productive as possible, then let's move  
24 toward video conferencing. My question to the Staff is how

1 long does it take to set that up? Would you need to make  
2 our next meeting a video conferencing meeting?

3 MR. URSO: Probably see if they have it  
4 available here, if we can stay at this location, in-person  
5 meeting. So, Cathy, maybe you can check with -- that's  
6 Cathy Clarke, by the way, everybody. She's the new  
7 Administrative Assistant in the Board's office.

8 MR. PICK: Frank, I might suggest, based on  
9 the experience I have with the other boards, once video  
10 conferencing is available, it's usually Springfield and  
11 Chicago, and there's no need to travel to a central  
12 location.

13 MR. URSO: Okay.

14 CHAIRMAN WAXMAN: As much as -- again, I just  
15 like the personal -- I like to look at faces and see what  
16 they really mean as opposed to trying to get through the  
17 newspaper what somebody is agreeing to. And I don't care  
18 how you write that but that's probably not the appropriate  
19 way to say it. But, anyway --

20 MR. URSO: However you say it, she's going to  
21 write it.

22 (Laughter)

23 CHAIRMAN WAXMAN: We had that discussion.  
24 But, again, I do like watching people's reactions in a

1 meeting, because it makes it easier as Chair to understand  
2 that people are understanding where we're going and is in  
3 agreement and we're all on the same page. But if video  
4 conferencing is what it's going to take to make this a more  
5 efficient meeting, then I think we need to move on.

6 MR. SULLIVAN: Michael, I think just about  
7 everyone who sits around here sits on other committees that  
8 have become increasingly used to video conferencing, and  
9 I -- if you're not comfortable with it, I understand that,  
10 although it certainly beats conference calling, because you  
11 do get to see reactions and stuff like that. And I'll toss  
12 out -- I mean, Public Health has a video conferencing unit  
13 with both downtown and Belwood and Springfield, although  
14 the quality is never the greatest. I'm also willing to  
15 offer the Illinois Healthcare and Illinois Council site in  
16 Chicago.

17 CHAIRMAN WAXMAN: Which is where, Terry?

18 MR. SULLIVAN: In Chicago it's up --

19 MR. CONSTANTINO: Hello. Who is on the phone.

20 MS. DEDERER: This is Teri Dederer.

21 MR. CONSTANTINO: Teri is now with us.

22 CHAIRMAN WAXMAN: Can we identify if  
23 Stephanie is there?

24 MR. CONSTANTINO: Is Stephanie still with us?

1 (No response)

2 MR. SULLIVAN: The Council office is up on  
3 Peterson, right off of Eden's, and the Illinois Healthcare  
4 is on South 4th in Springfield. Our quality is a little  
5 bit better and it's been used by owe as sack and a number  
6 of other state committees and so I offer that.

7 CHAIRMAN WAXMAN: According to --

8 MR. SULLIVAN: And we have free parking, as  
9 opposed to the downtown offices.

10 MS. O'DEA EVANS: I don't think we're being  
11 reimbursed for our parking.

12 MR. SULLIVAN: We give out cookies, lox and  
13 bagels, too.

14 CHAIRMAN WAXMAN: Now you're talking. At \$28  
15 a pound, now you're talking about a serious meeting.

16 Our next meeting is scheduled for July 26th.  
17 That was on the original schedule. So if that works for  
18 everybody, then my next question is can we set July 26th up  
19 as a video conferencing date? And where is the pleasure of  
20 the committee to do this at? Terry has been kind enough to  
21 offer cookies, lox and bagels. What are you guys offering?

22 MR. SULLIVAN: And free parking.

23 CHAIRMAN WAXMAN: And free parking.

24 MR. PICK: Even the validated parking downtown

1 is \$15.

2 MR. SULLIVAN: Or there is Belwood.

3 MS. O'DEA EVANS: I like the north site.

4 CHAIRMAN WAXMAN: Do we have an agreement  
5 that we will use IHC's offices?

6 (Pause)

7 MR. SULLIVAN: Okay. I'll set it up. Who do  
8 I send addresses to?

9 MS. AVERY: I'll get that for you.

10 MS. DEDERER: I don't know about everybody  
11 else on the phone, but I can barely here what's going on,  
12 and I am calling in because you need a quorum. Is that  
13 correct.

14 MR. PICK: Yes, and we appreciate you calling  
15 in, but we lost one while you called in.

16 MS. DEDERER: What?

17 MR. PICK: We lost one member. In the process  
18 of you calling in, somebody dropped out.

19 MS. DEDERER: Oh, so we still don't have a  
20 quorum?

21 MR. PICK: Right. But we just e-mailed  
22 Stephanie to see if we could get her back on.

23 MS. DEDERER: I can't hear what you're saying.

24 CHAIRMAN WAXMAN: The next meeting is going

1 to be July 26th. It's going to be held either your choice  
2 of IHC's offices in Springfield --

3 MS. DEDERER: Cool.

4 CHAIRMAN WAXMAN: -- or the Illinois  
5 Healthcare Council on Peterson in Chicago. Will the time  
6 be ten or --

7 MS. AVERY: Ten to two is what we had on the  
8 schedule.

9 CHAIRMAN WAXMAN: Ten to two?

10 MR. PICK: That works.

11 MS. O'DEA EVANS: We already had the date of  
12 the meeting set. That date was already set.

13 MR. PICK: We're just changing location.

14 MS. O'DEA EVANS: And I think the location to  
15 this point has always been predetermined.

16 CHAIRMAN WAXMAN: Okay. So that is done.  
17 Michael, thank you for doing the survey and all of the  
18 effort that went into trying to make a matrix out of it. I  
19 know you probably had as many different responses as many  
20 different people responded to it. So, again, thank you for  
21 doing it.

22 It looks like we're on to Claire. Claire, are  
23 you still on the phone?

24 MS. BERMAN: Yes, I am.

1 CHAIRMAN WAXMAN: Good for you. Thank you  
2 for staying with us.

3 MS. BERMAN: Can everyone hear me?

4 (Positive responses heard.)

5 CHAIRMAN WAXMAN: The floor is yours, so to  
6 speak.

7 MS. BERMAN: All right. You did receive, I  
8 believe, four documents. One was a repeat of something you  
9 already received from the last meeting. That's the CON  
10 States' Long-Term Bed Determination document. What I think  
11 would be a good way to start is to look at the chart that  
12 was sent to you. There's a chart, and that's entitled CON  
13 States' Long-Term Bed Need Determination Outline.  
14 Everybody has that, I hope. I'm just going to give a brief  
15 summary of what is in this document.

16 To start out, this document is an executive  
17 summary of the one that you received last month. This  
18 highlights really the basic components that are used in  
19 bed-need formulas, and this is pretty consistent throughout  
20 the states that have CON. There's a very basic kind of  
21 formula that everybody starts out with. That's the first  
22 consideration --

23 MR. CONSTANTINO: Can you hold on a minute,  
24 Claire? I didn't have that document and I didn't pass that

1 out.

2 MS. AVERY: It was the one that was e-mailed.

3 Does someone need a copy?

4 CHAIRMAN WAXMAN: Do you have copies?

5 MR. CONSTANTINO: I did not have a copy.

6 CHAIRMAN WAXMAN: I didn't print that

7 document. We're sharing.

8 MR. SCAVOTTO: We're good. Go ahead and

9 proceed.

10 MR. CONSTANTINO: Go ahead, Claire. Sorry.

11 MS. BERMAN: As I was saying, most states use

12 a population-based bed-need formula as a first

13 consideration of bed need. All that is is looking at the

14 utilization over a specified period of time, and usually

15 it's by age group. That's one of the starting points.

16 Other factors are considered as well and vary from state to

17 state. So, the bed-need formula is just the first point.

18 In Illinois, as you know, there are variances

19 to computed bed need in place for projects that do not

20 comply with the bed-need formula findings but they have

21 other characteristics that still demonstrate there is a

22 need for the project. Other states offer similar

23 considerations. For instance, in Delaware, when the

24 calculations for bed need are made, the board can adjust

1 the projection upward or downward but not by more than 10  
2 percent when it's concluded that the formula is likely to  
3 over estimate or under estimate bed need. Examples that  
4 they consider in doing this include things like new uses,  
5 like rehab, you know, if you have quite a few patients that  
6 come in needing rehab services, or if you have, for  
7 whatever reason, a doctor that -- or a referral agency or a  
8 source that wants to send AIDS patients into a skilled  
9 nursing facility, that's another thing that they would  
10 consider, or the other thing that they have cited is when  
11 there are occasional changes in Medicaid reimbursement  
12 policies. Then they feel that that is a basis for adding  
13 or subtracting beds from the need. So that's a little bit  
14 more flexible than some other states.

15 A few states use a weighted average of  
16 projected population changes in each age category, and the  
17 weights are based on the estimated percentage of nursing  
18 home patients in each of the age categories. So, the basic  
19 feeling is that the more aged a person is that goes into a  
20 nursing home, the more need there would be for those beds  
21 because they stay longer and you're still accommodating  
22 everybody else who has need to be in that facility.

23 Most states use the following age groups:  
24 Zero to 64; 65 to 74; 75 to 84; and, 85 and over. In

1 Illinois we use three groups. We use zero to 64; 65 to 74;  
2 and, 75 and over. So that is something that we can look at  
3 and, you know --

4 MS. DEDERER: Can I ask a question? Has  
5 anybody done an analysis as to whether breaking the age  
6 groups down into groupings, rather than just saying 65  
7 plus, gives you a much different -- gives you enough of a  
8 different result to justify going to all of that trouble?

9 MS. BERMAN: Yes. I think that what they  
10 found -- going back to the weighting of the different age  
11 groups, the tendency is that there is more weight given to  
12 the populations that are older, like the 75 plus. It's  
13 sort of like --

14 MS. DEDERER: What I'm saying is is there a  
15 significant variance across the state and what percentage  
16 of a given county, or whatever area you're looking at, is  
17 75 plus? I mean, does -- do the groupings swing much  
18 across the state so that some counties are heavily weighted  
19 towards the higher ages and some counties are not?

20 MS. BERMAN: That is a basic assumption. I  
21 personally don't know.

22 MS. DEDERER: I was asking if anybody has done  
23 an analysis to see if that was true or not.

24 MR. PICK: This is Eli. I can tell you that

1 there's data to support that under 65 is the  
2 fastest-growing population utilizing skilled services in  
3 nursing homes. The state average now is 5 percent. My  
4 personal experience at Ballard is we're over 20 percent  
5 under 65. So, there's data to support the fact that having  
6 these population groupings is indicative of changing  
7 patterns.

8 MS. DEDERER: Okay. I understand the under  
9 65, but about 65, is there something to suggest that those  
10 groupings vary widely among counties or other geographic  
11 areas?

12 MR. SULLIVAN: I'm not aware that people have  
13 broken it down by counties. Again, the working assumption  
14 is that people over 75 -- or 85, some states have -- are  
15 more likely to be using a long-term care facility rather  
16 than --

17 MS. DEDERER: I understand that part. What  
18 I'm saying is does Sangamon County have more people or  
19 fewer people who are 75 plus than Cook County does? Well,  
20 no, Cook County is a bad example. Take any other county in  
21 the state. Do we have variances among the counties by  
22 those age groupings, the very, very old and the very old?

23 MR. SCAVOTTO: Yes, you do, you do have  
24 variances.

1 MS. DEDERER: So there is data to support the  
2 variances?

3 MR. SCAVOTTO: There's no report, but every  
4 county I've studied has variation.

5 MS. DEDERER: Okay. That's what I wanted.  
6 Thank you.

7 MR. SULLIVAN: I don't know if there's data  
8 that would clearly identify the variances from county to  
9 county and what it means and whether there is a -- whether  
10 you make some kind of statistical assumption in one county  
11 that you don't make in the other. It all gets very  
12 complicated.

13 MR. SCAVOTTO: I don't think you do.

14 MR. PHILLIPPE: I do know, just in terms of  
15 doing market studies for new development, the standard in  
16 the field is to break it out like this, because we do find  
17 differences. It's done for different purposes, but it's  
18 still development, and we find actually different  
19 percentages by age groups in different areas. So that's  
20 the standard for development nationally, I think.

21 MS. DEDERER: Thank you.

22 CHAIRMAN WAXMAN: I think there's a general  
23 consensus that people are living longer. So you're going  
24 to find people in the higher group as time goes on. At one

1 extreme, I remember it was rare you found somebody in a  
2 nursing home that was a hundred plus and now, you know,  
3 almost all of them have many into the hundred two's,  
4 hundred one's, hundred three's. So, tracking that way does  
5 make sense.

6 MR. SCAVOTTO: But I think your use rate is  
7 going to be impacted by the presence of assisted living,  
8 for example, being a major factor, and if you've got a  
9 county that is well developed with assisted living, the use  
10 rate is going to be quite a bit lower.

11 MS. DEDERER: I agree with that.

12 CHAIRMAN WAXMAN: Even at the higher end?

13 MR. SCAVOTTO: I've done this in particular  
14 for Lake County, and that use rate is just dropping like a  
15 stone, and you can attribute it to a highly-developed  
16 assisted living presence there. And it would be different.  
17 Every other county we've studied has different quirks. You  
18 go to Rock Island and the use rate is, you know, not  
19 anywhere near as steep as Lake County.

20 MS. JOHNSON: Ombudsman see, too, that there  
21 are a lot of under 60 as well, even under 50, with the  
22 drug-related, motorcycle injuries, and then as troops start  
23 coming back home, I think we're going to see an even larger  
24 number of under 60 population.

1 MR. PICK: I think you also see services focus  
2 changes depending on the age group. The higher the age  
3 group, the more complexity and chronicity that occurs with  
4 multiple conditions, whereas in the 75 to 84, there may  
5 only be -- there may be chronic conditions, but they're not  
6 as advanced. So there's a variance in service intensity  
7 that is directly correlated to age.

8 CHAIRMAN WAXMAN: May we move on? Claire?

9 MS. BERMAN: Yes, yes.

10 CHAIRMAN WAXMAN: Thank you.

11 MS. BERMAN: Another component that we are  
12 trying to look at is the years that the population is  
13 projected. In the states that have CON, they vary from two  
14 years to four years in the way of projections. In  
15 Illinois, we currently provide 10-year projections, per the  
16 requirements of the Act. In general, shorter term  
17 projections are considered to be more reliable. Those are  
18 based on historical information and recent trends, and the  
19 farther out you project, the less reliable it becomes, is  
20 the idea.

21 MR. PICK: Claire, if I could ask, I thought  
22 the reason we used 10 years was because of census data. So  
23 in the absence of census data, what would be used for  
24 population numbers?

1 MS. BERMAN: It all starts from the Bureau of  
2 the Census.

3 MR. PICK: So it's a projection based on the  
4 most recent census?

5 MR. CONSTANTINO: We use an estimate, Terry --  
6 I'm sorry, not Terry.

7 MR. PICK: No problem.

8 MR. CONSTANTINO: I didn't mean to insult you.  
9 I'm sorry.

10 (Laughter)

11 MR. PICK: No insult.

12 MR. CONSTANTINO: Public Health does a  
13 calculation there. We use the -- like the 2000 census, and  
14 then we take the live births and deaths and then come up  
15 with an estimate and project from that.

16 MR. PICK: Okay. Sorry, Claire.

17 MS. BERMAN: All right. Then when we look at  
18 the annual occupancy rate in the states, that varies from  
19 between 85 percent to 97 percent, and the idea behind  
20 having the occupancy rate is that that's felt to be the  
21 point at which bed need is apparent in a facility. Gives  
22 you some wiggle room.

23 MR. SULLIVAN: Claire, could you repeat that  
24 about the occupancy? Are we talking about Illinois?

1 MS. BERMAN: The occupancy rates vary --

2 MR. SULLIVAN: Oh, okay.

3 MS. BERMAN: -- from 85 percent to 97 percent.

4 In Virginia, for example, exceptions are considered for  
5 facilities that operated at less than 93 percent average  
6 annual occupancy in the most recent year. One facility  
7 offers short-stay services, causing an average annual  
8 occupancy rate lower than 93 percent. So, they're  
9 recognizing that the short-stay services have a unique  
10 impact on the occupancy rate, and I don't know if that's  
11 something that the subcommittee wants to look further into  
12 or take into consideration, but these seem to be more  
13 current thoughts than the other states had in place.

14 MS. DEDERER: Can I ask if this committee  
15 would have the ability to add a category of patient care,  
16 short-term stay, to the collected data in Illinois? I know  
17 we've talked about it with other State agencies. I just  
18 wondered if the committee can make a recommendation or such  
19 a change, because without that, you have no idea if someone  
20 was intended to be a short stay or not. We all know that  
21 some short stays turn out to be long-term stays and we know  
22 that some long-term stays turn out to be short-term stays.  
23 How do we know what was really intended?

24 MR. PICK: The difficulty with a category of

1 short-term is you have a variety of instances, as you just  
2 outlined, where it's short-term for a whole host of other  
3 reasons. You can have a premature death, a complication  
4 that causes a patient to go to the hospital.

5 MS. DEDERER: I know that, and that's what I'm  
6 saying. If we have somebody admitted with the intention of  
7 it being short-term, then we would know that they're there  
8 for therapy or some other short-term convalescence, and,  
9 yes, they could die and, yes, those patients admitted  
10 short-term could die or go home or whatever.

11 MR. PICK: Let me finish. The transfer to the  
12 hospital is the most confounding aspect of trying to track  
13 short-term care and, in fact, there's quite an emphasis  
14 right now at the federal and state level to look at 30 days  
15 or less transfer to the hospital. So, I would advocate for  
16 something more specific than short-term care, whether it's  
17 post-surgical rehab or medical rehab, that is specific to a  
18 population, whether it's cardiac or pulmonary, but it  
19 provides more specific information and allows facilities to  
20 focus their service menus on specific populations and  
21 reporting accordingly.

22 MS. DEDERER: Okay. That's okay on really big  
23 population areas, but state-wide, I think that would be  
24 onerous for the nursing homes to try to do these

1 categories, and meaningless, as well. The population  
2 doesn't support that kind of variation of categories, I  
3 don't think.

4 MR. SULLIVAN: I tend to agree with you, Teri.  
5 Two years ago we had from the MDS 39,000 people leaving  
6 long-term care facilities in less than 90 days, not  
7 hospital, not death, going home or to a less restrictive --

8 MS. DEDERER: That's cool. So you have that  
9 data?

10 MR. SULLIVAN: Yes, we have that data, and  
11 last year it was 42,000. So, it's increasing, people  
12 leaving in less than 90 days, and state-wide, the average  
13 turnover is 200 percent, you've got facilities like Eli's  
14 that's --

15 MR. PICK: 600 percent.

16 MR. SULLIVAN: -- 600 percent turnover  
17 annually. We have that data. The question is what does it  
18 mean? And how do we put a formula on that of -- so, with a  
19 600 percent turnover at Eli's facility, does he need more  
20 beds? How do we come up -- it's always going to come down  
21 to an assumption of, well, let's take short-term stay into  
22 account in terms of bed need, but we're still going to have  
23 to make an assumption somewhere along the way based on  
24 data.

1 MS. DEDERER: I agree, and that's what I was  
2 suggesting. If we had some data, you could make some  
3 assumptions, because short-term stays are totally different  
4 than long-term stays in terms of turnover, and if the  
5 nursing home is in an area where there is a -- you know, an  
6 emergency center hospital -- I can't remember what they're  
7 called -- they're likely to have more people doing  
8 short-term convalescence than a county that's doesn't have  
9 a hospital. I'm just throwing out things to consider, but  
10 I think those are very real animals, and it may point to  
11 the need to have more beds. Because you have that much  
12 turnover, sometimes you're going to have more beds filled  
13 than other times.

14 MR. SCAVOTTO: Occupancy issue is still the  
15 same.

16 MR. PICK: The higher rate of turnover, the  
17 lower the occupancy.

18 MR. PHILLIPPE: That's the point I was going  
19 to make.

20 MS. DEDERER: The average occupancy, but you  
21 would want to know what the highest occupancy is to make a  
22 determination.

23 MR. PICK: It's not just average. It's peak  
24 bed occupancy and at lowest census, and the higher the

1 volume of short-term care, the lower the occupancy, is  
2 generally the outcome.

3 MR. PHILLIPPE: It's very difficult. We,  
4 obviously, have a high number of short-stay residents in  
5 the facility. The facility could run at a hundred percent  
6 virtually, the ones I have like that. However, you can't  
7 imagine a hundred percent with that kind of turnover, so it  
8 tends to be more like 90 to 95, because you can't manage  
9 the beds that well. Right? And that's what we're all  
10 saying here. How you factor that in the formula is a  
11 different issue.

12 MR. PICK: The point I'm trying to make is  
13 it's easy to hang out a shingle that says "We do short-term  
14 care".

15 MR. PHILLIPPE: Actually doing it --

16 MR. PICK: Right. It's about doing it and  
17 having the competencies to be able to manage the conditions  
18 effectively, and I think -- so we're talking about two  
19 different issues, one is determining bed need based on  
20 population in volumes, and the other is how does the Board  
21 regulate who's qualified to do certain things.

22 MR. SCAVOTTO: I thought we were talking about  
23 bed need.

24 MR. PICK: You're right. So I got distracted.

1 MR. SCAVOTTO: I want to get that straight.  
2 We're talking about bed need. What you do with your beds  
3 at Ballard, that's great. What you do at your place,  
4 that's great. You know, I'm more interested in what the  
5 bed need is.

6 MR. PICK: Point well taken, Mike.

7 MR. SCAVOTTO: Because you can do it different  
8 ways.

9 MR. PICK: Absolutely.

10 MR. PHILLIPPE: And I'm not telling anybody  
11 else what to do.

12 MR. SCAVOTTO: No.

13 MR. PHILLIPPE: It's actually complicated,  
14 because you've got the rural issues versus city and access  
15 to care. It's complicated, what people want, maybe what's  
16 best for them medically, and all that stuff.

17 CHAIRMAN WAXMAN: And you also have all of  
18 those traditions of what kinds of people will actually use  
19 a nursing home at certain ages.

20 Claire, move on, please.

21 MS. BERMAN: Yes. Then another component that  
22 was looked at is the incorporation of the subgroups of care  
23 that are offered by some states. Usually this is a  
24 consideration in the rule text but not in the formula.

1 None of these have seemed to have found a way to include it  
2 in the formula, and that's probably just as well since the  
3 formula is meant to be a basic starting point and not the  
4 final determination. An example is Montana. There is  
5 consideration of the actual needs and uses of people  
6 admitted to the long-term care facilities, and the types of  
7 services includes sub-acute care, rehab, Alzheimer's,  
8 traumatic brain injury, as well as any others that are  
9 designated by the applicant. So, that's how they try to  
10 bend to the current issues. And it might be interesting to  
11 go back to some of these states and find out how well their  
12 systems are perceived as being used and if they are  
13 effective.

14           These are just ideas for us to consider, and  
15 each state is unique. So there is a built-in caution to  
16 just borrowing other state's rules that works really well.  
17 This was just to give you an overview, again, of what's in  
18 place around the country and maybe spark some ideas for  
19 what might be an improvement to what we have in place.  
20 Okay. So that's what is happening with that document.

21           I thought next we could move to the -- there's  
22 a piece of the current rules that I sent to everyone. It's  
23 Section 1100.510, and this talks about the formula  
24 components and the planning area development policies so

1 that there's sort of a basic understanding of the approach  
2 that was taken in forming what we have right now. And  
3 we'll just go over this quickly and see if it raises any  
4 ideas.

5 It has -- the top line of it is titled "77  
6 Public Health" in bold. That's what the header is.

7 MR. PHILLIPPE: I just wanted to thank her if  
8 she is the one that actually put that spreadsheet together.  
9 In trying to read those pages and compare them, I just  
10 thought that was an outstanding effort to do that.

11 MR. PICK: Yes.

12 MR. SULLIVAN: Claire, once again, outstanding  
13 job.

14 MS. BERMAN: I'm glad it's useful to you and  
15 that way we can kind of pinpoint the things that we want to  
16 spend a lot of time on as opposed to reading a lot of  
17 words.

18 So, again, the reason I gave you this policy  
19 group of pages is just -- so we all have a basic  
20 understanding of how the formula we have come to be and the  
21 ideas behind it. And it's good -- I enjoyed reading it  
22 myself, because I hadn't looked at it for a while, and it  
23 was a good reminder.

24 Number one, there are a couple of ways to base

1 formulas on, and one is demand based, which includes  
2 skilled nursing -- that is a demand-based kind of  
3 service -- or incident-based formulas. So we'll just look  
4 at what the demand-based formula has in it. This kind of  
5 formula utilizes the concept that what has occurred in the  
6 past will occur in the future. It's sort of the same  
7 thing -- the same idea behind projecting. You look at what  
8 happened in the recent past and then you can project out  
9 maybe an equal number of years, depending on how many years  
10 in the past you're evaluating. So, it uses inpatient days  
11 of care. And I know you don't like the word "patient", but  
12 that's sort of a term of art. And it uses the population  
13 projections as the key data variable. So, after the use  
14 rate is calculated, then it's converted to a daily census,  
15 and then they apply the occupancy rate, and you come up  
16 with the gross number of beds needed, and in this case per  
17 planning area. And then once you have the gross number  
18 needed, the final step is subtracting the number of  
19 existing beds, and then you'll know how many beds people  
20 can come in and ask for. That sets the number that is  
21 dealt with at that point.

22 In Illinois, this type of formula is adjusted  
23 by the application of minimum and maximum use rates in the  
24 planning areas, and this is used because of facilities with

1 certain types of beds, where there's a high concentration  
2 of beds or services, which causes unnecessary duplication,  
3 or sometimes because of the mal-distribution of services,  
4 it helps to make beds available to under served areas, even  
5 if they don't have the utilization to back it up in the  
6 normal way. So it's sort of trying to help with the  
7 distribution of services, because that is one of the  
8 charges of the Board, is to review projects against the  
9 requirements that all citizens in the state need to have  
10 reasonable access to the services that they need, and  
11 that's one of the ways that it can be done.

12 MR. SCAVOTTO: I have a question.

13 CHAIRMAN WAXMAN: Claire, we have a question  
14 for you.

15 MR. SCAVOTTO: The minimum and maximum  
16 adjustment, is that -- what are those percentages? Is it  
17 60 and 160 or 60 and 100.

18 MS. BERMAN: It's 60 and 160. We'll get to  
19 that, because we are going to look at another document  
20 where that's laid out.

21 MR. SCAVOTTO: Okay. And is there a history  
22 behind the adoption of those figures?

23 MS. BERMAN: You know, I'm sure there is. I'm  
24 not aware of what that is.

1 MR. SCAVOTTO: Does anybody know?

2 MR. SULLIVAN: Yes, there is a history. It  
3 sounded good, I mean back in 1979.

4 (Laughter)

5 MS. BERMAN: We're hoping to bring in someone  
6 who is very much entrenched in that history and the  
7 development of policies and use of data, and hopefully we  
8 can bring that gentleman in for a future meeting, because  
9 he could be very helpful in clarifying some kinds of  
10 questions and giving us current thinking on how we approach  
11 policy and formulas. So, I'm hoping that that will happen  
12 hopefully at the next meeting.

13 So, this is our entry into working down the  
14 formula and the things that tie in with it. So then moving  
15 on to the planning area development policies, we use  
16 counties, by and large. If you've noticed for long-term  
17 care, it's groups of counties, and that's because the  
18 patients come from an area that's broader than a planning  
19 area or a neighborhood or even a community. It depends on  
20 a lot of different things, either the reputation of the  
21 facility, the services offered, the closeness to the  
22 resident's relatives and friends. So, there's other  
23 factors that go in to that which require it to have more of  
24 a region than a county --

1 CHAIRMAN WAXMAN: Claire, we have a question  
2 for you.

3 MR. PHILLIPPE: We use the regions, multiple  
4 counties. I'm just curious if when this was all set up in  
5 '79 or whenever, that people traveled a lot more for care  
6 like this and people are traveling -- prefer not to travel  
7 as much today.

8 MS. BERMAN: Well, that's a very good point.  
9 This does go back in time, certainly, and the things that  
10 they have considered can be reconsidered because there have  
11 been changes. If you've noticed as part of this, they kind  
12 of outline other factors that influenced planning area  
13 boundaries, natural geographic boundaries, whether you have  
14 a new highway in place now, transportation patterns, that  
15 kind of thing, time and distance, you know, and you're  
16 right, the travel time is a big issue. But it's -- it's a  
17 very special kind of service that you're offering, and many  
18 of the people that come for long-term care services are  
19 there for the long-term, and closeness to their own  
20 personal home is not the big issue.

21 MR. SULLIVAN: I did a marketing study in  
22 Chicago a while ago, tracking where people go in the  
23 Chicago area, and they inevitably go out west, north,  
24 south. Very few people come toward the city from their

1 home address.

2 MR. PHILLIPPE: They go where their family is,  
3 probably close to kids.

4 MS. DEDERER: They go what?

5 MR. PHILLIPPE: They go places close to their  
6 children or family members.

7 MS. DEDERER: Family members. That's what I  
8 couldn't hear. Thank you.

9 CHAIRMAN WAXMAN: I think there's a tendency  
10 to build where families -- where the second and third  
11 generation have moved to. I think --

12 MS. DEDERER: Do nursing home residents fill  
13 out any kind of a satisfaction survey that says, you know,  
14 I like where I am or I don't like where I am and here are  
15 the things I like, and that would be like closeness to  
16 family? Do we do anything like that?

17 MR. PICK: There is no State standard.  
18 Organizations do collect satisfaction data.

19 MS. DEDERER: They do what?

20 MR. PICK: They collect satisfaction data that  
21 includes the questions you just asked.

22 MS. DEDERER: Okay. What includes the  
23 questions you just asked?

24 MR. PICK: The satisfaction surveys.

1 MS. DEDERER: Okay. So we do do that?

2 MR. SCAVOTTO: Yes.

3 MR. SULLIVAN: But there's no Illinois  
4 standard.

5 MR. PHILLIPPE: Nor requirement.

6 MS. DEDERER: I'm not asking about a standard.  
7 I'm just saying do we have that data, if we had the staff  
8 and other resources, that we wanted analyze that as part of  
9 bed need? I mean, are people in places because they want  
10 to be or because there is no alternative?

11 MR. SCAVOTTO: Both.

12 MS. DEDERER: And they might prefer to be  
13 someplace else that has --

14 MS. O'DEA EVANS: There's different  
15 constituents. At some point, the family's wishes ends up  
16 overseeing the process versus where the existing person is  
17 overseeing their own process. So, there's a lot of  
18 different influencers, and it's not always the recipient of  
19 care.

20 MR. PHILLIPPE: That's true.

21 MR. PICK: Right.

22 MS. DEDERER: I didn't hear what you just  
23 said, but whatever it is is fine. This is awful. You pick  
24 up like a third of a syllable and try to patch it together.

1 I mean, yes. Did you just say that family  
2 members usually take the leave in placing their relatives  
3 in the nursing home?

4 MS. O'DEA EVANS: I'm not saying it's usually.  
5 Sometimes they do and sometimes they don't.

6 MR. PHILLIPPE: Yes.

7 CHAIRMAN WAXMAN: Claire, please move on.

8 MS. BERMAN: All right. There's just one  
9 other point to bring up about the planning area  
10 development. When these were put together, the planning  
11 areas for general long-term care were put together to  
12 contain a minimum population of 10,000, and it was felt  
13 that this population base would be sufficient to support  
14 100 nursing care beds, based upon a rate of 9 beds per  
15 1,000 population. And this is from 1997. So, that's  
16 something that, you know, we might want to look at and see  
17 if that's still --

18 MR. SULLIVAN: Claire, question. The  
19 boundaries for the HSA's were pretty much established back  
20 in '78, '79. We redid them in '97.

21 MR. FOLEY: Something like that.

22 MS. BERMAN: That was the last time that this  
23 was -- that had any change. It was looked at, oh, probably  
24 three, almost four years ago now, when we were trying to

1 relook at all of the rules in place. That was a  
2 requirement of the Act at the time, and that's why you saw  
3 a lot of rule activity in big chunks of the rules, because  
4 we were required to look at all of them and revamp them  
5 all. So it was looked at back then, but there was no big  
6 change that seemed to be apparent. I don't personally have  
7 the documents that were prepared by one of the professors  
8 at Governor's State who took on this task, and I do  
9 remember that the end result was that we did not change  
10 anything that was in place, and it doesn't mean that --

11 MR. SULLIVAN: I find that incredible.

12 MS. BERMAN: It doesn't mean that that's what  
13 happened at that time. It has been a while since that has  
14 been revised.

15 CHAIRMAN WAXMAN: Chuck, do you have a  
16 memory?

17 MR. FOLEY: I was just going to comment. It  
18 seems like the biggest problem we have today is not so much  
19 the boundary lines but, unfortunately, if you look at that  
20 30-minute drive time. So even though the bed-need  
21 methodology is based on the geographic, you know, boundary  
22 line and bed need is taken from that, we also look at a  
23 30-minute drive time and the occupancy rates therein. So  
24 that really and truly presents a most serious problem.

1 Obviously that was given to us back in the late 90's,  
2 through a court order. So, I don't know how we get around  
3 that, but something really needs to be done.

4 MR. SULLIVAN: I find it incredible that just  
5 looking at the legislative maps and everything that's going  
6 on with how things are shifting, population of 200,000  
7 people leaving Chicago and moving down and some pretty  
8 dramatic growth downstate, that the boundaries that we  
9 established back in 1979 are still -- I'd love to see what  
10 the population in each of the HSA's are. I think it can't  
11 be anywhere near equal at this point, I would presume.

12 MR. FOLEY: Well, we do have that, obviously.

13 MR. WAXMAN: Can you explain the 30-minute  
14 drive time ruling, where it came from and why?

15 MR. FOLEY: There was a court ruling, started  
16 down in St. Clair County, where a project was approved at a  
17 location right on the HSA or the planning area boundary  
18 line, and the Board says all we can look at at that time  
19 was all of the facilities within the planning area only,  
20 even though the boundary line -- across the street may have  
21 five facilities with a lot of empty beds, but the Board was  
22 not allowed to look at that. So the courts came back and  
23 ruled that you had to look at at least a 30-minute drive  
24 time. But so then as years progressed, we still had the

1 same bed need to each planning area, but yet on the other  
2 side, we're looking at a 30-minute drive time.

3 MR. PHILLIPPE: And the 30-minute drive time  
4 is really -- that's where the market is moving. That's  
5 where it has moved. If you do market studies on  
6 development, you look at percentages, you look at numbers  
7 in a 30-minute drive time. For managed care health  
8 insurers, they look at access in a 30-minute drive time.  
9 That is something that is used out there for 15 years  
10 probably.

11 MR. FOLEY: A lot of the studies that I looked  
12 at and our office has even conducted, we're looking at a  
13 primary market area anywhere from 10 to 15 minutes from the  
14 site and really very seldom go that 30 minutes, because you  
15 get up in the Chicago area --

16 MR. PHILLIPPE: Cities have different  
17 standards.

18 MR. PICK: -- depends on time of day, too.

19 MS. O'DEA EVANS: Thirty minutes could be next  
20 door.

21 (Laughter)

22 MR. PHILLIPPE: From a customer perspective,  
23 by the way, we probably know this ad hoc. I don't know  
24 that we've seen reports on it, but people in the cities

1 expect things to be closer. So I do know from health  
2 insurance days, we looked at 15 minutes access to multiple  
3 choices for healthcare, versus out in downstate, they're  
4 used to 30 minutes, it's true.

5 MS. DEDERER: Claire, before you go on, could  
6 I ask a question? Do we -- are there nursing homes who  
7 would have available beds who would still choose not to  
8 take someone who is on Medicaid?

9 MR. SULLIVAN: Yes.

10 MS. BERMAN: That's for the sub-committee.  
11 That's not for me.

12 MR. PICK: The answer is yes.

13 MS. DEDERER: It's not directed at you. If I  
14 could just interrupt you a minute. I know we have people  
15 on the subcommittee who know the answer to that.

16 MR. PICK: The answer is yes.

17 MR. SULLIVAN: Clearly.

18 MS. DEDERER: We're saying that virtually  
19 every nursing home in the state is running under capacity?

20 MR. SULLIVAN: Yes.

21 MS. DEDERER: Okay. Thank you.

22 MS. BERMAN: We'll be talking more about the  
23 controversy about the occupancy rate and the fact that many  
24 facilities have a hard time reaching that. But if we can

1 at this point, I'd like to move on to another document.

2 This one is -- has a big blue stripe across it. It says  
3 "Long-term Bed Care Determination Basic Formula". Does  
4 everyone have one to look at?

5 CHAIRMAN WAXMAN: Yes.

6 MS. BERMAN: Okay. Well, this is just the  
7 basic formula that pretty much all the states use. It uses  
8 the basic components that we just got done looking at and  
9 talking about, and this is how it's all worked together.  
10 Once you have the use rate and the projected population,  
11 you can calculate the planning area's projected patient  
12 days for each age group. That's the typical approach. And  
13 then you total all of those projected patient days for the  
14 age group. Then you have the planning area's total  
15 projected patient days. You take those and you divide it  
16 by the number of days in the year, and you get the average  
17 daily census, and then when you have the daily average  
18 census, you divide it by the occupancy target. In  
19 Illinois, it's 90 percent. And you get the projected  
20 planning area bed need, and this is a gross bed need  
21 number. Okay.

22 The final step is when you subtract from that  
23 the existing number of beds in the planning area. And as  
24 the subcommittee has already briefly discussed a couple of

1 times, the number of existing beds is a real important  
2 thing to look at and consider because if the count is not  
3 accurate, it skews all of the bed need numbers.

4 MS. DEDERER: Speaking of which, are we using  
5 the number of beds that are really available versus the  
6 number of beds that are on paper? I don't know what those  
7 two things are called, but there is a difference, right?

8 CHAIRMAN WAXMAN: We're using licensed beds,  
9 are we not?

10 MR. PICK: Yes, licensed beds.

11 MS. DEDERER: Licensed beds versus really the  
12 beds that are set up and available. When we use bed needs,  
13 do we do the licensed beds or the other beds?

14 MR. SULLIVAN: We use licensed.

15 MS. DEDERER: Why would we do that when we  
16 know in Illinois there's a pretty big difference, I would  
17 assume, among nursing homes between those two numbers?

18 MR. SULLIVAN: Because the number of set-up  
19 beds fluctuates much more than licensed beds do, and, you  
20 know, in which case you have a very fluctuating, moving  
21 target, but, also, we're dividing the average daily census  
22 with 90 percent when, in fact, pretty much across the state  
23 in every HSA, it's 80 percent. So you end up with a  
24 projected bed need that's a lot higher than actual need.

1 When you have 20,000 empty beds, in the words of the  
2 esteemed Vice Chairman, where's the need.

3 MR. PICK: I said that in Arlington Heights.

4 (Laughter)

5 MR. PICK: If we're using average daily  
6 census, it takes into account vacancy, because census tells  
7 you how many beds are being used.

8 MR. SULLIVAN: So why we are using a 90  
9 percent factor then?

10 MR. PICK: That's the question.

11 MR. FOLEY: We still have a lot of facilities  
12 out there with the so-called dead beds.

13 MR. PICK: But when they're calculating  
14 census, it's a percentage of all of the beds, even the dead  
15 beds. When we're -- because we're still using licensed  
16 beds as the end.

17 MR. FOLEY: That is correct.

18 MR. PICK: So your occupancy would account for  
19 that. It's the 90 percent that's erroneous.

20 MS. JOHNSON: What is a dead bed?

21 MR. PICK: A dead bed is theoretical. It's  
22 not set up to take a patient.

23 MS. DEDERER: Would we entertain an  
24 explanation to say a nursing facility has gone to all

1 private rooms and, therefore, their real bed availability  
2 is much lower than we're counting and, therefore, their  
3 occupancy is actually much higher than we're counting?

4 MR. PICK: No. There is a mechanism.  
5 Facilities are required to submit an annual long-term  
6 questionnaire. They're supposed to identify how many beds  
7 are set up.

8 MS. DEDERER: But I'm talking about when we  
9 give a Certificate of Need for new beds, if somebody wants  
10 new beds because they've gone to more private rooms or  
11 fewer quads or whatever.

12 MR. SCAVOTTO: The type of bed, whether the  
13 bed is obsolete or not, doesn't affect the calculation.

14 MR. PICK: That's correct.

15 MR. FOLEY: That's the problem.

16 MS. DEDERER: Could you repeat that, please?

17 MR. SCAVOTTO: The type of bed, whether it's  
18 obsolete or not, does no affect the calculation. You can  
19 have obsolete beds and they can be factored in to the  
20 calculation. You can have private-pay beds, semi-private  
21 beds, single rooms, palaces, they all go in to the  
22 calculation.

23 MR. FOLEY: Because it's licensed beds.

24 MR. SCAVOTTO: Because it's licensed. You can

1 have an obsolete bed that is licensed.

2 MR. PHILLIPPE: Could I ask a question about  
3 the occupancy target of 90 percent? It seems that was set  
4 at some point and that affects the formula but it's not an  
5 accurate measure of what's occurring in the state today.  
6 Is that what is going on?

7 MR. FOLEY: Well, it keeps the bed need  
8 somewhat down, and that's why Claire said earlier, you  
9 know, across the country, we're looking at it varies from  
10 85 percent to 97 percent.

11 MR. SCAVOTTO: I think it also goes back to  
12 what Mr. Bibo was talking about earlier --

13 (Laughter)

14 MR. SCAVOTTO: -- where we're not just able to  
15 run at 100 percent occupancy. 90 percent in a lot of other  
16 states is looked at as the maximum efficiency factor.

17 MR. PICK: Right.

18 MR. PHILLIPPE: Okay.

19 MR. PICK: It is affected by the type of  
20 service that you're running, because if it's general  
21 long-term care, you can have a hundred percent.

22 MR. SCAVOTTO: And I think that's the  
23 motivation of 100 percent in many states.

24 MR. PHILLIPPE: Let me just say, what I know

1 from talking to people is that most places, if they have a  
2 choice, they want to get as many Medicare people as they  
3 can, even if they're not short stay, because the Medicaid  
4 is under funded, most of us view, and the way you can  
5 manage to operate effectively is having Medicare. And so  
6 really, I -- there may be odd places out there where people  
7 just want to run their building full and not take anybody  
8 on Medicare, but I've not heard of it.

9 MS. O'DEA EVANS: There are places that are  
10 Medicaid only.

11 MR. SCAVOTTO: But it goes to the 90 percent  
12 then. If you're running at 90 percent and you want to turn  
13 your beds over with Medicare, you've got some room. If  
14 you're running at 100 percent, obviously you don't. If  
15 you're running at 95 percent, you might not have the  
16 flexibility, or even at 85, to turn your beds over, which  
17 is what these guys were talking about earlier.

18 MR. PHILLIPPE: So as long as it's not an  
19 intermediate care facility that isn't able to take  
20 Medicare, people are trying to keep their census down so  
21 they availability when somebody is asking on Medicare.

22 CHAIRMAN WAXMAN: From a pure mathematical  
23 point of view, it depends on the total bed count in your  
24 facility. I mean, if you've got 200 beds and you keep at

1 95 percent, you have a lot more leeway than if you've got  
2 85 beds and 95 percent. I mean, the absolute number of  
3 beds you can maneuver --

4 MR. PHILLIPPE: That's true.

5 CHAIRMAN WAXMAN: -- because as I learned  
6 very early on, if you don't take into account the fact that  
7 you can't put male and female in the same room --

8 MR. PICK: The other thing is isolation. It's  
9 a big issue now. It's much bigger now than it's ever been.  
10 So you end up with vacant beds that you can't use because  
11 you're isolating a patient with a communicable condition.  
12 So those things definitely impact your target and --

13 MS. O'DEA EVANS: It impacts availability.

14 MR. PICK: I think that is directly relevant  
15 to our 90 percent target where we may have had an isolation  
16 incident of 2 percent 20 years ago, now it's more like 10  
17 percent. So that has a significant impact on the number of  
18 available beds, even though they're empty.

19 MR. FOLEY: How does the 10-day hold beds for  
20 Medicaid affect occupancy rates?

21 MR. SULLIVAN: Very little.

22 MR. PICK: Very little.

23 MR. SULLIVAN: Because most facilities are --  
24 first of all, to get bed need, you have to be at 90 percent

1 Medicaid and 93 percent occupancy. There's probably maybe  
2 20 facilities in the state that reach that standard. So  
3 facilities are either not 90 percent Medicaid or not at 93  
4 percent occupancy. So that's a pretty high standard,  
5 purposely by HFS. So, where in the past, many facilities  
6 were eligible for that standard, it's about 20 now. Mostly  
7 IME's.

8 MR. PHILLIPPE: It would seem like when we're  
9 talking about high census, there are places that could be  
10 higher than they are. Okay? However, if we're talking the  
11 total, the total is what it is. You know, there's this  
12 many beds available and we could have a few more places  
13 running 97 and somebody else would be running 85 instead of  
14 90, but the total is what it is.

15 MR. SCAVOTTO: The total isn't what it is.  
16 That's the problem.

17 MR. PHILLIPPE: Why isn't it?

18 MR. SCAVOTTO: If you've got 90 percent as  
19 your efficiency factor and you've got semi-private rooms,  
20 it's a much -- you're not going to be anywhere near as  
21 efficient.

22 MR. PHILLIPPE: I'm not talking about that.  
23 I'm talking about if you've got a region and you've got 20  
24 buildings in the region, if you've got 1,000 beds or 5,000

1 beds, once you've got a certain population of beds, the  
2 individual facilities could change on their census. Okay?  
3 However, the total of people needing care compared to the  
4 total number of beds is still the same. Does that make  
5 sense? So it only matters if we're looking at one  
6 building, or if we're trying to set a standard for all of  
7 the buildings in the area need to be about 95 percent.

8 MR. SCAVOTTO: I'm going to have to chew on  
9 that one.

10 MR. PHILLIPPE: If we're talking about total  
11 number of beds available, it's the same.

12 MS. DEDERER: But what difference does that  
13 make?

14 MR. SULLIVAN: Right on.

15 MR. PHILLIPPE: Well, sometimes I think when  
16 we're arguing about why some buildings are not 95 or 100 is  
17 one thing. But when we stop looking at that and we talk  
18 about the number of beds available already, is there a need  
19 for more beds?

20 MS. DEDERER: But there's a possibility that  
21 you don't have as many beds set up in a given facility  
22 because it's a crummy facility and people don't choose to  
23 go there.

24 MR. PHILLIPPE: That's very true.

1 MS. DEDERER: It's not cost effective to have  
2 them set up or keep them set up.

3 MS. O'DEA EVANS: The only thing is as we get  
4 closer to having a requirement that people would have these  
5 high occupancy rates before we would consider a new  
6 project -- because that's really the crux of the matter --  
7 we're limiting choice of consumer and families, because if  
8 you talk about a huge regional area and we're going to  
9 count all of these vacant beds and say, oh, you don't need  
10 to put a new place here, you're not considering choice that  
11 families might have to have a place that's closer and we  
12 have these arbitrary bureaucratic 30-mile radius or -- I'm  
13 sorry, 30-minute radius in the planning area and all of  
14 this, but it doesn't take into consideration what the  
15 community might want or what the -- if there's a big  
16 regional hospital in that area, what their need is for  
17 placement. And we have consistently -- I work as a  
18 Discharge Planner at Northwest Community Hospital. We  
19 consistently have facilities near us that do not have beds  
20 available when we're trying to make discharges, and it's  
21 because we're drawing patients from a large area, and we  
22 have families that want to be close and they want choices  
23 about -- you know, they want resources near them.

24 MR. PHILLIPPE: I think whenever you take bed

1 need as a concept, what you're saying is every bed is the  
2 same as every other bed.

3 MR. SCAVOTTO: That's right.

4 MS. DEDERER: But it's not.

5 MR. PHILLIPPE: Whatever region you use,  
6 county, 30-minute region, you're saying every bed is the  
7 same. But what you're saying from a consumer perspective  
8 is every bed is not the same.

9 MS. O'DEA EVANS: Right.

10 MR. PHILLIPPE: It could be location, it could  
11 be how the building looks.

12 MS. O'DEA EVANS: It could be privacy.

13 MR. PHILLIPPE: All kinds of things.

14 MS. DEDERER: Nice staff can trump a very not  
15 nice looking building.

16 Can't we also do some analysis to look at  
17 nursing facilities that chronically are under utilized and  
18 then maybe, with the few staff resources that we have, go  
19 in and survey those facilities to maybe try to figure out  
20 why and then do something with that information, rather  
21 than saying we can't build another new bed in this planning  
22 area because this facility continues to sit at 80 percent?

23 MS. O'DEA EVANS: One of the things that we're  
24 doing in our process is we're looking at how this state is

1 doing it and this state, and we've never really identified  
2 where we want to go or what we want to -- like, if we have  
3 a vision as a group to say we would like to have more  
4 privacy, we would like to have more single-bed occupancy.  
5 Why don't we start out with some framework of where we want  
6 to get to, you know, just as a structural process of this  
7 committee, because we're kind of mired in all of these  
8 issues that are piecemeal, and it's taking us away from --  
9 I don't even know what other people in this group think  
10 about where they want this to go.

11 MR. FOLEY: Our piece of legislation we're  
12 working under right now does, in fact, dictate that we  
13 provide more private rooms. It doesn't say how many or  
14 anything, but it does say to some extent to provide more  
15 private accommodations.

16 MR. SULLIVAN: And the marketplace is heading  
17 that way.

18 CHAIRMAN WAXMAN: The next item on the agenda  
19 is strategies for next steps, so I think you're there. But  
20 I'm not sure the whole group is there yet, but that's what  
21 we're going to do next.

22 MR. SULLIVAN: I totally agree with you in  
23 terms of we should be deciding where we want to go with  
24 this. It seems like with bed need, there's three factors

1 coming into effect. One is collection of data and what  
2 data should we collect? Obviously, age and historic  
3 occupancies is the basis for what we have now and for most  
4 states, but we've brought up an awful lot of really good  
5 points of what about conditions, market preference,  
6 consumer need, the factors of community-based services,  
7 where we have more people in community-based services than  
8 in nursing homes now. We have 20,000 assisted living beds,  
9 10,000 supported living beds, all of the retirement  
10 communities, the whole short-term stay factor, and then, of  
11 course, how many beds are set up. We could have a formula  
12 that would drive everybody crazy, and I'm not sure we have  
13 the expertise to come up with that, because the second  
14 step, after you collect all of the data, is inevitably you  
15 make some judgments. So what does this data mean in terms  
16 of how many beds we need? And it's like well, it's  
17 (indicating), I think it's this, you think it's that, we'll  
18 meet in the middle. It inevitably comes down to that, and  
19 then as Claire said, all of this is just the starting point  
20 for the Board in making a decision of well, no, there's no  
21 bed need in this area, but this particular project -- you  
22 know, it's one more factor. I'm increasingly -- as I  
23 listen -- this is great conversation. I'm loving it, but  
24 are we ever going to get to a point of a formula that

1 really means something, given all of the factors and the  
2 changing nature of the marketplace?

3 MR. FOLEY: It's a number games versus  
4 reality, what is really going on in an area, and that is  
5 why our rules also allow for variances whereby if there is  
6 not a bed need based on a numbers game, so to speak, you  
7 still have the opportunity to identify all of these other  
8 needs, whether it's going to be short-term stay, whether  
9 it's going to be Alzheimer's, our innovative approaches  
10 we've been talking about. We have the opportunity to  
11 address those issues under a variance.

12 MR. SULLIVAN: Well said, Mr. Foley. We could  
13 do an awful lot of work on bed need and really not have an  
14 important factor in making a decision about the kind of  
15 long term care facilities we want in the future.

16 MR. FOLEY: But you need some place to start,  
17 and a bed need does give us a place to start. Even though  
18 it could be a, quote, numbers game, okay, but at least it's  
19 something in terms of a planning purpose. This is a  
20 planning body. We are supposed to be planning for the  
21 future, for tomorrow, and the only way we can do that is by  
22 looking at historical data, look at what we have now in  
23 order to project for tomorrow.

24 MR. SULLIVAN: And I think the formula will be

1 so complicated and.

2 MR. FOLEY: It doesn't have to be, Terry.

3 MR. SULLIVAN: Whatever formula we come up  
4 with is going to be based on data, then assumptions, and  
5 it's never going to be enough to --

6 MS. DEDERER: Did you say bad assumptions?

7 MR. SULLIVAN: And assumptions.

8 CHAIRMAN WAXMAN: What's interesting about  
9 what you're saying, Terry -- I just got done reading an  
10 article based on some research done, I forgot where, but  
11 the more information they fed a group of people, the worse  
12 decisions they made. So, I'm not suggesting that we don't  
13 look at data, but it's interesting that I just read that  
14 article and you're talking about the collection of all of  
15 this information and how are we going to put it to some  
16 useful use.

17 MS. DEDERER: Does Illinois have the same kind  
18 of rating system that Indiana has, where you get so many  
19 points for this and that and you have a listing of where  
20 you rank in the state. Anybody familiar with Indiana?

21 MR. PHILLIPPE: I have buildings in Indiana  
22 and so --

23 MS. DEDERER: So do we have anything like  
24 that?

1 MR. PHILLIPPE: No, I don't think so.

2 MR. SULLIVAN: Well, to a degree the Board  
3 does, not a formal rating system but, you know, as they go  
4 through the different criteria, the criteria is either met  
5 or not met, and then you explain the not method and the  
6 Board decides whether it's important to overrule the unmet  
7 part of the review.

8 CHAIRMAN WAXMAN: This young lady has been  
9 trying to speak.

10 MS. JOHNSON: You better hurry up, because I  
11 might forget what I was going to say. I come from an  
12 advocate/consumer perspective, and I don't know, it seems  
13 like we have to get to the immediate needs in the various  
14 areas, because it is what it is, regardless of how you  
15 slice it and come up with all of these formulas. This is  
16 a -- it seems to me it's all about the resident, the  
17 consumer and their choice and what they need in their  
18 specific areas. You can come up with all kind of different  
19 equations and thought processes and beautiful marketing  
20 plans, but if it doesn't meet the people who live in this  
21 area or live in this area or live down south or wherever,  
22 if it doesn't meet their needs, to me it's all for naught  
23 and you're spinning your wheels.

24 And then another question is about the public

1 hearings. I'm just wondering if maybe that might be a  
2 vehicle we might want to consider to find out what people  
3 really want in this specific area, because I still feel --  
4 and I'm coming from an ombudsman perspective -- that it  
5 depends on -- the staff and what services you offer depends  
6 on whether or not you have empty beds or not, whether you  
7 have high turnover or not, whether or not you have high  
8 psychotropic drug use, whether you have a waiting list for  
9 residents to come and live in your facility.

10 MR. PHILLIPPE: That's true.

11 MS. JOHNSON: Don't leave out the consumer and  
12 the resident in making your choices.

13 CHAIRMAN WAXMAN: I think you need to remind  
14 us, because you, I think, are probably the only one that  
15 represents that group. So, please feel free to make sure  
16 you continue repeating that, because that is a very  
17 valuable piece that we need to incorporate in our decision,  
18 is the consumer piece of it.

19 What's the status of lunch.

20 MS. CLARKE: It's almost ready.

21 (Discussion held off the record.)

22 MR. PHILLIPPE: Could I just mention -- I  
23 agree with you on the consumer, but I think my  
24 understanding of Certificate of Need laws in states are

1 actually not consumer focused by nature. By nature the  
2 history of the law is kept to do with efficiency or cost,  
3 whether that's right or wrong -- I'm not saying whether  
4 it's right or wrong -- and it doesn't take the consumer in.  
5 It kind of limits choice and new development, innovation in  
6 a marketplace, typically it does.

7 MR. FOLEY: One of our major problems today in  
8 trying to build a nursing home, to see what the consumer  
9 wants, at times our hands are tied because of licensure  
10 requirements. It then becomes a cost issue, whether you  
11 can afford to build. For instance, today the consumer  
12 wants all private rooms. Given the cost of construction  
13 and the way the construction standards are written, it's  
14 very, very expensive to build an all-private-room facility  
15 and to add all of the other extra amenities that a consumer  
16 may, in fact, want.

17 MR. PHILLIPPE: It's still happening, though.  
18 People are building them.

19 MR. FOLEY: People are still building them,  
20 but you're not --

21 MR. PHILLIPPE: There's two going on in  
22 Springfield. They've been approved for private rooms.

23 MR. FOLEY: That's my project, and the problem  
24 we're having right now is because of cost, and we don't

1 know whether that's going to go through or not. We did, in  
2 fact, get Planning Board approval, but we haven't got  
3 zoning approval, and that's part of the problem.

4 MR. PICK: But it's also early to tell. The  
5 all-private facility model is relatively new development.  
6 So while the one in Hanover Park that opened is doing quite  
7 well, it's only been running for six months. So it's --  
8 three to five years from now, where are we going to be?

9 MR. FOLEY: It's going to be an old facility.

10 MR. PICK: That's correct.

11 MR. FOLEY: What people want today, what we  
12 were talking about earlier, the smaller facility. They  
13 don't want the institutional appearance but -- 8 foot wide,  
14 120-foot long corridor, nurse's station -- but our  
15 licensure standards dictate that, so we don't have a  
16 choice, like at Hanover Park. You can camouflage a lot of  
17 that, but still you have to have at least 8 foot wide, et  
18 cetera, et cetera. Illinois does not approve the  
19 greenhouse concept yet, for instance, and Rick and I were  
20 talking about this earlier, which is something that the  
21 consumer wants. So, I think this committee here needs to  
22 now start to work somewhat close with our licensure folks.

23 MR. PICK: We need to reconcile, as Mike  
24 pointed out, this is a bed-need discussion.

1 MR. SCAVOTTO: That's where I was raising my  
2 hand.

3 MR. PICK: But what we're really talking about  
4 is not bed need, it's meeting consumer needs, and how do we  
5 reconcile those two?

6 MR. SCAVOTTO: You're going to have to have  
7 some foundation data. So, Charles, I want to ask you, who  
8 is keeping track of the types of beds? I mean, like when  
9 you fill out your long-term care annual survey report,  
10 semi-private, private, do they report obsolete beds or beds  
11 in wards? Do we have any data like that?

12 MR. FOLEY: Mike?

13 MR. SCAVOTTO: If we're going to do a bed-need  
14 formula, you ought to have some consideration in there for  
15 the numbers of beds that are obsolete.

16 CHAIRMAN WAXMAN: I guess lunch is here. But  
17 before we break, I'd like to ask Frank, how much in terms  
18 of the legal perspective of bed need and bed-need formulas  
19 can we incorporate what the consumer wants? I mean, from a  
20 legal point of view, the way the statute is written, can we  
21 meld these two concepts?

22 MR. URSO: I think you can. Mike, you can --  
23 Courtney can join in and, of course, Rick, too, from the  
24 licensure perspective. The statute is very broad. The

1 statute doesn't give much guidance. What gives the meat to  
2 the bed-need methodology is the Rules, and so there's a lot  
3 of latitude, so to speak, to incorporate variables and  
4 interests in the Rules. You just got to get them in a  
5 clear fashion that allows them on go through JCAR and all  
6 of the various boards, Joint Commission on Accreditation of  
7 Rules. But, there's a lot of latitude in the Rules, in my  
8 opinion, because there's not a lot of structure in the  
9 actual statute.

10 Michael, do you have any --

11 MR. CONSTANTINO: I think they've got the  
12 latitude to do it, Frank, yes.

13 MR. FOLEY: I think what the consumer wants  
14 today, quite honestly, is a assisted living, slash,  
15 supported living model licensed as a nursing home with a  
16 floating license.

17 MR. PICK: For long-term care.

18 MR. FOLEY: Yeah. That's the future, with a  
19 floating license of some sort.

20 CHAIRMAN WAXMAN: What's your perspective?

21 MR. DEES: Well, we have building design  
22 standards that have been around for decades, and we  
23 recognize that there needs to be some adjustments to the  
24 building design standards to incorporate the concept of

1 culture change and the various efforts to make these  
2 facilities a bit more home-like. But we also have to  
3 balance that with the fire codes, which are rather strict  
4 and rather black and white, that you have to have this and  
5 you have to have that. We also have to look at other  
6 related codes, like the food code, which is a State  
7 standard, which does have some restrictions on some of the  
8 aspects of culture change, and what we've been doing to  
9 date is kind of looking at things case by case and trying  
10 to see where there's flexibility and incorporate some of  
11 these new projects into the system. I would agree that  
12 part of this process is going to be to open up our building  
13 design standards and perhaps look at developing a component  
14 of our licensure regulations that recognizes culture change  
15 and establishes some parameters for facilities to follow if  
16 they have made a commitment to develop this kind of  
17 facility.

18 MR. FOLEY: Because other states do, in fact,  
19 have free-standing 20, 25, 30-bed facilities, licensed as  
20 skilled, Medicaid-certified. So why can't we? We're under  
21 the same federal guidelines for safety codes and otherwise.

22 MR. PHILLIPPE: We run into issues -- you  
23 identify them well -- that actually have to do with the  
24 kitchen, the dietary, and the fire code, issues that causes

1 us to need to put expensive stuff in a little building.

2 MR. DEES: That's right. When you look at  
3 issues like fire code and food codes, you also have local  
4 authorities that you're having to deal with. Under ICF/DD  
5 regulations, we established some exceptions to the State  
6 food code -- and this is many years ago -- to allow a more  
7 home-like environment for the 16-bed or less facility, and  
8 to this day, I still have issues with local health  
9 departments wanting to go in and apply the food code  
10 strictly as it is written, where we have some exemptions,  
11 and it's a routine thing for me to try to find some balance  
12 or compromise with local health authorities. The same can  
13 occur with local fire authorities, if there is any  
14 difference in the approach. So, I think we recognize that  
15 there needs to be some adjustments in our building design  
16 standards, but there are some limits to how far we can go,  
17 because we have these other variables.

18 CHAIRMAN WAXMAN: So, I guess I'm hearing  
19 that we can meld the concept of what consumer needs/wants  
20 are into a bed formula, you know, if we can figure out how  
21 to do it. Terry, you're saying no?

22 MR. SULLIVAN: Not in a bed formula. I think  
23 consumer needs needs to be part of the overall decision  
24 process of whether we expand or build a new facility. I

1 don't know if you can put consumer desires into a  
2 statistical bed-need formula. And what factor do you apply  
3 to that? But I think it should be a major part of the  
4 consideration of the CON process.

5 MS. DEDERER: I don't know why you can't meld  
6 the two.

7 MR. PICK: Let's get lunch for now.

8 CHAIRMAN WAXMAN: Claire, are you done with  
9 your presentation?

10 MS. BERMAN: Yes. The pages that follow just  
11 have some questions that can be picked up at another time.  
12 Some of it we've already gone over and discussed, and  
13 simply things to think about when you look at what's  
14 currently in place for determining bed need.

15 CHAIRMAN WAXMAN: Okay. I'd like to propose  
16 that we are now at the point that you brought up, what are  
17 we going to do next? But let's pause for lunch.

18 (Recess)

19 CHAIRMAN WAXMAN: Let's reconvene officially.

20 Michael, how many do we have on the phone?

21 MR. CONSTANTINO: Who is on the phone?

22 Claire, are you there?

23 MS. BERMAN: Yes, I'm there.

24 CHAIRMAN WAXMAN: Teri?

1 (No response)

2 CHAIRMAN WAXMAN: Claire, do you have  
3 anything you wish to add to your last presentation, or do  
4 you think you've covered it all?

5 MS. BERMAN: No, I think we've covered it all  
6 for now. Maybe after the next point of discussion, there  
7 might be something that you would need to be developed  
8 further.

9 CHAIRMAN WAXMAN: Okay. I guess you've heard  
10 it, maybe you heard it, hopefully you heard it, that we all  
11 really appreciate all of the work you've done in the  
12 summation, summary charts, background work, and research  
13 that you've done to bring this all together to us. We  
14 really do thank you for that.

15 (Applause)

16 MS. BERMAN: You've definitely more than  
17 welcome. Thank you.

18 CHAIRMAN WAXMAN: I would tell you you have a  
19 standing ovation, but you probably wouldn't believe me.

20 (Laughter)

21 CHAIRMAN WAXMAN: That being said, I agree  
22 with -- I think Terry said it earlier, that this discussion  
23 today has been educational, it's been fun, it's been a  
24 learning experience and, you know, hopefully we can take it

1 and put it into some productive use, and I think that  
2 brings us then to point 8, I think, without my glasses on.

3 MR. PICK: That's correct.

4 CHAIRMAN WAXMAN: Which is what we were  
5 talking about earlier, which is how are we going to put all  
6 of this together? How are we going to mesh all of this? I  
7 think what I'm hearing from a lot of people, and I think  
8 we've heard it from everyone throughout all of our  
9 meetings, is that we're trying to struggle with the whole  
10 concept or the process of how do we incorporate quality  
11 care, people, family, residents' demand for the services  
12 that they want, while we're complying with our task of  
13 developing some formula to determine where there are needed  
14 beds? Do I have agreement on that.

15 Okay. Now, I guess I'll throw it open to the  
16 floor. Where do we go? How do we put all of this stuff  
17 together.

18 Mike, do you have some thoughts? Have you had  
19 a chance -- I didn't mean to catch you off guard, but have  
20 you given some thought as to how the -- what you've done  
21 over the last years can be adjusted to incorporate what  
22 you're hearing from the group in terms of quality of care,  
23 market demand, that kind of stuff, can be brought into the  
24 formula?

1 MR. CONSTANTINO: Well, it's my opinion when  
2 you look at that bed-need formula, if that's where we're  
3 going to start, it's going to take -- it's going to be a  
4 long process and we're going to be limited by the amount of  
5 data that we can collect. What we're able to do and what  
6 you want to do are two different things. We don't have the  
7 staff to redefine those Health Service Areas or those  
8 Health Planning Areas. That would take a big effort on our  
9 part. You're probably looking a year or better to do just  
10 that portion of it.

11 I personally -- you know, you probably could  
12 take a look at the occupancy percentage, adjust that maybe  
13 and maybe the age coordinates of the current bed-need  
14 methodology. But beyond that, I don't know how you could  
15 incorporate the other things we've been talking this  
16 morning about without a really lengthy process to get that  
17 done, just from my experience. Now, I don't know what our  
18 timeline is going to be to have this wrapped up. I don't  
19 know if you want to go out a year or better just to do a  
20 portion of this bed-need methodology.

21 CHAIRMAN WAXMAN: I think I said 19 years  
22 when asked that question.

23 (Laughter)

24 MR. CONSTANTINO: We had a professor on

1 contract three or four years ago. He took a look at this  
2 and he didn't do anything with it. That wasn't meant to be  
3 a criticism. But he left it alone. I mean, it is a big  
4 effort to readjust those Planning and Service Areas.

5 CHAIRMAN WAXMAN: Terry, what are you  
6 thinking?

7 MR. SULLIVAN: In terms of next step, I think  
8 I go back to the question of what do we want to accomplish?  
9 In my mind, it comes to what does the consumer want? What  
10 are we looking for in the next 10 years? I think Chuck  
11 summed it up, or at least took first shot, of what the  
12 consumer wants -- an assisted living facility with skilled  
13 nursing capability, sort of like  
14 the-license-follows-the-person concept. I guess I'd like  
15 to see, more than bed need, the concentration on the  
16 variances being the source of the facilities that we want  
17 to build, both in terms of maybe the defined population,  
18 opening that up to the clinical groupings also, not just  
19 ethnic and religious. Specialization is going to be a key  
20 factor in the next 10 years, and I think a facility willing  
21 to establish some kind of specialty service should somehow  
22 get a variance, because that's something we want to  
23 encourage.

24 There is certainly that whole innovation

1 concept, which was deliberately vague, but I think this  
2 committee could get really excited about beginning to  
3 define some of the innovation, consumer-oriented things  
4 that we like, giving the Board additional leeway. I mean,  
5 once, I think, we hash out that innovation concept, the  
6 Board will have some ideas of parameters of where to go  
7 further, if they need to, and, of course, we will always  
8 have this committee to advise and offer our opinion about  
9 whether, in fact, all green walls are really an innovative  
10 concept. Some of it is obvious, but others you kind of go,  
11 "Is that innovative?" But I think all of that is worth  
12 discussing.

13           And then, I suppose, in the smaller  
14 department, without increasing -- we had that debate of how  
15 many beds are really being used and are there really 20,000  
16 empty beds, but, yes, there are 20,000 empty beds -- all of  
17 that is there, but without increasing the number of beds in  
18 the system, without increasing the rinky-dink beds in the  
19 system, I would like to be able to have that recycling  
20 concept out there where a facility can sell 30 unused beds.  
21 It may very well help that set-up issue, because they're  
22 not set up, but the bank wants them to keep them. But if  
23 you can sell them, the bank is happy and you can convert --  
24 you'll have the money to convert to the private rooms, and

1 somebody who wants beds can get them.

2 I think those are three areas that would be  
3 productive when we're talking about the next 10 years.

4 CHAIRMAN WAXMAN: When Eli and I had the  
5 opportunity to speak with the Mother Board, that was the  
6 one concept that created some controversy, buying and  
7 selling beds. There were some responses to that.

8 MR. PICK: Well, the view was that they saw  
9 how it benefited operators to sell beds. They didn't  
10 understand how it benefited consumers, and I tried to  
11 elaborate that if a consumer wants service in a local area  
12 where it's not available because that facility happens to  
13 be full, if they could buy some beds, even though there's  
14 no bed need, then they can expand the services to meet the  
15 needs of their customers. But they were stuck on that  
16 provider's benefit because you can sell beds.

17 MR. SULLIVAN: But I can sell beds now. I  
18 just have to sell all hundred of my beds, and I'm not sure  
19 that's good for the system. It leads to stagnation.

20 CHAIRMAN WAXMAN: One of the things I heard  
21 this morning that I never -- I've been around this for  
22 20-plus years, and I guess I knew it but never heard it  
23 said before, and I think Tim said it, that the whole need  
24 is not consumer driven, the whole formula is not consumer

1 driven. It's cost and efficiency, and I guess if you don't  
2 say it, you don't believe it until you hear it. So, thank  
3 you for that.

4 Mike, what are you thinking?

5 MR. SCAVOTTO: I'm thinking that if you're  
6 going to have a planning effort, at some point you're going  
7 to have to refine this bed-need formula, and it seems to me  
8 that you can -- you're going to have to address the issue  
9 of usable beds and identify them somehow. I'm not  
10 suggesting the Planning Areas. I don't have a big deal  
11 with the Planning Areas, but I think you ought to know  
12 what's in inventory. I don't know who's got that data.

13 MR. CONSTANTINO: Mike, we did something with  
14 the hospitals. We're now doing an Annual Bed Report that  
15 we survey the hospitals every year. So, we've  
16 eliminated -- I don't know -- I think 5,000 beds.

17 MR. SCAVOTTO: Yeah. And I'm saying, to me  
18 that would be useful. Now, whether or not for planning  
19 purposes, if you're going to identify the obsolete beds,  
20 that gives you a place to work from. Now, a provider may  
21 not have to eliminate those beds. You can still choose to  
22 license them or not set them up or something. But if I'm  
23 looking at a -- Charles and I were talking about this over  
24 the break. If we're looking at a provider that's got

1 several 4-bed ward rooms in the facility, I'm not sure that  
2 advances the purposes of the Planning Board to have those  
3 beds in the inventory.

4 MS. O'DEA EVANS: Can I make a suggestion?  
5 Part of what I think is missing with us as a group is we  
6 need to structure something. We can sit here and --

7 MR. SCAVOTTO: Structure what?

8 MS. O'DEA EVANS: Our ideas, our concepts,  
9 where we're going. We need a process.

10 MR. SCAVOTTO: We're working on it.

11 MS. O'DEA EVANS: No. We're having a  
12 discussion. We're having individual discussions. We're  
13 having individual comments being made. It's not a  
14 strategic process. That's what concerns me.

15 MR. SCAVOTTO: Well, excuse me for  
16 disagreeing, but I think we're answering his question.

17 CHAIRMAN WAXMAN: I think what I'm trying to  
18 do is get to the point where we can start finding some  
19 common areas that we can structure, and I guess I want  
20 to -- I guess I'm looking to see if there are some areas of  
21 agreement that we can do that. That's what I'm trying to  
22 ask.

23 I mean, I certainly don't disagree with what  
24 you're saying, but I think you're moving one step ahead of

1 me again. That's fine. That's not a problem.

2 MR. PICK: Can I ask for a point of  
3 clarification? Our discussion seems to kind of flip back  
4 and forth between new development and existing services  
5 that are provided. So, what's our area of focus? Are we  
6 looking at both, or are we only looking at new development?

7 CHAIRMAN WAXMAN: I think our charge is to  
8 look at both.

9 MR. PICK: And if our charge is to look at  
10 both, what do we do -- what's our ability to implement an  
11 action plan as it relates to existing providers?

12 CHAIRMAN WAXMAN: Well, that's kind of why I  
13 put him on the spot by asking him what legally we can do,  
14 and Frank said that it's pretty broad and that we can  
15 incorporate -- it would be the Rules that we have to deal  
16 with and not the statute, so that I guess I'm searching to  
17 see if we can get some agreement and then begin formulating  
18 our next step to send to the Mother Board.

19 MR. PHILLIPPE: In talking about the long-term  
20 and with its 10-year kind of vision, it seems like one of  
21 the issues is who are the stakeholders here? Because when  
22 we talk about things, we're actually crossing the different  
23 stakeholders, and maybe it would help to clarify that. I  
24 don't know if that's the 10-year vision, but I think

1 that's at least trying to clarify what the issues are. I  
2 think the Board -- they have -- that's a stakeholder; they  
3 have an interest, they have limits of what they want to see  
4 changed what they're willing to listen to, it sounds like,  
5 and they have a role to fulfill. You have current  
6 providers; some current providers want to make sure they  
7 don't have too much competition to kill their business or  
8 to harm the quality of care they're trying to provide, or  
9 to be able to sell beds so we can make some money to invest  
10 back in their property maybe, or other reasons. You have  
11 new providers or people who want to maybe build new places,  
12 which is probably the most clear view of the Board's task,  
13 I think, is to make that decision. And you have consumers  
14 that we're talking about, and I don't think they all have  
15 the same goals, and maybe if we could be clear on the  
16 goals, it would -- and state them more obviously, then we  
17 could actually get to something. That's one way of looking  
18 at it here. And we've got people who are consultants, too,  
19 by the way, and they are stakeholders and they have  
20 interests in issues in the process, also.

21 Chuck?

22 MR. FOLEY: Thank you, Tim, but I think our  
23 sole intent and purpose here in terms of who do we look at  
24 and I think our biggest problem today are the existing

1 providers and the fact that they do have a lot of empty  
2 beds. Their Medicaid rate is low. We are not giving the  
3 providers any incentives -- I'm talking about the State.  
4 We're not giving the providers any incentives at all to  
5 help them to upgrade in order to compete in a marketplace.  
6 Whether or not we can do anything about that or not, I  
7 don't know, because of the way our budget crunch is right  
8 now, but we do, in fact, have a lot of empty beds, and it  
9 goes back to what Mr. Scavotto was saying. How many of  
10 those beds are actually real versus dead beds, as we talked  
11 about before? There should be a mechanism to identify the  
12 so-called dead beds. Have they been out of circulation for  
13 the last two, three, four years? I think a decision could  
14 be made to determine that. Maybe we should look at the --  
15 you know, devise a bed-need methodology. Instead of  
16 looking at the license capacity, look at the capacity of  
17 beds in use, operational beds. But let's don't forget  
18 about the providers at the same time in that they may have  
19 these beds out of circulation today, doesn't mean that, you  
20 know, a year from now, two years from now, they might be in  
21 better financial position if they want to add on. If they  
22 give up those beds, they should have a right to get those  
23 beds back without going through a CON process. I would not  
24 have a problem with something like that. We have to do

1 something to work with our existing providers. We've got  
2 to give them some encouragement to upgrade, to modernize,  
3 to do something. I think that is very important.

4 CHAIRMAN WAXMAN: Rick, do you have any data  
5 on dead beds?

6 MR. DEES: We wouldn't. Does the Planning  
7 Board have any?

8 MR. CONSTANTINO: We collect data every year  
9 and we start with licensed beds and then we have set-up  
10 beds. We collect that data. We would have to do a  
11 separate survey, similar to what we did with the hospitals,  
12 to identify what beds are not in service.

13 MR. PHILLIPPE: So, you do collect on set-up  
14 beds, you said?

15 MR. CONSTANTINO: Yes, we collect on  
16 utilization beds.

17 MR. PHILLIPPE: That doesn't catch the issue  
18 of dead beds then.

19 MR. CONSTANTINO: We've got transitional  
20 beds -- we've got definitions of what is a bed, and that's  
21 what we use to determine what beds to remove from  
22 inventory. Then you would have to come up with a mechanism  
23 to allow us to do that as part of our Rules for long-term  
24 care. I mean, that would be your task. We can collect the

1 data. Okay, here's the beds that are not -- are dead beds.  
2 How do you propose we get rid of these and will these  
3 providers allow us to do that? That would be your task.

4 MR. PHILLIPPE: The Government decides.

5 MR. FOLEY: You also have a mortgage issue.  
6 You're sitting here holding these beds and you've got a  
7 mortgage for a 100-bed facility, and only using 75.  
8 Obviously you're going to have to see about getting a  
9 clearance from the lending institution or HUD. Is it  
10 possible? Yeah, it is possible by the sell concept. It  
11 could technically be done right now today, if somebody  
12 really wanted to, because you could have a buyer and  
13 seller -- help me out with this, Mike -- you could have a  
14 buyer and seller working together in terms of buying beds.  
15 You don't need a permit for a partial discontinuation of  
16 nursing beds, but if you had a written agreement with an  
17 existing provider that you're going to buy those beds, the  
18 Planning Board doesn't care if they buy beds, and to add it  
19 to another facility, the other facility has to file a  
20 permit to add beds, 10 beds or 20 percent of their existing  
21 licensed capacity.

22 MR. CONSTANTINO: That would be another area  
23 you want to look at. Do you want to continue to allow  
24 facilities that are running at 50 percent to add beds under

1 that 10 percent, or the lesser of 10 percent or 20-bed  
2 rule, or do we make a change to that and not allow them to  
3 do that? We get a lot of that. We have facilities that  
4 are not at 90 percent come and tell us they want the  
5 additional beds under that 10 percent, lesser of 10 percent  
6 or 20-bed rule.

7 MR. PHILLIPPE: And is this because the use of  
8 the buildings change?

9 MR. CONSTANTINO: I don't know -- they don't  
10 have to tell us the reason why they're doing that. They  
11 can do it under our current Rules.

12 MR. PHILLIPPE: I'm just curious as to why  
13 they do that.

14 MR. PICK: They believe it adds value to the  
15 building because you're adding beds.

16 MR. PHILLIPPE: And it's actually preparing to  
17 go to this bed selling. They're banking beds, basically.

18 MR. CONSTANTINO: Do you want to allow them to  
19 do that?

20 CHAIRMAN WAXMAN: Do they become licensed  
21 beds?

22 MR. CONSTANTINO: Yes, after Licensing goes  
23 out and looks at it.

24 CHAIRMAN WAXMAN: So they're going to pay bed

1 tax on those beds.

2 MR. FOLEY: And Illinois needs that bed tax  
3 money.

4 MS. O'DEA EVANS: Very good point.

5 MR. PICK: Again, because we're going back and  
6 forth between existing providers and new development, my  
7 sense of what we need to do at this point is define our  
8 goal, which is what Pat said. Let's set aside all of the  
9 operational elements and issues that are coming into play,  
10 whether it's the existing Rule or the restrictions that we  
11 have, that if we can set those aside for discussion sake,  
12 and let's really determine what's our purpose, and if our  
13 purpose -- and this is not to say this is what I'm saying  
14 it is, but if our purpose is that we want to focus on  
15 consumer needs, then how do we take a system that's  
16 designed around promoting and maximizing efficiency but  
17 reorient it around how do we meet consumer needs in the  
18 most effective manner. That's an expressed goal. We can  
19 begin to look at what's the Rule and how does that fit into  
20 this goal. But we keep going back and forth between the  
21 current rules, what's happening in the market, what's  
22 market driven, and I believe the proposals that we have,  
23 through the collaboration that we put together, was really  
24 oriented around how do we redesign the system to become

1 more consumer oriented and market driven, and that's a  
2 significant element that doesn't exist in our current  
3 process. So I think we need to resolve what is it that we  
4 want to accomplish?

5 MR. PHILLIPPE: I agree. I think -- because  
6 really, by talking -- people have different perspectives  
7 here, different stakeholders. That's the way it was put  
8 together. That's the way it should be. If we can agree on  
9 the goals and get that done, then it would be easier to  
10 figure out a way to meet the goals.

11 CHAIRMAN WAXMAN: Is it your belief that  
12 there is a goal or multiple goals?

13 MR. PICK: I think there is an overarching  
14 goal. We need to find on what that is. In my own  
15 experience in trying to devise and design an approach,  
16 everyone has to buy in to the vision. There has to be some  
17 agreement on what the end point is. Once you do that, then  
18 you come back to each of the elements and say, "Does this  
19 fit in or not", because we're going back and forth. We're  
20 talking about goals, we're talking about elements, we're  
21 talking about systems, and as a result -- it's a healthy  
22 discussion, but I think we're at a point where we need to  
23 kind of sit down and do our work. What is the overarching  
24 goal.

1 CHAIRMAN WAXMAN: Pat, you've sort of been  
2 advocating this for hours. Have you thought about the  
3 conflict of a goal.

4 MS. O'DEA EVANS: I think there has to be a  
5 process to get to what Eli is saying. We have to  
6 determine -- we have to maybe get everybody's specific  
7 overreaching points of where they want us to go. We need  
8 to create our dream, kind of our dream, where we would like  
9 to end up here, and if we can create that, then quit  
10 interrupting ourself with what's restraining ourselves from  
11 that and we quit interrupting ourselves with what the  
12 current situation is and we get to a different -- we can  
13 start a process of dismantling it how to get there.

14 MR. SCAVOTTO: I have a question.

15 MS. O'DEA EVANS: So more of using a strategic  
16 planning process for the Board.

17 CHAIRMAN WAXMAN: Mike?

18 MR. SCAVOTTO: This committee was put together  
19 for a reason?

20 CHAIRMAN WAXMAN: Sounds like a question.

21 MR. SCAVOTTO: I thought we had a reason for  
22 our existence.

23 CHAIRMAN WAXMAN: Right.

24 MR. SCAVOTTO: And I thought we went through

1 that the first couple of meetings.

2 CHAIRMAN WAXMAN: Right, we did.

3 MR. SCAVOTTO: And I thought today's  
4 discussion was -- I mean, you got me fooled. I thought it  
5 was on the bed need, and so is the bed need consistent with  
6 the reason that we were chartered?

7 CHAIRMAN WAXMAN: Yes.

8 MR. FOLEY: Yes.

9 MR. PICK: One element of it.

10 MR. SCAVOTTO: So, if we were chartered for a  
11 reason, why are we going astray?

12 CHAIRMAN WAXMAN: I'm not sure we're going  
13 astray. I think some of us is struggling with can our bed  
14 need incorporate more than just a mathematical formula?

15 MR. FOLEY: Again, that's very good, because  
16 that's what we were talking about earlier in that the bed  
17 need is just a numbers game, and we've got to deal with  
18 reality, reality being what the hell is going on in this  
19 specific geographic area. So -- but a bed need is, in  
20 fact, and is only, in fact, a planning tool. It is not the  
21 absolute, God must, here it is. It is just strictly a  
22 planning tool based on historical data, today's utilization  
23 and tomorrow, where we would like to be tomorrow.

24 We also have in place what is called the

1 variances to the State's computed bed need, and under these  
2 variances, we could come in and introduce some of these  
3 maybe consumer-driven elements that everybody would like to  
4 have as a variance. For instance, we have the Act that  
5 this committee is working under, and I believe that Act  
6 even talks about looking at alternative measures. I think  
7 we should be taking a look at that. I think that's a very  
8 important tool as well. But we need to focus ourselves on  
9 the bed-need methodology itself, use it as a planning tool.  
10 I think there's room here to tweak that bed need. I don't  
11 think it's the most perfect tool out there, but it's better  
12 than anything else we have until somebody comes up with  
13 something better. But I think it can be tweaked. I think  
14 it can be worked on, only as -- and only as, again, a  
15 planning tool. I don't know -- I'll shut up -- if that  
16 makes sense, what I'm saying.

17 MS. DEDERER: Okay. I couldn't hear  
18 everything that Charles is saying, but I think that we need  
19 to discuss the concept of including consumer need with the  
20 bed-need formula, because need is a matter of what don't we  
21 have that we want, and to the extent that there is the want  
22 in there, it doesn't -- it isn't necessarily just a  
23 mathematical formula. And I think there's lots of things  
24 we need to look at. Maybe we can't -- and I'm sorry I'm on

1 the phone rather than there. I'd much rather be there,  
2 because this is very hideously difficult to understand what  
3 is being said. But I hope we're not going to throw that  
4 out today, as something we ought to think about a little  
5 bit more.

6 CHAIRMAN WAXMAN: Pat, do you envision this  
7 being small group process, a task where each of us think  
8 about it and bring back ideas to a bigger group, or that it  
9 is a big group process?

10 MS. O'DEA EVANS: I think it's a big group  
11 process, but I think we need to be led, you know, in the  
12 strategic way. I think that -- you know, what's most  
13 interesting to me is most of the discussion that we're  
14 having, I agree with like 85 percent of everything that's  
15 been discussed. I think we're all really very close to  
16 being on the same page, except the process is difficult  
17 because of the strengths of the different members and the  
18 different backgrounds, that we're not all speaking the same  
19 language at the same time.

20 CHAIRMAN WAXMAN: Which is why this Board was  
21 put together.

22 MS. DEDERER: Could you repeat that? We're  
23 all on the same page except for --

24 MS. O'DEA EVANS: We're not all -- it's like

1 we're not all speaking the same language at the same time.  
2 So, I think that for me, it's difficult because I'm not a  
3 contractor and I don't own a nursing home. I'm coming at  
4 it from a different perspective than other people. But I  
5 think that for the most part, we're all in agreement that  
6 certain things have to be different. Just how do we get  
7 there? I think Mike's point about facilities are basically  
8 asking for their 10 percent every year -- or I'm not sure  
9 what the time period -- is that two years? But they're  
10 allowed to do that and then they bank those beds and then  
11 that affects the formula. There's all these things that  
12 are affecting the current formula in not necessarily the  
13 way it was designed to be utilized, and I also agree with  
14 Chuck about we need to protect our current providers, you  
15 know, in making that formula. So, all of these things are  
16 really good points, but they're not like on some -- we're  
17 not able to bank them anywhere and pull on them, because  
18 our process of having it just be on one dimension, on this  
19 verbal exchange dimension, and we're not kind of utilizing  
20 it to say, "Okay let's include this, not include this."  
21 It's just the strategic discussion I find problematic.

22 MR. FOLEY: I know we were working under a  
23 time line, but we are not any longer; is that correct?

24 CHAIRMAN WAXMAN: That's correct.

1 MR. FOLEY: Unless the Chair wants to  
2 introduce a timeline of some sort.

3 MS. O'DEA EVANS: I don't think dinner is on  
4 the agenda.

5 CHAIRMAN WAXMAN: Right.

6 MR. URSO: Bull's game is at 7:30.

7 MR. PHILLIPPE: Is it possible to bring in  
8 somebody, because it's hard to do this without a  
9 facilitator.

10 MS. O'DEA EVANS: We do need a facilitator.

11 MR. PHILLIPPE: Facilitates the process, helps  
12 the group get to some basic goals or --

13 MS. DEDERER: You mean like a facilitator?

14 MS. O'DEA EVANS: Yes, we need a strategic  
15 planning facilitator. Any one of us could probably do it,  
16 but we would have to be up for that task.

17 MR. PHILLIPPE: That's right. You could step  
18 back and just do that.

19 CHAIRMAN WAXMAN: I could do that, but I'm  
20 hesitant, because I sit on the committee also. But I can  
21 take that role, if that's the way you want to go. I'd be  
22 happy to do that, or we can bring in somebody else,  
23 although I'm not sure -- if you bring in somebody else,  
24 they're not going to be attuned to what's going on.

1 MS. DEDERER: Can't you also put together some  
2 sort of structure to the discussion? I think what Claire  
3 said today was wonderful, and I doubt that she's still on  
4 the phone and somebody should tell her that again. I know  
5 that somebody did again already. But couldn't we try to  
6 make a list of our talking points, the decision points,  
7 things that we need to do to get to some of the issues?  
8 She brought up an outline of things that are used  
9 elsewhere, and then we have brought up things that we're  
10 interested in, and why can't you use that structure just to  
11 guide conversation, rather than needing to go to a  
12 facilitator or just having random thoughts thrown on the  
13 table willy-nilly?

14 CHAIRMAN WAXMAN: The easiest way to do that,  
15 I think, in my mind is once the transcript comes out, Staff  
16 can pull from the transcripts the key points of all of our  
17 discussions and look for the common elements. That's kind  
18 of what I was trying to head for.

19 MR. PICK: In all fairness, the last two  
20 meetings we haven't had a quorum, so the comments that are  
21 being pulled from are a small subset of the larger group.

22 MR. SULLIVAN: Of the people who really care.

23 MS. DEDERER: We're going to have a video  
24 conference next time, right?

1 MR. PICK: I think the opportunity we have,  
2 since we're going to implement a video conferencing option,  
3 is to circulate the information, make sure that all of the  
4 numbers are aware that we are at this point now of we're  
5 going to get to the real grassroots of trying to formulate  
6 a policy or a goals discussion and that their opportunity  
7 to participate is at this next meeting.

8 MR. WAXMAN: I mean, there are 60 days between  
9 now and the next meeting, I believe, and within 30 days --  
10 Staff, is 30 days fair to go through the transcripts and  
11 pull out information that you kind of glean from all of our  
12 discussions and get to everybody's hands so they can make  
13 comments and be prepared for the next meeting? Is 30 days  
14 enough?

15 MS. DEDERER: Make comments in writing or  
16 bring comments to the July meeting?

17 CHAIRMAN WAXMAN: I would bring comments to  
18 the meeting, have them in some kind of form so they can be  
19 submitted. Since we're not going to be in one spot at one  
20 time, I would say it would be an open discussion, but if  
21 you put it in writing, it would be easy to fax to Mike's  
22 office or somebody's office and, again, they'll have it in  
23 writing.

24 MS. DEDERER: I prefer verbal conversation

1 to -- I think putting it in writing means somebody devotes  
2 time to putting it in writing, and then after the third  
3 sentence, someone else in the group said something that  
4 changed everything they thought, and so what they did was  
5 totally pointless.

6 MR. WAXMAN: Well, I think some people are  
7 more committed to their concepts than others, so I think no  
8 matter what is said, they're going to believe what they  
9 brought with them.

10 MS. DEDERER: Part of the problem is there's a  
11 number of us who are not nursing home owners, who don't  
12 know what's out there, what is available. I know I've  
13 asked on a number occasions what data is available and yet  
14 today I learn that there is a whole set of data available  
15 that I didn't know about that would be really nice. I was  
16 led to believe the last time I asked about it was the  
17 Long-term Chair Report was it. But today you have all  
18 sorts of spices and dices on that information. So, we  
19 don't know as much as you do, and we can't have the really  
20 helpful information that you do. We can, however, benefit  
21 from you educating us as we throw out some of our naive  
22 beliefs and see where that takes us all. Just my opinion.

23 MR. PHILLIPPE: Could I -- you offered. It  
24 would seem to me that if we -- we need someone to actually

1 take a little more hand next time and kind of push us, and  
2 you offered to do that. I think you're capable of doing  
3 that, if you know that's your role, and I think we have to  
4 get in some agreement that these are our goals, and it may  
5 be that I had a goal that was different but, tough, that's  
6 not the goal of the committee now.

7 CHAIRMAN WAXMAN: To be honest, I've tried to  
8 stay as neutral as possible as Chair.

9 MR. PHILLIPPE: I understand.

10 CHAIRMAN WAXMAN: And I would be happy to  
11 step into the other role much -- again, I think the concept  
12 is we'll let Staff pull and then we'll lead it through  
13 the --

14 MR. PHILLIPPE: And work from that, and I  
15 think we can get to where we need to be.

16 CHAIRMAN WAXMAN: I agree with you.

17 MR. PICK: And I think we need to refresh our  
18 memory of what the Act charges us to do.

19 MR. PHILLIPPE: Yes, the limitations.

20 MR. URSO: Do you want me to read the first  
21 two that I think are most pertinent? Establish --

22 MS. DEDERER: Michael, I think you cannot be  
23 neutral. If you just tell us you're going to step out of  
24 you neutral role and here is what the other Michael thinks.

1 We can benefit from what you think, is all I'm saying.

2 MR. URSO: According to the statutory  
3 authority for this sub-committee, I think the first two  
4 points are pertinent. Let me just preface by saying I've  
5 been listening to the entire discussion here, and I don't  
6 think you should underestimate what you've been talking  
7 about and where you're at at this point, because you would  
8 have never gotten to this point to push yourselves to say,  
9 "Hey, we're getting close", but we've got a lot of dialogue  
10 here and going in certain directions. I think a lot of  
11 good stuff has been said here, and you shouldn't  
12 underestimate that, and I would encourage you to continue  
13 to do that, be it with Mr. Waxman or whatever, but I think  
14 we've come a long way. This is difficult stuff. This is  
15 not easy to comprehend and put together. I'll be quiet.

16 But I'll just tell you what I want to say  
17 about the statutory authority. "Establish a separate set  
18 of rules and guidelines for the long-term care that  
19 recognizes that nursing homes are a different business line  
20 and service model from other regulated facilities."

21 And the second one gives us a little more  
22 guidance, I think. It says, "Develop an open and  
23 transparent process that considers the following: How  
24 skilled nursing fits into the continuum of care with other

1 care providers, the modernization of nursing homes, the  
2 establishment of more private rooms, the development of  
3 alternative services, and the current trends in long-term  
4 care services."

5 To me, you touched on all of this. So, I  
6 mean, you're right there. So, this subcommittee is not far  
7 afield. It's dealing with a difficult subject matter. So,  
8 does that help?

9 MR. SULLIVAN: Yes.

10 MR. PHILLIPPE: Yes.

11 CHAIRMAN WAXMAN: Greg, do you have anything  
12 you want to.

13 MR. WILL: I'll just throw this out here. I  
14 was initially like debating whether to say this, because I  
15 think that kind of going to the big picture is a good place  
16 to be if we are going to decide where we want to be. I  
17 think it was two meetings ago where we were just finishing  
18 up our step-by-step through the Rules that we were required  
19 to do. There was a part near the end where something  
20 clicked for me, and I was like this might be a way to  
21 proceed. We filed the initial Rules and are at liberty to  
22 have this sort of discussion. It was towards the very end.  
23 We were at something that dealt with specialized services.  
24 It was something you said, Eli, based on the idea that the

1 industry is going in this direction, and I was like, okay,  
2 that might mean that when one is revising this thing, one  
3 proceeds backward from there, as in you use that sort of  
4 framework to say, well, what are the types of services we  
5 see evolving, what are the types of services that we want  
6 to see evolve, and proceed backward from there that -- for  
7 example, say, variances are how to handle these types of  
8 inventory of beds, you kind of get to bed need last, and by  
9 the time you get to it, it may be formulae rather than  
10 formula. You can tell me if I'm wrong. Technically it is  
11 two formulae, because there's one for DD facilities; is  
12 that correct? You could have like a parallel structure,  
13 and by the time you were at talking about bed need, you  
14 would be basically satisfied that it matched to your  
15 services, and in spite of a instinct of someone, like me,  
16 who is pretty data driven to try to put everything in a  
17 formula and come up with something that probably made my  
18 head explode in addition to making Terry's head explode,  
19 that you could basically be satisfied with something that,  
20 you know, was not too simplistic because you felt driven  
21 that way, or too entire complex. You could have middle  
22 ground and feel like this is satisfactory for the type of  
23 service that we're trying to describe here. And at that  
24 point it clicked, and I've been thinking about it since.

1           The one negative that I can think of is it did  
2 come out of a part where we were reading through the Rules,  
3 section by section. I thought, all right, are there other  
4 parts in kind of our intent, you know, that would lead to  
5 not wanting to do it? But I'm still there. I still think  
6 in some ways you proceed kind of backwards from those  
7 sections, how we read them.

8           CHAIRMAN WAXMAN: So what you're saying is  
9 if, I'm hearing you correctly, define all of the potential  
10 variances and usage, which would then create the logic  
11 follows that, that would then create the amount of beds  
12 that you would need based upon all of the potential usages?

13           MR. WILL: Yeah. The framework that is in  
14 there now is the specialized framework, and there's a  
15 suggestion coming from Eli -- and I remember that when you  
16 made this that I wasn't the only one nodding my head when  
17 you were talking about it. That you could use that  
18 specialized framework not just to do disabilities but to do  
19 some of these other emerging fields where someone needs to  
20 be involved with that expertise, go backwards from that to,  
21 for example, variance, and then backwards from that to  
22 determining bed need and some of the other nuts and bolts.

23           CHAIRMAN WAXMAN: Is there anywhere that  
24 states a minimum size for a nursing home?

1 MR. SULLIVAN: Four beds in the licensure  
2 rules.

3 MR. DEES: Three or more residents personally  
4 needing nursing home care.

5 MR. SULLIVAN: Unrelated people.

6 MR. DEES: Literally a facility is -- yeah,  
7 unrelated to the owner by blood or marriage. It is  
8 basically, you have three individuals that you're providing  
9 nursing and/or personal care, you become a facility that  
10 requires a license. So I guess three is the --

11 MS. O'DEA EVANS: So, we really are squashing  
12 the whole idea of having group care facilities in this  
13 state with that rule.

14 MR. DEES: With three?

15 MS. O'DEA EVANS: No, because they would be  
16 under the licensure requirement.

17 MR. DEES: If they had three.

18 MS. O'DEA EVANS: So, it squashes -- in other  
19 states they have a pretty big market of small group homes  
20 that are a lot different, have a lot less, that are less  
21 regulated.

22 MR. DEES: They have a different licensure  
23 scheme for those facilities that are separate from the  
24 nursing home scheme. Florida has that and a few other

1 states have that. I'm familiar with that.

2 MS. O'DEA EVANS: Arizona.

3 CHAIRMAN WAXMAN: So, theoretically, if I say  
4 I'm going to open a specialized cardiac care unit, I could  
5 build a 20-bed licensed nursing home, but then I'm going to  
6 run up against what Chuck is talking about. The cost of  
7 doing it is going to be driven by the life safety codes and  
8 the food codes.

9 MR. PHILLIPPE: Nurses.

10 MR. DEES: Staff ratios.

11 MR. PICK: If you think about why it came to  
12 three or four, it came from people renting rooms and then  
13 they're taking their Social Security checks. There were no  
14 rules, no guidelines as to what they had to do for them.  
15 So they're unlicensed nursing homes.

16 MR. DEES: It's fairly common that we have  
17 facilities that have 7, 8, 10, 12 residents under one roof,  
18 and if they have twelve, they may have two individuals that  
19 are getting some level of personal care, maybe even some  
20 limited skilled nursing care, and the other 10 are  
21 independent living. They can operate freely without any of  
22 our involvement, because they don't meet the definition.  
23 It's when that one person's needs increase to the point  
24 where they need nursing care, they cross over the licensure

1 threshold for the Nursing Home Care Act.

2 CHAIRMAN WAXMAN: And you think there are  
3 buildings out there like that?

4 MR. DEES: Yes, there are. Yes, we have an  
5 ongoing program where we get complaints on those  
6 facilities, and we literally have to go out the best we can  
7 make an assessment of the needs of those residents and  
8 determine, have they crossed that threshold, and if they've  
9 crossed that threshold, then we need to pursue a case  
10 against them as an unlicensed nursing home.

11 CHAIRMAN WAXMAN: Wow. Do they intend to be  
12 in the rural areas?

13 MR. DEES: They're distributed. We probably  
14 have -- the larger ones are in the rural area, because they  
15 go unnoticed easier than they would in a more metropolitan  
16 area, where they may present a competition issue for other  
17 facilities. So it's not uncommon for us to receive the  
18 complaints from nearby facilities. But we do see them in  
19 rural areas, and they're very hometown-ish operations where  
20 everybody knows everybody that's there, and it's not -- I  
21 can tell you from the years that I've been doing this, it's  
22 not -- we don't commonly find very serious, serious quality  
23 of care problems at these facilities. We find serious  
24 building design issues and fire safety concerns because of

1 the manner. In many of these facilities, the quality of  
2 care is actually acceptable, because you tend to have a  
3 fairly high staffing ratio and that sort of thing. But it  
4 is a common issue that we deal with, the facilities that  
5 cross over that licensure threshold.

6 CHAIRMAN WAXMAN: I didn't realize that.

7 MS. JOHNSON: Are you talking about boarded  
8 care?

9 MR. DEES: I'm talking about private operated  
10 entities. They may describe themselves as boarded care or  
11 describe themselves whatever title they come up with.  
12 They're just unlicensed operations. And some were boarded  
13 care, and some of those boarded care were technically  
14 unlicensed nursing homes, and a lot of these facilities,  
15 when we do investigate and we determine that they're  
16 violating the law, we do tend to push them in the direction  
17 of assisted living, because that's the easiest set of  
18 standards to go under and, again, that's dependent upon the  
19 level of care provided, because there is currently a care  
20 ceiling in assisted living. If their needs exceed the  
21 residency requirements in assisted living, then their only  
22 alternative is to relocate those residents to an  
23 appropriate setting or shut down.

24 MS. JOHNSON: The Department on Aging several

1 years ago tried to license boarded care, and it just forced  
2 them to go underground. I think they had three that  
3 actually signed up to become licensed, and the rest of them  
4 went underground.

5 CHAIRMAN WAXMAN: You don't have any in your  
6 group, do you, Tim?

7 MR. PHILLIPPE: No. I know one of them in the  
8 towns. It's interesting that we talk about it because I  
9 didn't know how they operated.

10 MR. URSO: I remember one in Evergreen Park.

11 MR. FOLEY: They're all over the place.

12 MS. O'DEA EVANS: They're all over.

13 MR. DEES: We do probably a hundred  
14 investigations a year. It's a booming market out there.  
15 Unless we actually get a complaint, we don't actually go  
16 out looking for them. Sometimes when they have a half page  
17 ad in the newspapers, it's a little hard for us --

18 (Laughter)

19 MR. DEES: We have had some of them that have  
20 converted to assisted living and --

21 MR. FOLEY: Does it seem worse now that we are  
22 coming into the Baby Boomers?

23 MR. DEES: Yes, because the market is driven  
24 by individuals that do not want to have the 120 foot

1 corridors and the nurses stations. They want the more  
2 home-like environment, and that is a valid issue for us as  
3 a regulatory program, because our standards to some degree  
4 are still based on the old medical model. Even with  
5 assisted living, we don't truly have an aging-in-place  
6 concept, because the way the statute was written, there's a  
7 ceiling. You're in assisted living until you hit that  
8 ceiling, and then you've got to go to some other level.

9 CHAIRMAN WAXMAN: Let me -- I think we've all  
10 kind of reached an agreement that our next meeting will be  
11 more focused, more driven to get to our goals, our  
12 significant goal and objectives under it, and we're going  
13 to do teleconferencing. Are there -- besides the requests  
14 we've made of Staff to go through the transcripts and pull  
15 out our talking points, if you will, and get them to all of  
16 the Board members prior to the meeting, with instructions  
17 to be prepared to defend, add, subtract and discuss, that  
18 we are going to come out of that meeting with hopefully our  
19 written goals, is there any other information you would  
20 like Staff to prepare for that meeting or gather for that  
21 meeting, reasonably requested?

22 MR. PICK: I would suggest the statute be  
23 redistributed.

24 MR. PHILLIPPE: The purpose.

1 MR. SULLIVAN: Not the whole statute.

2 MR. PHILLIPPE: The purpose.

3 We talked about data. Is there easy access to  
4 something we could all have that would just be data on  
5 average census, some of the things we've been talking  
6 about, occupancy by region? You know, do we have already  
7 data available on the set-up beds versus licensed number  
8 total?

9 MS. AVERY: Would it be helpful if we just  
10 sent out a summary of the data that the Department does  
11 collect?

12 MR. PHILLIPPE: That's what I mean.

13 MS. AVERY: And then we'll see what is  
14 applicable.

15 CHAIRMAN WAXMAN: Mike, does that seem hard to  
16 get?

17 MR. CONSTANTINO: No.

18 MR. FOLEY: Wouldn't it be just as easy to  
19 send them a link to the profiles and they could just click  
20 on the profiles? You've got state-wide, you've got  
21 Planning Area, and you've got individual facilities.

22 MS. AVERY: We'll figure out the easiest.

23 CHAIRMAN WAXMAN: Mike, you look perplexed.  
24 Are you okay?

1 MR. SCAVOTTO: I'm fine.

2 CHAIRMAN WAXMAN: Just dreaming of your trip  
3 back to St. Louis?

4 Anything anybody else would like to add,  
5 subtract, delete, multiply to the agenda?

6 (Pause)

7 CHAIRMAN WAXMAN: I can't ask for a motion to  
8 adjourn, but I would like to thank everyone for  
9 participating.

10 MR. PICK: You can recess.

11 CHAIRMAN WAXMAN: Mr. Legal Counsel, what are  
12 we doing?

13 MR. URSO: Just inform everyone that there is  
14 another meeting.

15 MS. O'DEA EVANS: Can I ask the -- what the  
16 plan is, if there is a plan, to try to gain a quorum for  
17 our meeting?

18 CHAIRMAN WAXMAN: Well, hopefully, by making  
19 it teleconferencing, we'll solve that problem.

20 MS. O'DEA EVANS: Have those individuals who  
21 have not been attending -- is someone reaching out to them  
22 and addressing their interest in coming to the meetings?

23 CHAIRMAN WAXMAN: Yes, Staff is doing that.

24 MR. PHILLIPPE: Having the meetings planned

1 farther ahead -- I mean, there was some comments about the  
2 last meeting that I saw. I was one that couldn't come  
3 because people already had travel plans and stuff. I think  
4 with longer notice, we'll get more people, too.

5 MS. AVERY: I think at that point, it was an  
6 assumption that everybody had this list, and then we  
7 canceled a meeting and rescheduled, and it was kind of a  
8 short time frame, but we can go back to --

9 CHAIRMAN WAXMAN: The next three meeting  
10 dates are September 27th, November 29th, September 27th,  
11 November 29th.

12 MR. PHILLIPPE: We had those on our original  
13 calendar.

14 CHAIRMAN WAXMAN: We'll try to get everyone  
15 reconnected. We had some promises of people to be on the  
16 phone to get us a forum, so hopefully switching to video  
17 conferencing in two locations will help.

18 Meeting recessed.

19

20 END TIME: 1:50 P.M.

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CERTIFICATE OF REPORTER

I, KAREN K. KEIM, CRR, RPR, 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 writing; that I am neither counsel for, related to, nor employed by any of the parties to the action, 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 the action.



KAREN K. KEIM

CRR, RPR, CSR-IL, CCR-MO

<b>A</b>	46:9	after 31:13 54:14 66:6 79:22 90:2	84:6 93:3 99:22	appropriate 9:18 99:23
ability 23:15 74:10 105:6	Act 6:14 21:16 38:2 84:4,5 91:18 98:1	again 7:7 9:14,24 13:20 18:13 29:17 30:12,18 74:1 80:5 83:15 84:14 88:4,5 89:22 91:11 99:18	although 10:10,13 87:23	approval 3:4,5 60:2 60:3
able 7:18 27:17 46:14 47:19 68:5 70:19 75:9 86:17	action 6:17 74:11 105:8,12	aging 15:15 16:16,18 16:23 17:5,10 18:22 19:19 21:2 21:2,7 42:12,14 54:2 68:13	Altman 2:11	approve 5:8 60:18
about 6:15 8:11 10:6 11:15 12:10 18:9 22:24,24 23:17 27:16,18,22 28:2 29:23 36:6 37:9 41:22,23 42:9 45:8 46:2,12 47:17 49:6,9,22 49:23 50:7,10,16 50:18 51:8,23 53:10 54:5 55:10 55:14 56:8,14 57:16,24 60:12,20 61:3 65:13 67:5 68:16 70:2,8 71:3 72:23 74:19,22 75:14 76:3,6,11 76:18 78:8 81:20 81:20,21 82:2 83:16 84:6 85:4,8 86:7,14 90:15,16 92:7,17 94:13,24 95:17 97:6,11 99:7,9 100:8 102:3,6 104:1	actual 29:5 43:24 62:9	aged 16:19	Alzheimer's 29:7 55:9	approved 39:16 59:22
above-entitled 105:5	actually 19:18 27:15 28:13,18 30:8 45:3 59:1 63:23 74:22 75:17 76:10 79:16 90:24 99:2 100:3,15,15	aging-in-place 101:5	amendment 6:16	approximately 8:4
absence 21:23	ad 40:23 100:17	ago 25:5 34:22 37:24 48:16 64:6 69:1 93:17 100:1	amenities 59:15	April 3:5 7:24
absences 6:16	add 23:15 59:15 66:3 76:21 78:18 78:20,24 101:17 103:4	agree 20:11 25:4 26:1 53:22 58:23 63:11 66:21 81:5 81:8 85:14 86:13 91:16	among 18:10,21 43:17	arbitrary 51:12
absolute 48:2 83:21	adding 16:12 79:15	agencies 23:17	amount 68:4 95:11 52:16	area 8:5 17:16 26:5 29:24 31:17 33:15 33:18,19 34:12,23 37:9 39:17,19 40:1,13,15 42:20 42:23 50:7 51:8 51:13,16,21 52:22 54:21 55:4 57:21 57:21 58:3 71:11 74:5 78:22 83:19 98:14,16 102:21
Absolutely 28:9	addition 94:18	agenda 3:1,4 5:2,7 53:18 87:4 103:5	animals 26:10	areas 18:11 19:19 24:23 31:24 32:4 37:11 57:14,18 68:7,8 69:4 71:2 72:10,11 73:19,20 98:12,19
acceptable 99:2	additional 70:4 79:5	ages 17:19 28:19	annual 22:18 23:6,7 45:5 61:9 72:14	arguing 50:16
access 28:14 32:10 40:8 41:2 102:3	address 35:1 55:11 72:8	Aging 99:24	annually 25:17	Arizona 97:2
accommodating 16:21	addresses 12:8	aging-in-place 101:5	another 6:9 8:14,16 16:9 21:11 28:21 32:19 42:1 52:21 57:24 65:11 78:19 78:22 103:14	Arlington 44:3
accommodations 53:15	addressing 103:22	agrecing 9:17	answer 6:7 41:12 41:15,16	around 4:5 6:2 10:7 29:18 39:2 62:22 71:21 80:16,17,24
accomplish 69:8 81:4	adds 79:14	agreement 10:3 12:4 67:14 73:21 74:17 78:16 81:17 86:5 91:4 101:10	answering 73:16	arrangements 5:20
According 11:7 92:2	adjourn 103:8	ahead 15:8,10 73:24 104:1	anybody 17:5,22 28:10 33:1 47:7 56:20 103:4	art 31:12
accordingly 24:21	Adjournment 3:13	AIDS 16:8	anything 35:16 38:10 53:14 56:23 66:3 69:2 76:6 84:12 93:11 103:4	article 56:10,14
account 25:22 44:6 44:18 48:6	adjust 15:24 68:12	allow 55:5 64:6 77:23 78:3,23 79:2,18	anyway 9:19	aside 80:8,11
Accreditation 62:6	adjusted 31:22 67:21	allowed 39:22 86:10	anywhere 20:19 39:11 40:13 49:20 86:17 95:23	asked 7:2 35:21,23 68:22 90:13,16
accurate 43:3 46:5	adjustment 32:16	allows 24:19 62:5	apparent 22:21 38:6	asking 8:1 17:22 36:6 47:21 74:13 86:8
acknowledgement 5:21	adjustments 62:23 64:15	all-private 60:5	appearance 60:13	aspect 24:12
across 17:15,18 39:20 42:2 43:22	advances 73:2	all-private-room 59:14	Applause 66:15	aspects 63:8
	advise 70:8	almost 20:3 37:24 58:20	applicable 102:14	assessment 98:7
	Advisory 1:11,14	alone 69:3	applicant 29:9	Assistant 2:15 9:7
	advocate 24:15	along 25:23	application 31:23	assisted 20:7,9,16 54:8 62:14 69:12 99:17,20,21 100:20 101:5,7
	advocate/consumer 57:12	already 13:11,12 14:9 42:24 50:18 65:12 88:5 102:6 104:3	apply 31:15 64:9 65:2	assume 5:7 43:17
	advocating 82:2	alternative 36:10	appointees 6:4	assumption 17:20 18:13 19:10 25:21 25:23 104:6
	affect 45:13,18 48:20		appreciate 12:14 66:11	assumptions 26:3 56:4,6,7
	affected 46:19		approach 30:1 33:10 42:12 64:14 81:15	
	affecting 86:12		approaches 55:9	
	affects 46:4 86:11			
	afford 59:11			
	afield 93:7			

<p>astray 83:11,13  attendance 6:18  attending 103:21  attorney 105:10  attribute 20:15  attuned 87:24  authorities 64:4,12  64:13  authority 92:3,17  availability 45:1  47:21 48:13  available 9:4,10  32:4 41:7 43:5,12  48:18 49:12 50:11  50:18 51:20 71:12  90:12,13,14 102:7  Avenue 1:17 2:23  average 16:15 18:3  23:5,7 25:12  26:20,23 42:16,17  43:21 44:5 102:5  Avery 2:14 4:14,14  7:2 12:9 13:7 15:2  102:9,13,22 104:5  aware 18:12 32:24  89:4  away 36:8  awful 53:23 54:4  55:13  a.m 1:16 4:1</p> <hr/> <p style="text-align: center;"><b>B</b></p> <p>Baby 100:22  back 5:19,21,24  12:22 17:10 20:23  29:11 32:5 33:3  34:9 37:19 38:5  39:1,9,22 46:11  69:8 74:3 75:10  76:9,23 80:5,20  81:18,19 85:8  87:18 103:3 104:8  background 66:12  backgrounds 85:18  backward 94:3,6  backwards 95:6,20  95:21  bad 18:20 56:6  bagels 11:13,21  balance 63:3 64:11  Ballard 18:4 28:3  bank 70:22,23  86:10,17  banking 79:17  barely 12:11  base 30:24 37:13  based 9:8 16:17</p>	<p>21:18 22:3 25:23  27:19 31:1 37:14  38:21 55:6 56:4  56:10 83:22 93:24  95:12 101:4  basic 14:18,20  16:18 17:20 29:3  30:1,19 42:3,7,8  87:12  basically 79:17 86:7  94:14,19 96:8  basis 16:12 54:3  beats 10:10  beautiful 57:19  become 10:8 79:20  80:24 96:9 100:3  becomes 21:19  59:10  bed 14:10,13 15:13  15:19,24 16:3  22:21 25:22 26:24  27:19,23 28:2,5  36:9 38:22 40:1  42:3,20,20 43:3  43:12,24 44:20,21  45:1,12,13,17  46:1,7 47:23  48:24 51:24 52:1  52:2,6,8,21 53:24  54:21 55:6,13,17  61:4,18 64:20,22  65:14 69:15 71:14  72:14 77:20 79:17  79:24 80:2 83:5,5  83:13,16,19 84:1  84:10 94:8,13  95:22  beds 16:13,20 25:20  26:11,12 27:9  28:2 31:16,19,19  32:1,2,4 37:14,14  39:21 41:7 42:23  43:1,5,6,8,10,11  43:12,13,13,19,19  44:1,7,12,14,15  44:16 45:6,9,10  45:19,20,21,23  47:13,16,24 48:2  48:3,10,18,19  49:12,24 50:1,1,4  50:11,18,19,21  51:9,19 54:8,9,11  54:16 58:6 61:8  61:10,10,15 67:14  70:15,16,16,17,18  70:20 71:1,7,9,13  71:16,17,18 72:9</p>	<p>72:16,19,21 73:3  75:9 76:2,8,10,10  76:12,17,17,19,22  76:23 77:5,9,10  77:12,14,16,18,20  77:21 78:1,1,6,14  78:16,17,18,20,20  78:24 79:5,15,17  79:21 80:1 86:10  94:8 95:11 96:1  102:7  bed-need 14:19  15:12,17,20 38:20  60:24 61:13,18  62:2 65:2 68:2,13  68:20 72:7 76:15  84:9,20  before 41:5 51:5  61:17 71:23 76:11  begin 1:15 74:17  80:19  beginning 70:2  behind 22:19 30:21  31:7 32:22  being 11:10 20:8  24:7 29:12 44:7  66:21 69:16 70:15  73:13 83:18 85:3  85:7,16 88:21  belief 81:11  beliefs 90:22  believe 8:17 14:8  66:19 72:2 79:14  80:22 84:5 89:9  90:8,16  Belwood 10:13 12:2  bend 29:10  benefit 71:16 90:20  92:1  benefited 71:9,10  Berman 2:18 3:10  7:11,11 13:24  14:3,7 15:11 17:9  17:20 21:9,11  22:1,17 23:1,3  28:21 30:14 32:18  32:23 33:5 34:8  37:8,22 38:12  41:10,22 42:6  65:10,23 66:5,16  besides 101:13  best 28:16 98:6  105:6  better 11:5 57:10  68:9,19 76:21  84:11,13  between 22:19</p>	<p>43:17 74:4 80:6  80:20 89:8  beyond 68:14  Bibo 2:6 4:13 46:12  big 24:22 34:16,20  38:3,5 42:2 43:16  48:9 51:15 68:8  69:3 72:10 85:9  85:10 93:15 96:19  bigger 48:9 85:8  biggest 38:18 75:24  Bill 2:17 4:19  births 22:14  bit 11:5 16:13 20:10  63:2 85:5  black 63:4  blood 96:7  blue 42:2  board 1:2,14 6:11  7:4 15:24 27:20  32:8 39:18,21  54:20 57:2,6 60:2  70:4,6 71:5 73:2  74:18 75:2 77:7  78:18 82:16 85:20  101:16  boarded 99:7,10,12  99:13 100:1  boards 6:4 9:9 62:6  Board's 9:7 75:12  body 55:20  bold 30:6  bolts 95:22  Boomers 100:22  booming 100:14  borrowing 29:16  both 10:13 36:11  69:17 74:6,8,10  boundaries 34:13  34:13 37:19 39:8  boundary 38:19,21  39:17,20  brain 29:8  break 19:16 61:17  72:24  breaking 17:5  breaks 5:17  brief 14:14  briefly 42:24  bring 33:5,8 37:9  66:13 85:8 87:7  87:22,23 89:16,17  brings 6:14 67:2  broad 61:24 74:14  broader 33:18  broken 18:13  brought 54:4 65:16</p>	<p>67:23 88:8,9 90:9  budget 76:7  build 35:10 52:21  59:8,11,14 64:24  69:17 75:11 97:5  building 47:7 50:6  52:11,15 59:18,19  62:21,24 63:12  64:1,15 79:15  98:24  buildings 49:24  50:7,16 56:21  79:8 98:3  built-in 29:15  Bull's 87:6  Bureau 22:1  bureaucratic 51:12  business 5:3 75:7  92:19  buy 71:13 78:17,18  81:16  buyer 78:12,14  buying 71:6 78:14  bylaws 6:16</p> <hr/> <p style="text-align: center;"><b>C</b></p> <p>calculate 42:11  calculated 31:14  calculating 44:13  calculation 22:13  45:13,18,20,22  calculations 15:24  calendar 104:13  call 3:2,3 4:3,4 6:3,7  6:19 7:19  called 12:15 26:7  43:7 83:24  calling 10:10 12:12  12:14,18  call-in 7:18 8:3  came 30:20 39:14  39:22 97:11,12  camouflage 60:16  canceled 104:7  capability 69:13  capable 91:2  capacity 41:19  76:16,16 78:21  cardiac 24:18 97:4  care 1:11,14 9:17  18:15 23:15 24:13  24:16 25:6 27:1  27:14 28:15,22  29:6,7 31:11  33:17 34:5,18  36:19 37:11,14  40:7 42:3 46:21</p>
---	---	---	---	---

<p>47:19 50:3 55:15 61:9 62:17 67:11 67:22 75:8 77:24 78:18 88:22 92:18 92:24 93:1,4 96:4 96:9,12 97:4,19 97:20,24 98:1,23 99:2,8,10,13,13 99:19,19 100:1</p> <p>carry 5:3 case 31:16 43:20 63:9,9 98:9 catch 67:19 77:17 categories 16:18 25:1,2 category 16:16 23:15,24 Cathy 2:15 9:5,6 cause 105:5 causes 24:4 32:2 63:24 causing 23:7 caution 29:15 CCR-MO 105:17 ceiling 99:20 101:7 101:8 census 21:22,23 22:2,4,13 26:24 31:14 42:17,18 43:21 44:6,6,14 47:20 49:9 50:2 102:5 center 26:6 central 9:11 certain 27:21 28:19 32:1 50:1 86:6 92:10 certainly 10:10 34:9 69:24 73:23 Certificate 45:9 58:24 105:1 Certified 105:3 certify 105:5 cetera 60:18,18 Chair 10:1 87:1 90:17 91:8 Chairman 2:1 4:3,7 4:16,22 5:2 7:14 7:20 8:14,19 9:14 9:23 10:17,22 11:7,14,23 12:4 12:24 13:4,9,16 14:1,5 15:4,6 19:22 20:12 21:8 21:10 28:17 32:13 34:1 35:9 37:7 38:15 42:5 43:8</p>	<p>44:2 47:22 48:5 53:18 56:8 57:8 58:13 61:16 62:20 64:18 65:8,15,19 65:24 66:2,9,18 66:21 67:4 68:21 69:5 71:4,20 73:17 74:7,12 77:4 79:20,24 81:11 82:1,17,20 82:23 83:2,7,12 85:6,20 86:24 87:5,19 88:14 89:17 91:7,10,16 93:11 95:8,23 97:3 98:2,11 99:6 100:5 101:9 102:15,23 103:2,7 103:11,18,23 104:9,14 chance 67:19 change 23:19 37:23 38:6,9 50:2 63:1,8 63:14 79:2,8 changed 75:4 90:4 changes 16:11,16 21:2 34:11 changing 13:13 18:6 55:2 characteristics 15:21 charge 74:7,9 charges 32:8 91:18 Charles 2:19 61:7 72:23 84:18 chart 14:11,12 chartered 83:6,10 charts 66:12 check 9:5 checks 97:13 chew 50:8 Chicago 2:23 8:5 9:11 10:16,18 13:5 34:22,23 39:7 40:15 children 35:6 choice 13:1 47:2 51:7,10 57:17 59:5 60:16 choices 41:3 51:22 58:12 choose 41:7 50:22 72:21 chronic 21:5 chronically 52:17 chronicity 21:3 Chuck 38:15 69:10</p>	<p>75:21 86:14 97:6 chunks 38:3 circulate 7:4 89:3 circulation 76:12 76:19 cited 16:10 cities 40:16,24 citizens 32:9 city 28:14 34:24 Clair 39:16 Claire 2:18 7:11 13:22,22 14:24 15:10 21:8,21 22:16,23 28:20 30:12 32:13 34:1 37:7,18 41:5 46:8 54:19 65:8,22 66:2 88:2 Clare 3:9 clarification 74:3 clarify 74:23 75:1 clarifying 33:9 Clarke 2:15 9:6 58:20 clear 62:5 75:12,15 clearance 78:9 clearly 19:8 41:17 click 102:19 clicked 93:20 94:24 clinical 69:18 close 35:3,5 51:22 60:22 85:15 92:9 closeness 33:21 34:19 35:15 closer 41:1 51:4,11 code 63:6,24 64:3,6 64:9 codes 63:3,6,21 64:3 97:7,8 collaboration 80:23 collect 5:19 35:18 35:20 54:2,14 68:5 77:8,10,13 77:15,24 102:11 collected 23:16 collection 54:1 56:14 come 16:6 22:14 25:20,20 31:15,20 33:18 34:18,24 54:13 56:3 57:11 57:15,18 58:9 77:22 79:4 81:18 84:2 92:14 94:17 95:2 99:11 101:18 104:2 comes 54:18 69:9</p>	<p>84:12 88:15 comfortable 10:9 coming 20:23 54:1 58:4 80:9 86:3 95:15 100:22 103:22 comment 3:6 38:17 comments 73:13 88:20 89:13,15,16 89:17 104:1 Commission 6:23 62:6 commitment 63:16 committed 90:7 committee 5:14 6:9 7:24 8:7 11:20 23:14,18 53:7 60:21 70:2,8 82:18 84:5 87:20 91:6 committees 10:7 11:6 common 73:19 88:17 97:16 99:4 commonly 98:22 communicable 48:11 communities 54:10 community 33:19 51:15,18 community-based 54:6,7 compare 30:9 compared 50:3 Comparison 3:9 compete 76:5 competencies 27:17 competition 75:7 98:16 complaint 100:15 complaints 98:5,18 complete 5:17 completed 6:6 completing 5:23 complex 94:21 complexity 21:3 complicated 19:12 28:13,15 56:1 complication 24:3 comply 15:20 complying 67:12 component 21:11 28:21 63:13 components 14:18 29:24 42:8 comprehend 92:15 compromise 64:12</p>	<p>computed 15:19 84:1 CON 3:9 14:9,12,20 21:13 65:4 76:23 concentration 32:1 69:15 concept 31:5 52:1 60:19 62:24 64:19 67:10 69:14 70:1 70:5,10,20 71:6 78:10 84:19 91:11 101:6 concepts 61:21 73:8 90:7 concerns 73:14 98:24 concluded 16:2 condition 48:11 conditions 21:4,5 27:17 54:5 conducted 40:12 conference 8:3,4 10:10 88:24 conferecing 8:20 8:21,24 9:2,10 10:4,8,12 11:19 89:2 104:17 conflict 82:3 confounding 24:12 consensus 8:2,7 19:23 consider 16:4,10 26:9 29:14 43:2 51:5 58:2 consideration 14:22 15:13 23:12 28:24 29:5 51:14 61:14 65:4 considerations 15:23 considered 15:16 21:17 23:4 34:10 considering 51:10 considers 92:23 consistent 14:19 83:5 consistently 51:17 51:19 Constantino 2:16 3:8 4:5,24 7:9,23 8:13,17 10:19,21 10:24 14:23 15:5 15:10 22:5,8,12 62:11 65:21 68:1 68:24 72:13 77:8 77:15,19 78:22 79:9,18,22 102:17</p>
--	--	--	--	--

<p>constituents 36:15  construction 59:12  59:13  consultants 75:18  consumer 51:7 52:7  54:6 57:17 58:11  58:18.23 59:1,4,8  59:11,15 60:21  61:4,19 62:13  64:19,23 65:1  69:9,12 71:11,24  71:24 80:15,17  81:1 84:19  consumers 71:10  75:13  consumer-driven  84:3  consumer-oriented  70:3  contain 37:12  continue 58:16  78:23 92:12  continues 52:22  continuum 92:24  contract 69:1  contractor 86:3  controversy 41:23  71:6  convalescence 24:8  26:8  conversation 54:23  88:11 89:24  convert 70:23,24  converted 31:14  100:20  Cook 18:19,20  cookies 11:12,21  cool 13:3 25:8  coordinates 68:13  copies 15:4  copy 15:3,5  correct 5:4 6:15  12:13 44:17 45:14  60:10 67:3 86:23  86:24 94:12  correctly 95:9  correlated 21:7  corridor 60:14  corridors 101:1  cost 51:1 59:2,10,12  59:24 72:1 97:6  Council 10:15 11:2  13:5  counsel 2:13 103:11  105:7,10  count 43:2 47:23  51:9</p>	<p>counties 17:18,19  18:10,13,21 33:16  33:17 34:4  counting 45:2,3  country 29:18 46:9  county 17:16 18:18  18:19,20,20 19:4  19:8,9,10 20:9,14  20:17,19 26:8  33:24 39:16 52:6  couple 30:24 42:24  83:1  course 54:11 61:23  70:7  court 39:2,15 105:3  Courtney 2:14 4:14  61:23  courts 39:22  cover 5:11  covered 66:4,5  crazy 54:12  create 7:3 8:20 82:8  82:9 95:10,11  created 71:6  criteria 57:4,4  criticism 69:3  cross 97:24 99:5  crossed 98:8,9  crossing 74:22  CRR 2:22 105:3,17  CRR-MO 2:22  crummy 50:22  crunch 76:7  crux 51:6  CSR-IL 2:22  105:17  culture 63:1,8,14  curious 34:4 79:12  current 23:13 29:10  29:22 33:10 68:13  75:5,6 79:11  80:21 81:2 82:12  86:12,14 93:3  currently 21:15  65:14 99:19  customer 40:22  customers 71:15</p> <hr/> <p style="text-align: center;"><b>D</b></p> <p>daily 31:14 42:17  42:17 43:21 44:5  Dart 2:17 4:19,19  data 18:1,5 19:1,7  21:22,23 23:16  25:9,10,17,24  26:2 31:13 33:7  35:18,20 36:7</p>	<p>54:1,2,14,15  55:22 56:4,13  61:7,11 68:5  72:12 77:4,8,10  78:1 83:22 90:13  90:14 94:16 102:3  102:4,7,10  date 11:19 13:11,12  63:9  dates 104:10  Dave 2:3 4:20  day 40:18 64:8  days 24:14 25:6,12  31:10 41:2 42:12  42:13,15,16 89:8  89:9,10,13  DD 94:11  dead 44:12,14,20,21  76:10,12 77:5,18  78:1  deal 64:4 72:10  74:15 83:17 99:4  dealing 93:7  dealt 31:21 93:23  death 24:3 25:7  deaths 22:14  debate 70:14  debating 93:14  decades 62:22  decide 93:16  decides 57:6 78:4  deciding 53:23  decision 54:20  55:14 58:17 64:23  75:13 76:13 88:6  decisions 56:12  Dederer 2:11 7:17  10:20,20 12:10,16  12:19,23 13:3  17:4,14,22 18:8  18:17 19:1,5,21  20:11 23:14 24:5  24:22 25:8 26:1  26:20 35:4,7,12  35:19,22 36:1,6  36:12,22 41:5,13  41:18,21 43:4,11  43:15 44:23 45:8  45:16 50:12,20  51:1 52:4,14 56:6  56:17,23 65:5  84:17 85:22 87:13  88:1,23 89:15,24  90:10 91:22  Dees 2:9 4:21,21  62:21 64:2 77:6  96:3,6,14,17,22</p>	<p>97:10,16 98:4,13  99:9 100:13,19,23  defend 101:17  define 70:3 80:7  95:9  defined 69:17  definitely 48:12  66:16  definition 97:22  definitions 77:20  degree 57:2 101:3  Delaware 15:23  delete 103:5  deliberately 70:1  demand 31:1 67:11  67:23  demand-based 31:2  31:4  demonstrate 15:21  department 70:14  99:24 102:10  departments 64:9  dependent 99:18  depending 21:2  31:9  depends 33:19  40:18 47:23 58:5  58:5  describe 94:23  99:10,11  design 62:21,24  63:13 64:15 81:15  98:24  designated 29:9  designed 80:16  86:13  desires 65:1  determination  14:10,13 26:22  29:4 42:3  determine 67:13  76:14 77:21 80:12  82:6 98:8 99:15  determining 27:19  65:14 95:22  develop 63:16 92:22  developed 20:9 66:7  developing 63:13  67:13  development 19:15  19:18,20 29:24  33:7,15 37:10  40:6 59:5 60:5  74:4,6 80:6 93:2  devise 76:15 81:15  devotes 90:1  dialogue 92:9</p>	<p>dices 90:18  dictate 53:12 60:15  die 24:9,10  dietary 63:24  difference 43:7,16  50:12 64:14  differences 19:17  different 13:19,20  17:7,8,10 19:17  19:18,19 20:16,17  26:3 27:11,19  28:7 33:20 36:14  36:18 40:16 57:4  57:18 68:6 74:22  81:6,7 82:12  85:17,18 86:4,6  91:5 92:19 96:20  96:22  difficult 27:3 85:2  85:16 86:2 92:14  93:7  difficulty 23:24  dimension 86:18,19  dinner 87:3  directed 6:3 41:13  direction 94:1  99:16  directions 92:10  directly 21:7 48:14  disabilities 95:18  disagree 73:23  disagreeing 73:16  Discharge 51:18  discharges 51:20  discontinuation  78:15  discuss 84:19  101:17  discussed 8:8 42:24  65:12 85:15  discussing 70:12  discussion 3:9 9:23  58:21 60:24 66:6  66:22 73:12 74:3  80:11 81:22 83:4  85:13 86:21 88:2  89:6,20 92:5  93:22  discussions 73:12  88:17 89:12  dismantling 82:13  distance 34:15  distracted 27:24  distributed 98:13  distribution 32:7  divide 42:15,18  dividing 43:21</p>
---	--	--	--	---

doctor 16:7	47:17 60:12,20	enough 11:20 17:7	14:21 16:22 54:12	24:19 25:6,13
document 14:10,15	66:22 67:5 83:16	56:5 89:14	84:3 98:20,20	29:6 31:24 39:19
14:16,24 15:7	early 48:6 60:4	entertain 44:23	104:6	39:21 41:24 44:11
29:20 32:19 42:1	easier 10:1 81:9	entire 92:5 94:21	everybody's 82:6	45:5 48:23 49:2,3
documents 14:8	98:15	entities 99:10	89:12	49:5 50:2 51:19
38:7	easiest 88:14 99:17	entitled 14:12	everyone 5:4,12	52:17,19 55:15
Dodgen 2:12 7:13	102:22	entrenched 33:6	10:7 14:3 29:22	63:2,15,19 69:16
7:13	easy 27:13 89:21	entry 33:13	42:4 67:8 81:16	78:24 79:3 86:7
doing 6:24 7:6 8:12	92:15 102:3,18	envelopes 5:22	103:8,13 104:14	92:20 94:11 96:12
13:17,21 16:4	Eden's 11:3	environment 64:7	everyone's 8:10	96:23 97:17 98:6
19:15 26:7 27:15	educating 90:21	101:2	everything 39:5	98:17,18,23 99:1
27:16 52:24 53:1	educational 66:23	envision 85:6	84:18 85:14 90:4	99:4,14 102:21
60:6 63:8 72:14	effect 54:1	equal 31:9 39:11	94:16	facility 16:9,22
79:10 91:2 97:7	effective 29:13 51:1	equations 57:19	evolve 94:6	18:15 22:21 23:6
98:21 103:12,23	80:18	erroneous 44:19	evolving 94:5	25:19 27:5,5
done 8:8 13:16 17:5	effectively 27:18	establish 69:21	example 18:20 20:8	33:21 44:24 47:19
17:22 19:17 20:13	47:5	91:21 92:17	23:4 29:4 94:7	47:24 50:21,22
32:11 39:3 42:8	efficiency 46:16	established 37:19	95:21	52:22 58:9 59:14
56:9,10 65:8	49:19 59:2 72:1	39:9 64:5	Examples 16:3	60:5,9,12 63:17
66:11,13 67:20	80:16	establishes 63:15	exceed 99:20	64:7,24 69:12,20
68:17 78:11 81:9	efficient 10:5 49:21	establishment 93:2	except 85:16,23	70:20 71:12 73:1
door 40:20	effort 13:18 30:10	esteemed 44:2	exceptions 23:4	78:7,19,19 96:6,9
doubt 88:3	68:8 69:4 72:6	estimate 16:3,3 22:5	64:5	fact 5:21 18:5 24:13
down 5:2 17:6	efforts 63:1	22:15	exchange 86:19	41:23 43:22 48:6
18:13 25:20 33:13	either 13:1 33:20	estimated 16:17	excited 70:2	53:12 59:16 60:2
39:7,16 46:8	49:3 57:4	et 60:17,18	excuse 73:15	63:18 70:9 76:1,8
47:20 54:18 57:21	elaborate 71:11	ethic 5:12	executive 14:16	83:20,20
81:23 99:23	element 81:2 83:9	ethics 3:7 5:10,16	exemptions 64:10	factor 20:8 27:10
downstate 39:8	elements 80:9 81:18	5:17 6:5,14,23	exist 81:2	44:9 46:16 49:19
41:3	81:20 84:3 88:17	ethnic 69:19	existence 82:22	54:10,22 55:14
downtown 10:13	Eli 2:2 4:17 17:24	evaluating 31:10	existing 31:19 36:16	65:2 69:20
11:9,24	71:4 82:5 93:24	Evans 2:5 4:18,18	42:23 43:1 74:4	factored 45:19
downward 16:1	95:15	6:9,21 7:1 11:10	74:11 75:24 77:1	factors 15:16 33:23
dramatic 39:8	eligible 49:6	12:3 13:11,14	78:17,20 80:6,10	34:12 53:24 54:6
drawing 51:21	eliminate 72:21	36:14 37:4 40:19	expand 64:24 71:14	55:1
dream 82:8,8	eliminated 72:16	47:9 48:13 51:3	expect 41:1	fair 89:10
dreaming 103:2	Eli's 25:13,19	52:9,12,23 73:4,8	expensive 59:14	fairly 97:16 99:3
drive 38:20,23	elsewhere 88:9	73:11 80:4 82:4	64:1	fairness 88:19
39:14,23 40:2,3,7	emergency 26:6	82:15 85:10,24	experience 9:9 18:4	familiar 56:20 97:1
40:8 54:12	emerging 95:19	87:3,10,14 96:11	66:24 68:17 81:15	families 35:10 51:7
driven 71:24 72:1	emphasis 24:13	96:15,18 97:2	expertise 54:13	51:11,22
80:22 81:1 94:16	employed 105:8,10	100:12 103:15,20	95:20	family 35:2,6,7,16
94:20 97:7 100:23	employee 105:9	even 6:4 11:24	explain 39:13 57:5	37:1 67:11
101:11	empty 39:21 44:1	20:12,21,23 32:4	explanation 44:24	family's 36:15
dropped 12:18	48:18 58:6 70:16	33:19 38:20 39:20	explode 94:18,18	far 64:16 93:6
dropping 20:14	70:16 76:1,8	40:12 44:14 47:3	expressed 80:18	farther 21:19 104:1
drug 58:8	encourage 69:23	47:16 48:18 53:9	extent 53:14 84:21	fashion 62:5
drug-related 20:22	92:12	55:17 71:13 84:6	extra 59:15	fastest-growing
due 5:24	encouragement	97:19 101:4	extreme 20:1	18:2
duplication 32:2	77:2	ever 48:9 54:24	e-mailed 12:21 15:2	fax 89:21
during 5:17	end 20:12 38:9	Evergreen 100:10		fed 56:11
	43:23 44:16 48:10	every 6:22 8:4 19:3	<b>F</b>	federal 24:14 63:21
<b>E</b>	81:17 82:9 93:19	20:17 41:19 43:23	faces 9:15	feel 16:12 58:3,15
each 16:16,18 29:15	93:22 104:20	52:1,2,6,8 72:15	Facilitates 87:11	94:22
39:10 40:1 42:12	ends 36:15	77:8 86:8	facilitator 87:9,10	feeling 16:19
81:18 85:7	enjoy 8:12	everybody 6:1 9:6	87:13,15 88:12	felt 22:20 37:12
earlier 7:16 46:8,12	enjoyed 30:21	11:18 12:10 14:14	facilities 1:2,13 23:5	94:20

female 48:7	78:5 80:2 83:8,15	free-standing 63:19	giving 33:10 70:4	good 14:1,11 15:8
few 16:5,15 34:24	86:22 87:1 100:11	frequent 8:9	76:2,4	30:21,23 33:3
49:12 52:18 96:24	100:21 102:18	Friday 5:24	glad 5:19 6:7 30:14	34:8 54:4 71:19
fewer 18:19 45:11	folks 60:22	friends 33:22	glasses 67:2	80:4 83:15 86:16
field 19:16	follow 63:15 65:10	from 14:9 15:16	glean 89:11	92:11 93:15
fields 95:19	following 16:23	16:13 19:8 21:13	go 4:5 5:2 15:8,10	gotten 92:8
figure 52:19 64:20	92:23	22:1,15,18 23:3	20:18 24:4,10	Government 78:4
81:10 102:22	follows 95:11	25:5 33:18 34:24	29:11 30:3 33:23	Governor's 38:8
figures 32:22	food 63:6 64:3,6,9	37:15 38:22 39:14	34:9,22,23 35:2,4	grassroots 89:5
file 78:19	97:8	40:13,13,22 41:1	35:5 40:14 41:5	great 28:3,4 54:23
filed 93:21	fooled 83:4	42:22 46:9 47:1	45:21 50:23 52:18	greatest 10:14
fill 35:12 61:9	foot 60:13,17	47:22 51:21 52:7	53:2,10,23 57:3	green 70:9
filled 26:12	100:24	53:8 57:11 58:4	60:1 62:5 64:9,16	greenhouse 60:19
final 29:4 31:18	forced 100:1	60:8 61:19,23	67:16 68:19 69:8	Greg 2:3 4:20 93:11
42:22	forget 57:11 76:17	67:7,8,22 68:17	70:6,10 79:17	gross 31:16,17
finalized 8:6	forgot 4:8 56:10	72:20 76:20,20	82:7 87:21 88:11	42:20
financial 76:21	form 5:19,21 89:18	77:21 78:9 82:10	89:10 95:20 98:6	ground 94:22
financially 105:11	formal 57:3	86:4 88:16,21	98:15 99:18 100:2	group 3:11 15:15
find 19:16,18,24	forming 30:2	89:11 90:21 91:14	100:15 101:8,14	19:24 21:2,3
29:11 38:11 39:4	formula 14:21	92:1,20 94:3,6	104:8	30:19 42:12,14
58:2 64:11 81:14	15:12,17,20 16:2	95:6,15,20,21	goal 80:8,18,20	53:3,9,20 56:11
86:21 98:22,23	25:18 27:10 28:24	96:23 97:12 98:18	81:12,14,24 82:3	58:15 67:22 73:5
finding 73:18	29:2,3,23 30:20	98:21	91:5,6 101:12	85:7,8,9,10 87:12
findings 15:20	31:4,5,22 33:14	fulfill 75:5	goals 75:15,16 81:9	88:21 90:3 96:12
fine 7:5 36:23 74:1	42:3,7 46:4 54:11	full 47:7 71:13	81:10,12,20 87:12	96:19 100:6
103:1	54:24 55:24 56:3	fun 66:23	89:6 91:4 101:11	groupings 17:6,17
finish 24:11	61:14 64:20,22	funded 47:4	101:19	18:6,10,22 69:18
finishing 93:17	65:2 67:13,24	further 23:11 66:8	God 83:21	groups 16:23 17:1,6
fire 63:3,24 64:3,13	68:2 71:24 72:7	70:7 105:9	goes 16:19 19:24	17:11 19:19 33:17
98:24	83:14 84:20,23	future 31:6 33:8	46:11 47:11 76:9	growth 39:8
first 14:21 15:12,17	86:11,12,15 94:10	55:15,21 62:18	79:22	guard 67:19
48:24 69:11 83:1	94:17		going 9:20 10:2,4	guess 7:22 61:16
81:20 92:3	formulae 94:9,11		12:11,24 13:1	64:18 66:9 67:15
fit 80:19 81:19	formulas 14:19 31:1		14:14 17:8,10	69:14 71:22 72:1
fits 92:24	31:3 33:11 57:15	gain 103:16	19:23 20:7,10,23	73:19,20 74:16
five 39:21 60:8	61:18	game 55:6,18 83:17	25:7,20,22 26:12	96:10
flexibility 47:16	formulate 89:5	87:6	26:18 32:19 38:17	guidance 62:1
63:10	formulating 74:17	games 55:3	39:5 46:6 49:20	92:22
flexible 16:14	forth 74:4 80:6,20	gather 101:20	50:8 51:8 53:21	guide 88:11
flip 74:3	81:19	gave 30:18	54:24 55:4,8,9	guidelines 63:21
floating 62:16,19	forum 104:16	general 8:2,6 19:22	56:4,5,15 57:11	92:18 97:14
floor 1:3 14:5 67:16	forward 5:5	21:16 37:11 46:20	59:21 60:1,8,9	guys 11:21 47:17
Florida 96:24	found 17:10 20:1	generally 27:2	61:6,13 63:12	
fluctuates 43:19	29:1	generation 35:11	65:17 67:5,6 68:3	
fluctuating 43:20	foundation 61:7	gentleman 33:8	68:3,3,4,18 69:19	
focus 21:1 24:20	four 14:8 21:14	geographic 18:10	72:6,6,8,19 73:9	
74:5 80:14 84:8	37:24 69:1 76:13	gets 19:11	76:23 78:8,17	
focused 59:1 101:11	96:1 97:12	getting 78:8 92:9	79:24 80:5,20	
Foley 2:19 5:9 7:16	frame 104:8	97:19	81:19 83:11,12,18	
37:21 38:17 39:12	framework 53:5	give 11:12 14:14	85:3 87:24,24	
39:15 40:11 44:11	94:4 95:13,14,18	29:17 45:9 55:17	88:23 89:2,5,19	
44:17 45:15,23	Frank 2:13 3:7 4:15	62:1 76:22 77:2	90:8 91:23 92:10	
46:7 48:19 53:11	5:10 7:15 9:8	given 17:11,16 39:1	93:15,16 94:1	
55:3,12,16 56:2	61:17 62:12 74:14	50:21 55:1 59:12	97:4,5,7 101:12	
59:7,19,23 60:9	free 11:8,22,23	67:20	101:18	
60:11 61:12 62:13	58:15	gives 17:7,7 22:21	gone 44:24 45:10	
62:18 63:18 75:22	freely 97:21	62:1 72:20 92:21	65:12	

## G

## H

<p><b>happens</b> 71:12  <b>happy</b> 70:23 87:22  91:10  <b>hard</b> 41:24 87:8  100:17 102:15  <b>harm</b> 75:8  <b>hash</b> 70:5  <b>having</b> 18:5 22:20  27:17 47:5 51:4  59:24 64:4 73:11  73:12,13 85:14  86:18 88:12 96:12  103:24  <b>head</b> 88:18 94:18  94:18 95:16  <b>header</b> 30:6  <b>heading</b> 53:16  <b>health</b> 1:2,13 10:12  22:12 30:6 40:7  41:1 64:8,12 68:7  68:8  <b>healthcare</b> 10:15  11:3 13:5 41:3  <b>healthy</b> 81:21  <b>hear</b> 12:23 14:3  35:8 36:22 72:2  84:17  <b>heard</b> 14:4 47:8  66:9,10,10 67:8  71:20,22  <b>hearing</b> 64:18 67:7  67:22 95:9  <b>hearings</b> 58:1  <b>heavily</b> 17:18  <b>Heights</b> 44:3  <b>held</b> 1:15 13:1  58:21  <b>hell</b> 83:18  <b>Hello</b> 10:19  <b>help</b> 32:6 70:21  74:23 76:5 78:13  93:8 104:17  <b>helpful</b> 33:9 90:20  102:9  <b>helps</b> 32:4 87:11  <b>her</b> 7:18 12:22 30:7  88:4  <b>hesitant</b> 87:20  <b>hesitate</b> 6:3,6  <b>Hey</b> 92:9  <b>HFS</b> 49:5  <b>HFSRB</b> 2:13,14,16  2:17,18  <b>hideously</b> 85:2  <b>high</b> 27:4 32:1 49:4  49:9 51:5 58:7,7  99:3</p>	<p><b>higher</b> 17:19 19:24  20:12 21:2 26:16  26:24 43:24 45:3  49:10  <b>highest</b> 26:21  <b>highlights</b> 14:18  <b>highly-developed</b>  20:15  <b>highway</b> 34:14  <b>him</b> 74:13,13  <b>historic</b> 54:2  <b>historical</b> 21:18  55:22 83:22  <b>history</b> 32:21 33:2,6  59:2  <b>hit</b> 101:7  <b>hoc</b> 40:23  <b>hold</b> 8:1,3,8 14:23  48:19  <b>holding</b> 78:6  <b>Holiday</b> 1:16  <b>home</b> 16:18,20 20:2  20:23 24:10 25:7  26:5 28:19 34:20  35:1,12 37:3  41:19 59:8 62:15  86:3 90:11 95:24  96:4,24 97:5 98:1  98:10  <b>homes</b> 18:3 24:24  41:6 43:17 54:8  92:19 93:1 96:19  97:15 99:14  <b>hometown-ish</b>  98:19  <b>home-like</b> 63:2 64:7  101:2  <b>honest</b> 91:7  <b>honestly</b> 62:14  <b>hope</b> 14:14 85:3  <b>hopefully</b> 33:7,12  66:10,24 101:18  103:18 104:16  <b>hoping</b> 7:19 33:5,11  <b>hospital</b> 24:4,12,15  25:7 26:6,9 51:16  51:18  <b>hospitals</b> 72:14,15  77:11  <b>host</b> 24:2  <b>hour</b> 1:16  <b>hours</b> 82:2  <b>HSA</b> 39:17 43:23  <b>HSA's</b> 37:19 39:10  <b>HUD</b> 78:9  <b>huge</b> 51:8  <b>hundred</b> 20:2,3,4,4</p>	<p>27:5,7 46:21  71:18 100:13  <b>hurry</b> 57:10</p> <hr/> <p style="text-align: center;"><b>I</b></p> <p><b>ICF/DD</b> 64:4  <b>idea</b> 21:20 22:19  23:19 31:7 93:24  96:12  <b>ideas</b> 29:14,18 30:4  30:21 70:6 73:8  85:8  <b>identified</b> 53:1  <b>identify</b> 10:22 19:8  45:6 55:7 63:23  72:9,19 76:11  77:12  <b>IHC's</b> 12:5 13:2  <b>IL</b> 2:23  <b>Illinois</b> 1:1,4,13,17  10:15,15 11:3  13:4 15:18 17:1  21:15 22:24 23:16  31:22 36:3 42:19  43:16 56:17 60:18  80:2 105:4  <b>imagine</b> 27:7  <b>IME's</b> 49:7  <b>immediate</b> 57:13  <b>impact</b> 23:10 48:12  48:17  <b>impacted</b> 20:7  <b>impacts</b> 48:13  <b>implement</b> 74:10  89:2  <b>important</b> 43:1  55:14 57:6 77:3  84:8  <b>improvement</b> 29:19  <b>incentives</b> 76:3,4  <b>incident</b> 48:16  <b>incident-based</b> 31:3  <b>include</b> 16:4 29:1  86:20,20  <b>includes</b> 29:7 31:1  35:21,22  <b>including</b> 5:14  84:19  <b>incorporate</b> 58:17  61:19 62:3,24  63:10 67:10,21  68:15 74:15 83:14  <b>incorporation</b>  28:22  <b>increase</b> 97:23  <b>increasing</b> 25:11  70:14,17,18</p>	<p><b>increasingly</b> 10:8  54:22  <b>incredible</b> 38:11  39:4  <b>independent</b> 97:21  <b>Indiana</b> 56:18,20,21  <b>indicated</b> 7:17  <b>indicating</b> 54:17  <b>indicative</b> 18:6  <b>individual</b> 50:2  73:12,13 102:21  <b>individuals</b> 7:9 96:8  97:18 100:24  103:20  <b>industry</b> 94:1  <b>inevitably</b> 34:23  54:14,18  <b>influenced</b> 34:12  <b>influencers</b> 36:18  <b>inform</b> 103:13  <b>information</b> 21:18  24:19 52:20 56:11  56:15 89:3,11  90:18,20 101:19  <b>initial</b> 93:21  <b>initially</b> 93:14  <b>injuries</b> 20:22  <b>injury</b> 29:8  <b>Inn</b> 1:16  <b>innovation</b> 59:5  69:24 70:3,5  <b>innovative</b> 55:9  70:9,11  <b>inpatient</b> 31:10  <b>instance</b> 15:23  59:11 60:19 84:4  <b>instances</b> 24:1  <b>instead</b> 49:13 76:15  <b>instinct</b> 94:15  <b>institution</b> 78:9  <b>institutional</b> 60:13  <b>instructions</b> 101:16  <b>insult</b> 22:8,11  <b>insurance</b> 41:2  <b>insurers</b> 40:8  <b>intend</b> 98:11  <b>intended</b> 23:20,23  <b>intensity</b> 21:6  <b>intent</b> 75:23 95:4  <b>intention</b> 24:6  <b>interest</b> 75:3 103:22  <b>interested</b> 28:4  88:10 105:11  <b>interesting</b> 29:10  56:8,13 85:13  100:8  <b>interests</b> 62:4 75:20</p>	<p><b>intermediate</b> 47:19  <b>interrupt</b> 41:14  <b>interrupting</b> 82:10  82:11  <b>introduce</b> 84:2 87:2  <b>inventory</b> 72:12  73:3 77:22 94:8  <b>invest</b> 75:9  <b>investigate</b> 99:15  <b>investigations</b>  100:14  <b>involved</b> 95:20  <b>involvement</b> 97:22  <b>in-person</b> 9:4  <b>Island</b> 20:18  <b>isolating</b> 48:11  <b>isolation</b> 48:8,15  <b>issue</b> 26:14 27:11  34:16,20 48:9  59:10 70:21 72:8  77:17 78:5 98:16  99:4 101:2  <b>issues</b> 27:19 28:14  29:10 53:8 55:11  63:22,24 64:3,8  74:21 75:1,20  80:9 88:7 98:24  <b>item</b> 53:18</p> <hr/> <p style="text-align: center;"><b>J</b></p> <p><b>Jason</b> 2:20 7:12  <b>JCAR</b> 62:5  <b>Jefferson</b> 1:3  <b>job</b> 30:13  <b>Johnson</b> 2:8 4:11,11  20:20 44:20 57:10  58:11 99:7,24  <b>join</b> 61:23  <b>Joint</b> 62:6  <b>Joliet</b> 1:17  <b>judgments</b> 54:15  <b>July</b> 11:16,18 13:1  89:16  <b>June</b> 5:24  <b>just</b> 4:5 5:5 7:2,7  9:14 10:6 12:21  13:13 14:14 15:17  17:6 19:14 20:14  23:17 24:1 26:9  26:23 29:2,14,16  29:17 30:3,7,9,19  31:3 34:4 35:21  35:23 36:7,22  37:1,8 38:17 39:4  41:14 42:6,8  46:14,24 47:7  53:6 54:19 56:9</p>
---	---	--	--	--

56:13 58:1,22 62:4 65:10 68:9 68:17,19 69:18 71:18 79:12 83:14 83:17,21 84:22 86:6,18,21 87:18 88:10,12 90:22 91:23 92:4,16 93:13,17 95:18 99:12 100:1 102:4 102:9,18,19 103:2 103:13 justifies 7:1 justify 17:8	41:1,14,15 43:6 43:16,20 46:9,24 49:11 51:23 53:6 53:9 54:22 57:3 57:12 60:1 64:20 65:1,5 66:24 68:11,14,17,19 72:11,12,16 74:24 76:7,15,20 79:9 84:15 85:11,12 86:15,22 88:4 90:12,12,15,19 91:3 94:20 95:4 100:7,9 102:6 knows 98:20	legislation 53:11 legislative 39:5 lending 78:9 lengthy 68:16 less 21:19 23:5 24:15 25:6,7,12 64:7 96:20,20 lesser 79:1,5 let 5:20,24 24:11 46:24 91:12 92:4 101:9 letter 5:12 let's 8:23 25:21 65:7 65:17,19 76:17 80:8,12 86:20 level 24:14 97:19 99:19 101:8 liberty 93:21 license 62:16,19 72:22 76:16 96:10 100:1 licensed 43:8,10,11 43:13,14,19 44:15 45:23,24 46:1 62:15 63:19 77:9 78:21 79:20 97:5 100:3 102:7 licensing 79:22 licensure 59:9 60:15,22 61:24 63:14 96:1,16,22 97:24 99:5 life 97:7 like 4:3 8:1,21 9:15 9:15,24 10:11 12:3 13:22 16:4,5 17:12,13 19:16 20:14 22:13 25:13 27:6,8 31:11 34:6 35:14,14,15,15,16 36:24 37:21 38:18 42:1 48:16 49:8 53:2,3,4,24 54:16 56:23 57:13 60:16 61:8,11,17 63:6 64:3 65:15 69:13 69:14 70:4,19 74:20 75:4 76:24 82:8,20 83:23 84:3 85:14,24 86:16 87:13 93:14 93:20 94:1,12,15 94:22 98:3 101:20 103:4,8 likely 16:2 18:15 26:7 limitations 91:19	limited 68:4 97:20 limiting 51:7 limits 59:5 64:16 75:3 line 30:5 38:22 39:18,20 86:23 92:19 lines 38:19 link 102:19 list 58:8 88:6 104:6 listen 54:23 75:4 listening 92:5 listing 56:19 literally 96:6 98:6 litigation 2:22 little 11:4 16:13 48:21,22 64:1 85:4 91:1 92:21 100:17 live 22:14 57:20,21 57:21 58:9 living 19:23 20:7,9 20:16 54:8,9 62:14,15 69:12 97:21 99:17,20,21 100:20 101:5,7 local 64:3,8,12,13 71:11 location 9:4,12 13:13,14 39:17 52:10 locations 104:17 logic 95:10 long 9:1 47:18 55:15 60:14 68:4 92:14 longer 16:21 19:23 86:23 104:4 long-term 1:11,14 14:10,13 18:15 23:21,22 25:6 26:4 29:6 33:16 34:18,19 37:11 42:3 45:5 46:21 61:9 62:17 74:19 77:23 90:17 92:18 93:3 look 9:15 14:11 17:2 21:12 22:17 23:11 24:14 31:3 31:7 32:19 37:16 38:4,19,22 39:18 39:22,23 40:6,6,8 42:4 43:2 52:16 55:22 56:13 63:5 63:13 64:2 65:13 68:2,12 69:1 74:8	74:9 75:23 76:14 76:16 78:23 80:19 84:7,24 88:17 102:23 looked 28:22 30:22 37:23 38:5 40:11 41:2 46:16 looking 15:13 17:16 39:5 40:2,12 42:8 46:9 50:5,17 52:15,24 55:22 63:9 68:9 69:10 72:23,24 73:20 74:6,6 75:17 76:16 84:6 100:16 looks 13:22 52:11 79:23 lost 12:15,17 lot 20:21 30:16,16 33:20 34:5 36:17 38:3 39:21 40:11 43:24 44:11 46:15 48:1 54:4 55:13 60:16 62:2,7,8 67:7 76:1,8 79:3 92:9,10 96:20,20 99:14 lots 84:23 Louis 103:3 love 39:9 loving 54:23 low 76:2 lower 20:10 23:8 26:17 27:1 45:2 lowest 26:24 Lowitzki 2:3 4:20 lox 11:12,21 lunch 58:19 61:16 65:7,17
<b>K</b>	<b>L</b>			
<b>K</b> 2:21 105:3,16 <b>Karen</b> 2:21 105:3 105:16 <b>keep</b> 47:20,24 51:2 70:22 80:20 <b>keeping</b> 61:8 <b>keeps</b> 46:7 <b>Keim</b> 2:21 105:3,16 <b>kept</b> 59:2 <b>key</b> 31:13 69:19 88:16 <b>kids</b> 35:3 <b>kill</b> 75:7 <b>kind</b> 11:20 14:20 19:10 25:2 27:7 30:15 31:2,4 34:11,15,17 35:13 53:7 55:14 56:17 57:18 59:5 63:9 63:16 67:23 69:21 70:10 74:3,12,20 81:23 82:8 86:19 88:17 89:11,18 91:1 93:15 94:8 95:4,6 101:10 104:7 <b>kinds</b> 28:18 33:9 52:13 <b>kitchen</b> 63:24 <b>knew</b> 71:22 <b>know</b> 5:17,20,24 6:9,20,23 8:7,9 12:10 13:19 15:18 16:5 17:3,21 19:7 19:14 20:2,18 23:10,16,20,21,23 24:5,7 26:5,21 28:4 31:11,19 32:23 33:1 34:15 35:13 37:16 38:21 39:2 40:23,23	<b>lady</b> 57:8 <b>laid</b> 32:20 <b>Lake</b> 20:14,19 <b>language</b> 85:19 86:1 <b>large</b> 33:16 51:21 <b>larger</b> 20:23 88:21 98:14 <b>Larkin</b> 1:17 <b>last</b> 14:9,17 25:11 37:22 66:3 67:21 76:13 88:19 90:16 94:8 104:2 <b>late</b> 39:1 <b>later</b> 5:8 <b>latitude</b> 62:3,7,12 <b>Laughter</b> 9:22 22:10 33:4 40:21 44:4 46:13 66:20 68:23 100:18 <b>Laurinda</b> 2:12 5:1 7:13 <b>law</b> 59:2 99:16 <b>laws</b> 58:24 <b>lead</b> 91:12 95:4 <b>leads</b> 71:19 <b>learn</b> 90:14 <b>learned</b> 48:5 <b>learning</b> 66:24 <b>least</b> 39:23 55:18 60:17 69:11 75:1 <b>leave</b> 37:2 58:11 <b>leaving</b> 25:5,12 39:7 <b>led</b> 85:11 90:16 <b>leeway</b> 48:1 70:4 <b>left</b> 69:3 <b>legal</b> 2:13 61:18,20 103:11 <b>legally</b> 74:13			
				<b>M</b>
				<b>made</b> 15:24 56:12 63:16 73:13 76:14 94:17 95:16 101:14 <b>major</b> 20:8 59:7 65:3 <b>make</b> 7:18 9:1 10:4 13:18 19:10,11 20:5 23:18 25:23 26:2,19,21 27:12 32:4 50:4,13 51:20 54:15 58:15 63:1 73:4 75:6,9 75:13 79:2 88:6 89:3,12,15 98:7 <b>makes</b> 10:1 84:16

<p>making 8:22 54:20 55:14 58:12 86:15 94:18 103:18 male 48:7 mal-distribution 32:3 manage 27:8,17 47:5 managed 40:7 maneuver 48:3 manner 80:18 99:1 many 13:19,19 20:3 31:9,19 34:17 41:23 44:7 45:6 46:23 47:2 49:5 49:12 50:21 53:13 54:11,16 56:18 64:6 65:20 70:15 76:9 99:1 maps 39:5 market 19:15 40:4 40:5,13 54:5 67:23 80:21,22 81:1 96:19 100:14 100:23 marketing 34:21 57:19 marketplace 53:16 55:2 59:6 76:5 marriage 96:7 matched 94:14 material 5:12 6:3,5 materials 5:15 mathematical 47:22 83:14 84:23 matrix 13:18 matter 51:6 84:20 90:8 93:7 matters 50:5 maximizing 80:16 maximum 31:23 32:15 46:16 may 1:15 4:4 21:4,5 21:8 26:10 39:20 47:6 48:15 59:16 70:21 72:20 76:18 91:4 94:9 97:18 98:16 99:10 maybe 9:5 28:15 29:18 31:9 49:1 52:18,19 58:1 66:6,10 68:12,13 69:17 74:23 75:10 75:11,15 76:14 82:6 84:3,24 97:19 MDS 25:5</p>	<p>mean 9:16 10:12 17:17 22:8 25:18 33:3 36:9 37:1 38:10,12 47:24 48:2 54:15 61:8 61:19 67:19 69:3 70:4 73:23 76:19 77:24 83:4 87:13 89:8 93:6 94:2 102:12 104:1 meaningless 25:1 means 19:9 55:1 90:1 meant 29:3 69:2 measure 46:5 measures 84:6 meat 62:1 mechanism 45:4 76:11 77:22 Medicaid 16:11 41:8 47:3,10 48:20 49:1,3 76:2 Medicaid-certified 63:20 medical 24:17 101:4 medically 28:16 Medicare 47:2,5,8 47:13,20,21 meet 54:18 57:20,22 71:14 80:17 81:10 97:22 meeting 1:12,13 3:12 4:3 6:23 8:14 8:15,16 9:2,2,5 10:1,5 11:15,16 12:24 13:12 14:9 33:8,12 61:4 89:7 89:9,13,16,18 101:10,16,18,20 101:21 103:14,17 104:2,7,9,18 meetings 8:2,3,9,23 67:9 83:1 88:20 93:17 103:22,24 meld 61:21 64:19 65:5 member 12:17 members 8:1,7 35:6 35:7 37:2 85:17 101:16 memory 38:16 91:18 mention 58:22 menus 24:20 mesh 67:6 met 57:4,5 method 57:5</p>	<p>methodology 38:21 62:2 68:14,20 76:15 84:9 metropolitan 98:15 Michael 2:1,7,16 10:6 13:17 62:10 65:20 91:22,24 Michigan 2:23 middle 54:18 94:21 Midwest 2:22 might 9:8 29:10,19 36:12 37:16 47:15 51:11,15 57:11 58:1,2 66:7 76:20 93:20 94:2 Mike 2:6 3:8 4:8,9 4:13,16,22 7:2,8 7:19,21 28:6 60:23 61:12,22 67:18 72:4,13 78:13 82:17 102:15,23 Mike's 86:7 89:21 mind 69:9 88:15 minimum 31:23 32:15 37:12 95:24 minute 14:23 41:14 minutes 3:5 5:8 6:19 40:13,14,19 41:2,4 mired 53:7 missing 73:5 Missouri 105:4 model 60:5 62:15 92:20 101:4 modernization 93:1 modernize 77:2 money 70:24 75:9 80:3 Montana 29:4 month 14:17 months 8:4 60:7 more 8:8 10:4 16:1 16:14,19,20 17:11 18:15,18 21:3,17 23:12 24:16,19 25:19 26:7,11,12 27:8 28:4 33:23 34:5 41:22 43:19 45:10 48:1,16 49:12 50:19 53:3 53:4,13,14 54:7 54:22 56:11 63:2 64:6 66:16 69:15 75:16 81:1 82:15 83:14 85:5 90:7 91:1 92:21 93:2</p>	<p>96:3 98:15 101:1 101:11,11 104:4 morning 68:16 71:21 mortgage 78:5,7 most 15:11 16:23 22:4 23:6 24:12 38:24 47:1,4 48:23 54:3 75:12 80:18 84:11 85:12 85:13 86:5 91:21 Mostly 49:6 Mother 71:5 74:18 motion 103:7 motivation 46:23 motorcycle 20:22 move 8:23 10:5 21:8 28:20 29:21 37:7 42:1 moved 35:11 40:5 moving 5:5 33:14 39:7 40:4 43:20 73:24 much 8:11,19,20 9:14 17:7,17 26:11 33:6 34:7 37:19 38:18 42:7 43:19,22 45:2,3 48:9 49:20 61:17 62:1 75:7 85:1 90:19 91:11 multiple 21:4 34:3 41:2 81:12 multiply 103:5 must 83:21 myself 30:22</p>	<p>36:9 38:22 40:1 42:20,20 43:3,24 43:24 44:2 45:9 46:7 48:24 50:7 50:18 51:9,16 52:1 53:24 54:6 54:16,21 55:6,13 55:16,17 57:17 58:13,17,24 60:23 61:4,18 64:1 65:14 66:7 69:15 70:7 71:14,23 73:6,9 78:15 80:7 81:3,14,22 82:7 83:5,5,14,17,19 84:1,8,10,18,19 84:20,24 85:11 86:14 87:10,14 88:7 90:24 91:15 91:17 94:8,13 95:12,22 97:24 98:9 needed 31:16,18 67:13 needing 16:6 50:3 88:11 96:4 needs 6:5 29:5 39:3 43:12 55:8 57:13 57:22 60:21 61:4 62:23 64:15,23,23 71:15 80:2,15,17 95:19 97:23 98:7 99:20 needs/wants 64:19 negative 95:1 neighborhood 33:19 neither 105:7 Nenya 2:8 4:11 neutral 91:8,23,24 never 10:14 53:1 56:5 71:21,22 92:8 new 9:6 16:4 19:15 34:14 45:9,10 51:5,10 52:21 59:5 60:5 63:11 64:24 74:4,6 75:11,11 80:6 newspaper 9:17 newspapers 100:17 next 3:11,12 8:15 9:2 11:16,18 12:24 29:21 33:12 40:19 53:18,19,21 65:17 66:6 69:7 69:10,20 71:3</p>
--	--	---	---	--

<p>74:18 88:24 89:7 89:9,13 91:1 101:10 104:9 <b>nice</b> 52:14,15 90:15 <b>Nine</b> 5:1 <b>nodding</b> 95:16 <b>None</b> 29:1 <b>normal</b> 32:6 <b>north</b> 12:3 34:23 <b>Northwest</b> 51:18 <b>notice</b> 104:4 <b>noticed</b> 6:10 33:16 34:11 <b>November</b> 104:10 104:11 <b>number</b> 5:6 7:18 11:5 20:24 27:4 30:24 31:9,16,17 31:18,20 42:16,21 42:23 43:1,5,6,18 48:2,17 50:4,11 50:18 55:3 70:17 90:11,13 102:7 <b>numbers</b> 21:24 40:6 43:3,17 55:6,18 61:15 83:17 89:4 <b>nurses</b> 97:9 101:1 <b>nurse's</b> 60:14 <b>nursing</b> 16:9,17,20 18:3 20:2 24:24 26:5 28:19 31:2 35:12 37:3,14 41:6,19 43:17 44:24 52:17 54:8 59:8 62:15 69:13 78:16 86:3 90:11 92:19,24 93:1 95:24 96:4,9,24 97:5,15,20,24 98:1,10 99:14 <b>nuts</b> 95:22</p> <hr/> <p style="text-align: center;"><b>O</b></p> <p><b>objectives</b> 101:12 <b>objects</b> 5:4 <b>obsolete</b> 45:13,18 45:19 46:1 61:10 61:15 72:19 <b>obvious</b> 70:10 <b>obviously</b> 27:4 39:1 39:12 47:14 54:2 75:16 78:8 <b>occasional</b> 16:11 <b>occasions</b> 90:13 <b>occupancies</b> 54:3 <b>occupancy</b> 22:18,20 22:24 23:1,6,8,10</p>	<p>26:14,17,20,21,24 27:1 31:15 38:23 41:23 42:18 44:18 45:3 46:3,15 48:20 49:1,4 51:5 53:4 68:12 102:6 <b>occur</b> 31:6 64:13 <b>occurred</b> 31:5 <b>occurring</b> 46:5 <b>occurs</b> 21:3 <b>odd</b> 47:6 <b>Odea</b> 2:5 <b>off</b> 11:3 58:21 67:19 <b>offer</b> 10:15 11:6,21 15:22 58:5 70:8 <b>offered</b> 28:23 33:21 90:23 91:2 <b>offering</b> 11:21 34:17 <b>offers</b> 23:7 <b>office</b> 9:7 11:2 40:12 89:22,22 <b>offices</b> 11:9 12:5 13:2 <b>official</b> 5:5 <b>officially</b> 65:19 <b>oh</b> 8:13 12:19 23:2 37:23 51:9 <b>okay</b> 5:5,7,7 6:21 9:13 12:7 13:16 18:8 19:5 22:16 23:2 24:22,22 29:20 32:21 35:22 36:1 41:21 42:6 42:21 46:18 49:10 50:2 55:18 65:15 66:9 67:15 78:1 84:17 86:20 94:1 102:24 <b>old</b> 18:22,22 60:9 101:4 <b>older</b> 17:12 <b>ombudsman</b> 20:20 58:4 <b>once</b> 8:4 9:9 30:12 31:17 42:10 50:1 70:5 81:17 88:15 <b>one</b> 12:15,17 14:8 14:17 15:2,15 19:10,24 23:6 27:19 30:8,24 31:1 32:7,11 37:8 38:7 42:2,4 50:5,9 50:17 52:23 54:1 54:22 58:14 59:7 60:6 71:6,20 73:24 74:20 75:17</p>	<p>83:9 86:18 87:15 89:19,19 92:21 94:2,2,11 95:1,16 97:17,23 100:7,10 104:2 <b>onerous</b> 24:24 <b>ones</b> 27:6 98:14 <b>one's</b> 20:4 <b>ongoing</b> 98:5 <b>only</b> 5:9 21:5 39:19 47:10 50:5 51:3 55:21 58:14 60:7 74:6 78:7 83:20 84:14,14 95:16 99:21 <b>open</b> 63:12 67:15 89:20 92:22 97:4 <b>opened</b> 60:6 <b>opening</b> 69:18 <b>operate</b> 47:5 97:21 <b>operated</b> 23:5 99:9 100:9 <b>operational</b> 76:17 80:9 <b>operations</b> 98:19 99:12 <b>operators</b> 71:9 <b>opinion</b> 62:8 68:1 70:8 90:22 <b>opportunity</b> 55:7 55:10 71:5 89:1,6 <b>opposed</b> 9:16 11:9 30:16 <b>option</b> 89:2 <b>order</b> 3:2 4:4 39:2 55:23 76:5 <b>Organizations</b> 35:18 <b>oriented</b> 80:24 81:1 <b>original</b> 11:17 104:12 <b>other</b> 5:20 7:14 8:10 9:9 10:7 11:6 15:16,21,22 16:10 16:14 18:10,20 19:11 20:17 23:13 23:17 24:2,8 26:13 27:20 29:16 33:22 34:12 36:8 37:9 40:1 43:13 46:15 48:8 52:2 53:9 55:7 59:15 63:5,18 64:17 68:15 75:10 78:19 86:4 91:11,24 92:20,24 95:3,19 95:22 96:18,24</p>	<p>97:20 98:16 101:8 101:19 <b>others</b> 29:8 70:10 90:7 <b>otherwise</b> 63:21 105:11 <b>ought</b> 61:14 72:11 85:4 <b>ourself</b> 82:10 <b>ourselves</b> 82:10,11 84:8 <b>out</b> 5:11,15,20 7:24 10:12 11:12 12:18 13:18 14:16,21 15:1 19:16 21:19 23:21,22 26:9 27:13 29:11 31:8 32:20 34:23 35:13 40:9 41:3 44:12 47:6 52:19 53:5 58:2,11 60:24 61:9 64:20 68:19 70:5,20 76:12,19 78:13 79:23 81:10 84:11 85:4 88:15 89:11 90:12,21 91:23 93:13 95:2 98:3,6 100:14,16 101:15,18 102:10 102:22 103:21 <b>outcome</b> 27:2 105:11 <b>outline</b> 14:13 34:12 88:8 <b>outlined</b> 24:2 <b>outstanding</b> 30:10 30:12 <b>out-voted</b> 8:21 <b>ovation</b> 66:19 <b>over</b> 15:14 16:3,24 17:2 18:4,14 30:3 47:13,16 65:12 67:21 72:23 97:24 99:5 100:11,12 <b>overall</b> 64:23 <b>overarching</b> 81:13 81:23 <b>overreaching</b> 82:7 <b>overrule</b> 57:6 <b>overseeing</b> 36:16,17 <b>overview</b> 29:17 <b>owe</b> 11:5 <b>own</b> 34:19 36:17 81:14 86:3 <b>owner</b> 96:7 <b>owners</b> 90:11 <b>O'Dea</b> 4:18,18 6:9</p>	<p>6:21 7:1 11:10 12:3 13:11,14 36:14 37:4 40:19 47:9 48:13 51:3 52:9,12,23 73:4,8 73:11 80:4 82:4 82:15 85:10,24 87:3,10,14 96:11 96:15,18 97:2 100:12 103:15,20</p> <hr/> <p style="text-align: center;"><b>P</b></p> <p><b>packet</b> 5:12 <b>page</b> 10:3 85:16,23 100:16 <b>pages</b> 30:9,19 65:10 <b>palaces</b> 45:21 <b>paper</b> 43:6 <b>parallel</b> 94:12 <b>parameters</b> 63:15 70:6 <b>Park</b> 60:6,16 100:10 <b>parking</b> 11:8,11,22 11:23,24 <b>part</b> 5:13 18:17 34:11 36:8 57:7 60:3 63:12 64:23 65:3 68:9 73:5 77:23 86:5 90:10 93:19 95:2 <b>partial</b> 78:15 <b>participate</b> 89:7 <b>participating</b> 103:9 <b>participation</b> 3:6 5:18 <b>particular</b> 20:13 54:21 <b>parties</b> 105:8,10 <b>parts</b> 95:4 <b>pass</b> 14:24 <b>past</b> 31:6,8,10 49:5 <b>Pat</b> 80:8 82:1 85:6 <b>patch</b> 36:24 <b>patient</b> 23:15 24:4 31:11 42:11,13,15 44:22 48:11 <b>patients</b> 16:5,8,18 24:9 33:18 51:21 <b>Patricia</b> 2:5 4:18 <b>patterns</b> 18:7 34:14 <b>pause</b> 4:23 12:6 65:17 103:6 <b>pay</b> 79:24 <b>peak</b> 26:23 <b>people</b> 5:8,13,14 6:1 7:4 10:2 13:20</p>
--	---	---	--	--

<p>18:12,14,18,19 19:23,24 25:5,11 26:7 28:15,18 29:5 31:19 34:5,6 34:18,22,24 36:9 39:7 40:24 41:14 47:1,2,6,20 50:3 50:22 51:4 53:9 54:7 56:11 57:20 58:2 59:18,19 60:11 67:7,11 75:11,18 81:6 86:4 88:22 90:6 96:5 97:12 104:3 104:4,15 <b>people's</b> 9:24 <b>per</b> 21:15 31:16 37:14 <b>perceived</b> 29:12 <b>percent</b> 16:2 18:3,4 22:19,19 23:3,3,5 23:8 25:13,15,16 25:19 27:5,7 42:19 43:22,23 44:9,19 46:3,10 46:10,15,15,21,23 47:11,12,14,15 48:1,2,15,16,17 48:24 49:1,3,4,18 50:7 52:22 78:20 78:24 79:1,1,4,5,5 85:14 86:8 <b>percentage</b> 16:17 17:15 44:14 68:12 <b>percentages</b> 19:19 32:16 40:6 <b>perfect</b> 84:11 <b>perhaps</b> 63:13 <b>period</b> 15:14 86:9 <b>permit</b> 78:15,20 <b>perplexed</b> 102:23 <b>person</b> 5:9 16:19 36:16 <b>personal</b> 9:15 18:4 34:20 96:9 97:19 <b>personally</b> 8:20 17:21 38:6 68:11 96:3 <b>person's</b> 97:23 <b>perspective</b> 40:22 52:7 57:12 58:4 61:18,24 62:20 86:4 <b>perspectives</b> 81:6 <b>pertinent</b> 91:21 92:4 <b>Peterson</b> 11:3 13:5</p>	<p><b>Phillippe</b> 2:4 4:10 4:10 19:14 26:18 27:3,15 28:10,13 30:7 34:3 35:2,5 36:5,20 37:6 40:3 40:16,22 46:2,18 46:24 47:18 48:4 49:8,17,22 50:10 50:15,24 51:24 52:5,10,13 56:21 57:1 58:10,22 59:17,21 63:22 74:19 77:13,17 78:4 79:7,12,16 81:5 87:7,11,17 90:23 91:9,14,19 93:10 97:9 100:7 101:24 102:2,12 103:24 104:12 <b>phone</b> 5:1 6:1 7:7 7:10 10:19 12:11 13:23 65:20,21 85:1 88:4 104:16 <b>pick</b> 2:2 4:17,17 9:8 11:24 12:14,17,21 13:10,13 17:24 21:1,21 22:3,7,11 22:16 23:24 24:11 25:15 26:16,23 27:12,16,24 28:6 28:9 30:11 35:17 35:20,24 36:21,23 40:18 41:12,16 43:10 44:3,5,10 44:13,18,21 45:4 45:14 46:17,19 48:8,14,22 60:4 60:10,23 61:3 62:17 65:7 67:3 71:8 74:2,9 79:14 80:5 81:13 83:9 88:19 89:1 91:17 97:11 101:22 103:10 <b>picked</b> 65:11 <b>picture</b> 93:15 <b>piece</b> 29:22 53:11 58:17,18 <b>piecemeal</b> 53:8 <b>pinpoint</b> 30:15 <b>place</b> 15:19 23:13 28:3 29:18,19 34:14 38:1,10 51:10,11 55:16,17 65:14 72:20 83:24 93:15 100:11 <b>placement</b> 51:17</p>	<p><b>places</b> 35:5 36:9 47:1,6,9 49:9,12 75:11 <b>placing</b> 37:2 <b>plan</b> 74:11 103:16 103:16 <b>planned</b> 103:24 <b>Planner</b> 51:18 <b>planning</b> 5:23 29:24 31:17,24 33:15,18 34:12 37:9,10 39:17,19 40:1 42:11,14,20,23 51:13 52:21 55:19 55:20,20 60:2 68:8 69:4 72:6,10 72:11,18 73:2 77:6 78:18 82:16 83:20,22 84:9,15 87:15 102:21 <b>plans</b> 57:20 104:3 <b>play</b> 8:9 80:9 <b>please</b> 5:20,24 6:2 28:20 37:7 45:16 58:15 <b>pleasure</b> 11:19 <b>plus</b> 17:7,12,17 18:19 20:2 <b>point</b> 6:14,17 13:15 15:17 22:21 26:10 26:18 27:12 28:6 29:3 31:21 34:8 36:15 37:9 39:11 42:1 46:4 47:23 54:19,24 61:20 65:16 66:6 67:2 72:6 73:18 74:2 80:4,7 81:17,22 86:7 89:4 92:7,8 94:24 97:23 104:5 <b>pointed</b> 60:24 <b>pointless</b> 90:5 <b>points</b> 15:15 54:5 56:19 82:7 86:16 88:6,6,16 92:4 101:15 <b>policies</b> 16:12 29:24 33:7,15 <b>policy</b> 30:18 33:11 89:6 <b>population</b> 16:16 18:2,6 20:24 21:12,24 24:18,23 25:1 27:20 31:12 37:12,13,15 39:6 39:10 42:10 50:1 69:17</p>	<p><b>populations</b> 17:12 24:20 <b>population-based</b> 15:12 <b>portion</b> 68:10,20 <b>position</b> 76:21 <b>Positive</b> 14:4 <b>possibility</b> 50:20 <b>possible</b> 8:23 78:10 78:10 87:7 91:8 <b>post-surgical</b> 24:17 <b>potential</b> 95:9,12 <b>pound</b> 11:15 <b>predetermined</b> 13:15 <b>preface</b> 92:4 <b>prefer</b> 34:6 36:12 89:24 <b>preference</b> 54:5 <b>premature</b> 24:3 <b>prepare</b> 101:20 <b>prepared</b> 38:7 89:13 101:17 <b>preparing</b> 79:16 <b>presence</b> 20:7,16 <b>present</b> 2:1,10,13 5:13 98:16 <b>presentation</b> 65:9 66:3 <b>presents</b> 38:24 <b>presume</b> 39:11 <b>pretty</b> 14:19 37:19 39:7 42:7 43:16 43:22 49:4 74:14 94:16 96:19 <b>primary</b> 40:13 <b>print</b> 15:6 <b>prior</b> 101:16 <b>privacy</b> 52:12 53:4 <b>private</b> 45:1,10 53:13,15 59:12,22 61:10 70:24 93:2 99:9 <b>private-pay</b> 45:20 <b>probably</b> 6:15 9:3 9:18 13:19 29:2 35:3 37:23 40:10 40:23 49:1 58:14 66:19 68:9,11 75:12 87:15 94:17 98:13 100:13 <b>problem</b> 22:7 38:18 38:24 45:15 49:16 59:23 60:3 74:1 75:24 76:24 90:10 103:19 <b>problematic</b> 86:21</p>	<p><b>problems</b> 59:7 98:23 <b>proceed</b> 15:9 93:21 94:6 95:6 <b>proceedings</b> 105:5 <b>proceeds</b> 94:3 <b>process</b> 5:4 8:22 12:17 36:16,17 52:24 53:6 63:12 64:24 65:4 67:10 68:4,16 73:9,14 75:20 76:23 81:3 82:5,13,16 85:7,9 85:11,16 86:18 87:11 92:23 <b>processes</b> 57:19 <b>productive</b> 8:23 67:1 71:3 <b>professor</b> 68:24 <b>professors</b> 38:7 <b>profiles</b> 102:19,20 <b>program</b> 98:5 101:3 <b>progressed</b> 39:24 <b>project</b> 15:22 21:19 22:15 31:8 39:16 51:6 54:21 55:23 59:23 <b>projected</b> 16:16 21:13 42:10,11,13 42:15,19 43:24 <b>projecting</b> 31:7 <b>projection</b> 16:1 22:3 <b>projections</b> 21:14 21:15,17 31:13 <b>projects</b> 15:19 32:8 63:11 <b>promises</b> 104:15 <b>promoting</b> 80:16 <b>property</b> 75:10 <b>proposals</b> 80:22 <b>propose</b> 65:15 78:2 <b>protect</b> 86:14 <b>provide</b> 21:15 53:13 53:14 75:8 <b>provided</b> 74:5 99:19 <b>provider</b> 72:20,24 78:17 <b>providers</b> 74:11 75:6,6,11 76:1,3,4 76:18 77:1 78:3 80:6 86:14 93:1 <b>provider's</b> 71:16 <b>provides</b> 24:19 <b>providing</b> 96:8 <b>proxy</b> 4:20</p>
---	--	---	--	---

<p>psychotropic 58:8  public 3:6 5:9 10:12  22:12 30:6 57:24  pull 86:17 88:16  89:11 91:12  101:14  pulled 88:21  pulmonary 24:18  pure 47:22  purpose 55:19  75:23 80:12,13,14  101:24 102:2  purposely 49:5  purposes 19:17  72:19 73:2  pursue 98:9  push 91:1 92:8  99:16  put 25:18 30:8  37:10,11 48:7  51:10 56:15 64:1  65:1 67:1,5,16  74:13 80:23 81:7  82:18 85:21 88:1  89:21 92:15 94:16  putting 90:1,2  P.M 104:20</p> <hr/> <p style="text-align: center;"><b>Q</b></p> <p>quads 45:11  qualified 27:21  quality 10:14 11:4  67:10,22 75:8  98:22 99:1  question 8:24 11:18  17:4 25:17 32:12  32:13 34:1 37:18  41:6 44:10 46:2  57:24 68:22 69:8  73:16 82:14,20  questionnaire 45:6  questions 6:2,6,8  7:14 33:10 35:21  35:23 65:11  quickly 30:3  quiet 92:15  quirks 20:17  quit 82:9,11  quite 16:5 20:10  24:13 60:6 62:14  quorum 4:22 5:6  7:21 8:22 12:12  12:20 88:20  103:16  quote 55:18</p> <hr/> <p style="text-align: center;"><b>R</b></p>	<p>radius 51:12,13  raises 30:3  raising 61:1  random 88:12  rank 56:20  rare 20:1  rate 20:6,10,14,18  22:18,20 23:8,10  26:16 31:14,15  37:14 41:23 42:10  76:2  rates 23:1 31:23  38:23 48:20 51:5  rather 17:6 18:15  52:20 63:3,4 85:1  85:1 88:11 94:9  rating 56:18 57:3  ratio 99:3  ratios 97:10  reach 49:2  reached 101:10  reaching 41:24  103:21  reactions 9:24  10:11  read 30:9 56:13  91:20 95:7  reading 30:16,21  56:9 95:2  readjust 69:4  ready 58:20  real 26:10 43:1 45:1  76:10 89:5  reality 55:4 83:18  83:18  realize 99:6  really 6:11 8:10  9:16 14:18 23:23  24:22 29:16 38:24  39:3 40:4,14 43:5  43:11 47:6 51:6  53:1 54:4 55:1,4  55:13 58:3 61:3  66:11,14 68:16  70:2,9,15,15  78:12 80:12,23  81:6 85:15 86:16  88:22 90:15,19  96:11  reason 16:7 21:22  30:18 79:10 82:19  82:21 83:6,11  reasonable 32:10  reasonably 101:21  reasons 24:3 75:10  recall 7:23  receive 14:7 98:17</p>	<p>received 6:17 14:9  14:17  recent 21:18 22:4  23:6 31:8  recess 65:18 103:10  recessed 104:18  recipient 36:18  recognize 62:23  64:14  recognizes 63:14  92:19  recognizing 23:9  recommendation  23:18  reconcile 60:23  61:5  reconnected 104:15  reconsidered 34:10  reconvene 65:19  record 6:21 58:21  recycling 70:19  redefine 68:7  redesign 80:24  redid 37:20  redistributed  101:23  reduced 105:7  referral 16:7  refine 72:7  refresh 91:17  regardless 57:14  region 33:24 49:23  49:24 52:5,6  102:6  regional 51:8,16  regions 34:3  regulate 27:21  regulated 92:20  96:21  regulations 63:14  64:5  regulatory 101:3  rehab 16:5,6 24:17  24:17 29:7  reimbursed 11:11  reimbursement  16:11  related 63:6 105:7  relates 74:11  relative 105:9  relatively 60:5  relatives 33:22 37:2  relevant 48:14  reliable 21:17,19  religious 69:19  relocate 99:22  relook 38:1</p>	<p>remember 20:1  26:6 38:9 95:15  100:10  remind 58:13  reminder 30:23  remove 77:21  renting 97:12  reorient 80:17  repeat 14:8 22:23  45:16 85:22  repeating 58:16  report 19:3 61:9,10  72:14 90:17  Reported 2:21  Reporter 105:1,4  reporting 24:21  reports 40:24  represents 58:15  reputation 33:20  requested 101:21  requests 101:13  require 33:23  required 38:4 45:5  93:18  requirement 6:13  36:5 38:2 51:4  96:16  requirements 21:16  32:9 59:10 99:21  requires 96:10  rescheduled 104:7  research 56:10  66:12  residency 99:21  resident 57:16  58:12  residents 27:4  35:12 58:9 67:11  96:3 97:17 98:7  99:22  resident's 33:22  resolve 81:3  resources 36:8  51:23 52:18  responded 13:20  response 11:1 66:1  responses 13:19  14:4 71:7  rest 100:3  restraining 82:10  restrictions 63:7  80:10  restrictive 25:7  result 17:8 38:9  81:21  results 3:8 7:22  retirement 54:9</p>	<p>revamp 38:4  review 1:2,14 32:8  57:7  revised 38:14  revising 94:2  Rick 2:9 4:21 60:19  61:23 77:4  rid 78:2  right 5:4 11:3 12:21  14:7 22:17 24:14  27:9,16,24 30:2  34:16 36:21 37:8  39:17 43:7 46:17  50:14 52:3,9  53:12 59:3,4,24  64:2 76:7,22  78:11 82:23 83:2  87:5,17 88:24  93:6 95:3  rinky-dink 70:18  Rock 20:18  role 75:5 87:21 91:3  91:11,24  roll 3:3 4:4  roof 97:17  room 4:6 22:22  47:13 48:7 84:10  rooms 45:1,10,21  49:19 53:13 59:12  59:22 70:24 73:1  93:2 97:12  routine 64:11  RPR 2:22 105:3,17  rule 28:24 38:3 79:2  79:6 80:10,19  96:13  ruled 39:23  rules 8:8 29:16,22  38:1,3 55:5 62:2,4  62:7,7 74:15  77:23 79:11 80:21  92:18 93:18,21  95:2 96:2 97:14  ruling 39:14,15  run 6:18 27:5 46:15  47:7 63:22 97:6  running 41:19  46:20 47:12,14,15  49:13,13 60:7  78:24  rural 28:14 98:12  98:14,19</p> <hr/> <p style="text-align: center;"><b>S</b></p> <p>sack 11:5  safety 63:21 97:7  98:24</p>
--	---	---	---	--

sake 80:11	98:18 102:13	77:9,13 102:7	some 5:22 16:14	sorry 15:10 22:6,9
same 7:3 10:3 26:15	seem 23:12 49:8	seven 4:24	17:18,19 18:14	22:16 51:13 84:24
31:6,7 40:1 48:7	90:24 100:21	several 73:1 99:24	19:10 22:22 23:21	sort 17:13 30:1 31:6
50:4,11 52:2,7,8	102:15	shared 7:19	23:22 24:8 26:2,2	31:12 32:6 62:19
56:17 63:21 64:12	seemed 29:1 38:6	sharing 15:7	28:23 29:11,18	69:13 82:1 87:2
75:15 76:18 85:16	seems 38:18 46:3	sheet 7:3	33:9 36:15 39:7	88:2 93:22 94:3
85:18,19,23 86:1	53:24 57:12,16	sheets 6:10,12,19	46:4 47:13 50:16	99:3
86:1	72:7 74:3,20	shifting 39:6	52:16 53:5,14	sorts 90:18
Sangamon 18:18	seen 40:24	shingle 27:13	54:15 55:16 56:10	sounded 33:3
satisfaction 35:13	seldom 40:14	short 23:20,21 47:3	56:15 61:7,14	sounds 75:4 82:20
35:18,20,24	self-addressed 5:22	104:8	62:19,23 63:7,7	source 16:8 69:16
satisfactory 94:22	self-stamped 5:23	shorter 21:16	63:10,15 64:5,10	south 1:16 11:4
satisfied 94:14,19	sell 70:20,23 71:9	short-stay 23:7,9	64:11,15,16 65:11	34:24 57:21
saw 38:2 71:8 104:2	71:16,17,18 75:9	27:4	65:12 67:1,13,18	so-called 44:12
saying 12:23 15:11	78:10	short-term 23:16,22	67:20 69:21 70:3	76:12
17:6,14 18:18	seller 78:13,14	24:1,2,7,8,10,13	70:6,10 71:6,7,13	spark 29:18
24:6 27:10 36:7	selling 71:7 79:17	24:16 25:21 26:3	72:6 73:18,20	speak 14:6 55:6
37:4 41:18 52:1,6	semi-private 45:20	26:8 27:1,13	74:17 75:6,9 77:2	57:9 62:3 71:5
52:7,21 56:9 59:3	49:19 61:10	54:10 55:8	81:16 83:13 84:2	speaking 43:4 85:18
64:21 72:17 73:24	send 7:18 12:8 16:8	shot 69:11	86:16 87:2,12	86:1
76:9 80:13 82:5	74:18 102:19	shut 84:15 99:23	88:1,7 89:18 90:6	Speaks 2:20 7:12,12
84:16,18 92:1,4	sending 5:15	side 40:2	90:21 91:4 95:6	special 34:17
95:8	sense 20:5 50:5 80:7	sign 5:18 7:4	95:19,22 97:19,19	Specialization
says 27:13 35:13	84:16	signed 100:3	99:12,13 100:19	69:19
39:18 42:2 92:22	sent 7:23 14:12	significant 17:15	101:3,8 102:5	specialized 93:23
Scavotto 2:7 4:9,9	29:22 102:10	48:17 81:2 101:12	104:1,15	95:14,18 97:4
15:8 18:23 19:3	sentence 90:3	sign-in 7:3	somebody 5:3 9:17	specialty 69:21
19:13 20:6,13	separate 77:11	similar 15:22 77:11	12:18 20:1 24:6	specific 24:16,17,19
26:14 27:22 28:1	92:17 96:23	simplistic 94:20	45:9 47:21 49:13	24:20 57:18 58:3
28:7,12 32:12,15	September 104:10	simply 65:13	71:1 78:11 84:12	82:6 83:19
32:21 33:1 36:2	104:10	since 7:21 29:2	87:8,22,23 88:4,5	specified 15:14
36:11 45:12,17,24	serious 11:15 38:24	38:13 89:2,19	90:1	spend 30:16
46:11,14,22 47:11	98:22,22,23	94:24	somebody's 89:22	spices 90:18
49:15,18 50:8	served 32:4	single 45:21	somehow 69:21	spinning 57:23
52:3 61:1,6,13	service 21:6 24:20	single-bed 53:4	72:9	spite 94:15
72:5,17 73:7,10	31:3 34:17 46:20	sir 7:20	someone 15:3 23:19	spot 74:13 89:19
73:15 76:9 82:14	68:7 69:4,21	sit 52:22 73:6 81:23	33:5 41:8 90:3,24	spreadsheet 30:8
82:18,21,24 83:3	71:11 77:12 92:20	87:20	94:15 95:19	Springfield 1:4 8:5
83:10 103:1	94:23	site 10:15 12:3	103:21	9:10 10:13 11:4
schedule 11:17 13:8	services 1:2,14 2:22	40:14	someplace 36:13	13:2 59:22
scheduled 1:15 8:15	16:6 18:2 21:1	sits 10:7,7	something 14:8	squashes 96:18
8:15,16 11:16	23:7,9 29:7 32:2,3	sitting 78:6	17:2 18:9 23:11	squashing 96:11
schedules 8:10	32:7,10 33:21	situation 82:12	24:16 37:16,21	St 39:16 103:3
scheme 96:23,24	34:18 54:6,7 58:5	six 60:7	39:3 40:9 52:20	staff 2:16,17,18
searching 74:16	67:11 71:14 74:4	size 95:24	55:1,19 60:20	8:24 36:7 52:14
second 35:10 54:13	93:3,4,23 94:4,5	skews 43:3	66:7 69:22 72:13	52:18 58:5 68:7
92:21	94:15	skilled 16:8 18:2	72:22 73:6 75:17	88:15 89:10 91:12
section 29:23 95:3,3	set 9:1 11:18 12:7	31:2 63:20 69:12	76:24 77:1,3	97:10 101:14,20
sections 95:7	13:12,12 34:4	92:24 97:20	84:13 85:4 90:3	103:23
Security 97:13	43:12 44:22 45:7	slash 62:14	93:19,23,24 94:17	staffing 99:3
see 5:9,9 9:3,15	46:3 50:6,21 51:2	slice 57:15	94:19 102:4	stagnation 71:19
10:11 12:22 17:23	51:2 54:11 70:22	small 85:7 88:21	sometimes 26:12	stakeholder 75:2
20:20,23 21:1	72:22 80:8,11	96:19	32:3 37:5,5 50:15	stakeholders 74:21
30:3 37:16 39:9	90:14 92:17 99:17	smaller 60:12 70:13	100:16	74:23 75:19 81:7
59:8 63:10 69:15	sets 31:20	Social 97:13	somewhat 46:8	standard 19:15,20
73:20 74:17 75:3	setting 99:23	sole 75:23	60:22	35:17 36:4,6 49:2
78:8 90:22 94:5,6	set-up 43:18 70:21	solve 103:19	somewhere 25:23	49:4,6 50:6 63:7

standards 40:17 59:13 60:15 62:22 62:24 63:13 64:16 99:18 101:3 standing 66:19 start 4:1,8 14:11,16 20:22 53:5 55:16 55:17 60:22 68:3 73:18 77:9 82:13 started 39:15 starting 15:15 29:3 54:19 starts 14:21 22:1 state 1:1,13 6:4 11:6 15:16,17 17:15,18 18:3,21 23:17 24:14 29:15 32:9 35:17 38:8 41:19 43:22 46:5 49:2 52:24 53:1 56:20 63:6 64:5 75:16 76:3 96:13 states 3:9 14:10,13 14:20 15:11,22 16:14,15,23 18:14 21:13 22:18 23:13 28:23 29:11 42:7 46:16,23 54:4 58:24 63:18 95:24 96:19 97:1 105:4 state's 29:16 84:1 state-wide 24:23 25:12 102:20 station 60:14 stations 101:1 statistical 19:10 65:2 status 58:19 statute 61:20,24 62:1,9 74:16 101:6,22 102:1 statutory 92:2,17 stay 9:4 16:21 23:16 23:20 25:21 47:3 54:10 55:8 91:8 staying 14:2 stays 23:21,21,22 23:22 26:3,4 steep 20:19 step 31:18 42:22 54:14 69:7 73:24 74:18 87:17 91:11 91:23 Stephanie 2:11 5:1 10:23,24 12:22 steps 3:11 53:19 step-by-step 93:18	still 7:21 10:24 12:19 13:23 15:21 16:21 19:18 25:22 26:14 37:17 39:9 39:24 41:7 44:11 44:15 50:4 55:7 58:3 59:17,19 60:17 64:8 72:21 88:3 95:5,5 101:4 stone 20:15 stop 50:17 straight 28:1 strategic 73:14 82:15 85:12 86:21 87:14 strategies 3:11 53:19 street 1:3 39:20 strengths 85:17 strict 63:3 strictly 64:10 83:21 stripe 42:2 structural 53:6 structure 62:8 73:6 73:7,19 88:2,10 94:12 struggle 67:9 struggling 83:13 stuck 71:15 studied 19:4 20:17 studies 19:15 40:5 40:11 study 34:21 stuff 10:11 28:16 64:1 67:16,23 92:11,14 104:3 subcommittee 1:11 1:15 23:11 41:15 42:24 93:6 subgroups 28:22 subject 93:7 submit 6:10 45:5 submitted 89:19 submitting 6:12 subset 88:21 substituting 4:12 subtract 42:22 101:17 103:5 subtracting 16:13 31:18 sub-acute 29:7 sub-committee 41:10 92:3 sufficient 37:13 suggest 9:8 18:9 101:22 suggesting 26:2	56:12 72:10 suggestion 73:4 95:15 Sullivan 2:6 4:12,12 10:6,18 11:2,8,12 11:22 12:2,7 18:12 19:7 22:23 23:2 25:4,10,16 30:12 33:2 34:21 36:3 37:18 38:11 39:4 41:9,17,20 43:14,18 44:8 48:21,23 50:14 53:16,22 55:12,24 56:3,7 57:2 64:22 69:7 71:17 88:22 93:9 96:1,5 102:1 summary 14:15,17 66:12 102:10 summation 66:12 summed 69:11 support 18:1,5 19:1 25:2 37:13 supported 54:9 62:15 suppose 70:13 supposed 6:11 45:6 55:20 sure 8:22 32:23 53:20 54:12 58:15 71:18 73:1 75:6 83:12 86:8 87:23 89:3 survey 3:8 7:22,24 8:11 13:17 35:13 52:19 61:9 72:15 77:11 surveys 35:24 swing 17:17 switching 104:16 syllable 36:24 system 56:18 57:3 63:11 70:18,19 71:19 80:15,24 systems 29:12 81:21	38:22 105:6 takes 44:6 90:22 taking 53:8 84:7 97:13 talk 50:17 51:8 74:22 100:8 talked 6:15 7:16 23:17 76:10 102:3 talking 11:14,15 22:24 27:18,22 28:2 41:22 42:9 45:8 46:12 47:1 47:17 49:9,10,22 49:23 50:10 55:10 56:14 60:12,20 61:3 67:5 68:15 71:3 72:23 74:19 75:14 76:3 81:6 81:20,20,21 83:16 88:6 92:6 94:13 95:17 97:6 99:7,9 101:15 102:5 talks 29:23 84:6 target 42:18 43:21 46:3 48:12,15 task 38:8 67:12 75:12 77:24 78:3 85:7 87:16 tax 80:1,2 technically 6:19 78:11 94:10 99:13 teleconferencing 101:13 103:19 telephone 2:10,18 2:20 5:14 tell 7:10 17:24 60:4 66:18 79:4,10 88:4 91:23 92:16 94:10 98:21 telling 28:10 tells 44:6 ten 13:6,7,9 tend 25:4 99:2,16 tendency 17:11 35:9 tends 27:8 Teri 2:11 7:17 10:20,21 25:4 65:24 term 21:16 31:12 55:15 terms 6:24 19:14 25:22 26:4 53:23 54:15 55:19 61:17 67:22 69:7,17 75:23 78:14 Terry 2:6 4:12	10:17 11:20 22:5 22:6 56:2,9 64:21 66:22 69:5 Terry's 94:18 text 28:24 thank 7:20 13:17,20 14:1 19:6,21 21:10 30:7 35:8 41:21 66:14,17 72:2 75:22 103:8 their 24:20 29:11 34:19,24 35:2,5 36:17 37:2 45:1,2 47:7,20 50:2 51:16 57:17,17,22 71:15 75:7,10 76:2 78:20 86:8 89:6 90:7 97:13 99:20,21 103:22 themselves 99:10,11 theoretical 44:21 theoretically 97:3 therapy 24:8 thereto 105:10 the-license-follow... 69:14 thing 16:9,10 31:7 34:15 43:2 48:8 50:17 51:3 64:11 94:2 99:3 things 16:4 26:9 27:21 30:15 33:14 33:20 34:9 35:15 39:6 41:1 43:7 48:12 52:13,23 63:9 65:13 68:6 68:15 70:3 71:20 74:22 84:23 86:6 86:11,15 88:7,8,9 102:5 think 6:17,18 7:24 8:21 10:5,6 11:10 13:14 14:10 17:9 19:13,20,22 20:6 20:23 21:1 24:23 25:3 26:10 27:18 35:9,11 39:10 46:11,22 48:14 50:15 51:24 53:9 53:19 54:17,17 55:24 57:1 58:13 58:14,23 60:21 61:22 62:11,13 64:14,22 65:3,13 66:4,5,22 67:1,2,7 67:7 68:21 69:7 69:10,20 70:1,5
--	--	---	---	--

70:11 71:2,23 72:11,16 73:5,16 73:17,24 74:7,24 75:2,13,14,22,24 76:13 77:3 81:3,5 81:13,22 82:4 83:13 84:6,7,10 84:11,13,13,18,23 85:4,7,10,11,12 85:15 86:2,5,7 87:3 88:2,15 89:1 90:1,6,7 91:2,3,11 91:15,17,21,22 92:1,3,6,10,13,22 93:15,17 95:1,5 97:11 98:2 100:2 101:9 104:3,5 <b>thinking</b> 33:10 69:6 72:4,5 94:24 <b>thinks</b> 91:24 <b>third</b> 35:10 36:24 90:2 <b>Thirty</b> 40:19 <b>though</b> 38:20 39:20 48:18 55:17 59:17 71:13 <b>thought</b> 7:5 21:21 27:22 29:21 30:10 57:19 67:20 82:2 82:21,24 83:3,4 90:4 95:3 <b>thoughts</b> 6:8 23:13 67:18 88:12 <b>three</b> 17:1 37:24 53:24 60:8 69:1 71:2 76:13 96:3,8 96:10,14,17 97:12 100:2 104:9 <b>three's</b> 20:4 <b>threshold</b> 98:1,8,9 99:5 <b>through</b> 9:16 39:2 57:4 60:1 62:5 76:23 80:23 82:24 89:10 91:12 93:18 95:2 101:14 <b>throughout</b> 14:19 67:8 <b>throw</b> 67:15 85:3 90:21 93:13 <b>throwing</b> 26:9 <b>thrown</b> 88:12 <b>tie</b> 33:14 <b>tied</b> 59:9 <b>Tim</b> 4:10 71:23 75:22 100:6 <b>time</b> 4:1 6:10,12,24	8:19 13:5 15:14 19:24 30:16 34:9 34:15,16 37:22 38:2,13,20,23 39:14,18,24 40:2 40:3,7,8,18 41:24 65:11 76:18 85:19 86:1,9,23 88:24 89:20 90:2,16 91:1 94:9,13 104:8,20 <b>timeline</b> 68:18 87:2 <b>times</b> 2:10 26:13 43:1 59:9 <b>Timothy</b> 2:4 <b>title</b> 99:11 <b>titled</b> 30:5 <b>today</b> 5:19,24 7:16 8:16,18 34:7 38:18 46:5 59:7 59:11 60:11 62:14 66:23 75:24 76:19 78:11 85:4 88:3 90:14,17 <b>today's</b> 83:3,22 <b>together</b> 30:8 36:24 37:10,11 42:9 66:13 67:6,17 78:14 80:23 81:8 82:18 85:21 88:1 92:15 <b>tomorrow</b> 55:21,23 83:23,23 <b>tool</b> 83:20,22 84:8,9 84:11,15 <b>top</b> 30:5 <b>toss</b> 10:11 <b>total</b> 42:13,14 47:23 49:11,11,14,15 50:3,4,10 102:8 <b>totally</b> 26:3 53:22 90:5 <b>touched</b> 93:5 <b>tough</b> 91:5 <b>toward</b> 6:3 8:24 34:24 <b>towards</b> 17:19 93:22 <b>towns</b> 100:8 <b>track</b> 24:12 61:8 <b>tracking</b> 20:4 34:22 <b>traditions</b> 28:18 <b>training</b> 3:7 5:10,12 5:16,17 6:5 <b>transcript</b> 6:22 88:15 <b>transcripts</b> 88:16	89:10 101:14 <b>transfer</b> 24:11,15 <b>transitional</b> 77:19 <b>transparent</b> 92:23 <b>transportation</b> 34:14 <b>traumatic</b> 29:8 <b>travel</b> 9:11 34:6,16 104:3 <b>traveled</b> 34:5 <b>traveling</b> 34:6 <b>trends</b> 21:18 93:3 <b>tried</b> 71:10 91:7 100:1 <b>trip</b> 103:2 <b>troops</b> 20:22 <b>trouble</b> 17:8 <b>true</b> 17:23 36:20 41:4 48:4 50:24 58:10 <b>truly</b> 38:24 101:5 <b>trump</b> 52:14 <b>try</b> 24:24 29:9 36:24 52:19 64:11 88:5 94:16 103:16 104:14 <b>trying</b> 9:16 13:18 21:12 24:12 27:12 30:9 32:6 37:24 47:20 50:6 51:20 57:9 59:8 63:9 67:9 73:17,21 75:1 81:8,15 88:18 89:5 94:23 <b>turn</b> 23:21,22 47:12 47:16 <b>turnover</b> 25:13,16 25:19 26:4,12,16 27:7 58:7 <b>tweak</b> 84:10 <b>tweaked</b> 84:13 <b>twelve</b> 97:18 <b>two</b> 8:4 13:7,9 21:13 25:5 27:18 43:7,17 59:21 61:5,21 65:6 68:6 76:13,20 86:9 88:19 91:21 92:3 93:17 94:11 97:18 104:17 <b>two's</b> 20:3 <b>type</b> 7:3 31:22 45:12,17 46:19 94:22 <b>types</b> 29:6 32:1 61:8 94:4,5,7 <b>typical</b> 42:12	<b>typically</b> 59:6 <hr/> <b>U</b> <hr/> <b>uncommon</b> 98:17 <b>under</b> 16:3 18:1,5,8 20:21,21,24 32:4 41:19 47:4 52:17 53:12 55:11 63:20 64:4 78:24 79:5 79:11 84:1,5 86:22 96:16 97:17 99:18 101:12 <b>underestimate</b> 92:6 92:12 <b>underground</b> 100:2 100:4 <b>understand</b> 10:1,9 18:8,17 71:10 85:2 91:9 <b>understanding</b> 10:2 30:1,20 58:24 <b>unfortunately</b> 38:19 <b>unique</b> 23:9 29:15 <b>unit</b> 10:12 97:4 <b>unless</b> 5:3 87:1 100:15 <b>unlicensed</b> 97:15 98:10 99:12,14 <b>unmet</b> 57:6 <b>unnecessary</b> 32:2 <b>unnoticed</b> 98:15 <b>unrelated</b> 96:5,7 <b>until</b> 5:6 8:8 72:2 84:12 101:7 <b>unused</b> 70:20 <b>upgrade</b> 76:5 77:2 <b>upward</b> 16:1 <b>Urso</b> 2:13 3:7 4:15 4:15 5:11 6:13,22 7:5 8:12 9:3,13,20 61:22 87:6 91:20 92:2 100:10 103:13 <b>usable</b> 72:9 <b>usage</b> 95:10 <b>usages</b> 95:12 <b>use</b> 7:3 12:5 15:11 16:15,23 17:1,1 20:6,9,14,18 22:5 22:13 28:18 31:13 31:23 33:7,15 34:3 42:7,10 43:12,14 48:10 52:5 56:16 58:8 67:1 76:17 77:21 79:7 84:9 88:10	94:3 95:17 <b>used</b> 10:8 11:5 14:18 21:22,23 29:12 31:24 40:9 41:4 44:7 70:15 88:8 <b>useful</b> 30:14 56:16 72:18 <b>uses</b> 16:4 29:5 31:10 31:12 42:7 <b>using</b> 18:15 43:4,8 44:5,8,15 78:7 82:15 <b>usually</b> 9:10 15:14 28:23 37:2,4 <b>utilization</b> 15:14 32:5 77:16 83:22 <b>utilized</b> 52:17 86:13 <b>utilizes</b> 31:5 <b>utilizing</b> 18:2 86:19 <hr/> <b>V</b> <hr/> <b>vacancy</b> 44:6 <b>vacant</b> 48:10 51:9 <b>vague</b> 70:1 <b>valid</b> 101:2 <b>validated</b> 11:24 <b>valuable</b> 58:17 <b>value</b> 79:14 <b>variable</b> 31:13 <b>variables</b> 62:3 64:17 <b>variance</b> 17:15 21:6 55:11 69:22 84:4 95:21 <b>variances</b> 15:18 18:21,24 19:2,8 55:5 69:16 84:1,2 94:7 95:10 <b>variation</b> 19:4 25:2 <b>varies</b> 22:18 46:9 <b>variety</b> 24:1 <b>various</b> 2:10 57:13 62:6 63:1 <b>vary</b> 15:16 18:10 21:13 23:1 <b>vehicle</b> 58:2 <b>verbal</b> 86:19 89:24 <b>verify</b> 7:7 <b>versus</b> 28:14 36:16 41:3 43:5,11 55:3 76:10 102:7 <b>very</b> 14:20 18:22,22 18:22 19:11 26:10 27:3 33:6,9 34:8 34:17,24 40:14 43:20 48:6,21,22
--	---	--	--	---

<p>50:24 52:14 58:16 59:14,14 61:24 70:21 77:3 80:4 83:15 84:7 85:2 85:15 93:22 98:19 98:22 via 2:10,18,20 Vice 44:2 Vice-Chair 2:2 video 8:3,4,20,21,24 9:2,9 10:3,8,12 11:19 88:23 89:2 104:16 view 47:4,23 61:20 71:8 75:12 violating 99:16 Virginia 23:4 virtually 27:6 41:18 vision 53:3 74:20,24 81:16 volume 27:1 volumes 27:20 vote 5:6 voting 5:3</p> <hr/> <p style="text-align: center;"><b>W</b></p> <p>waiting 7:21 58:8 walls 70:9 want 26:21 28:1,15 30:15 36:9 37:16 47:2,7,12 51:15 51:22,22,23 53:2 53:2,5,10,23 55:15 58:2,3 59:16 60:11,13 61:7 67:12 68:6 68:19 69:8,9,16 69:22 73:19 75:3 75:6,11 76:21 78:23,23 79:4,18 80:14 81:4 82:7 84:21,21 87:21 91:20 92:16 93:12 93:16 94:5 100:24 101:1 wanted 6:23 19:5 30:7 36:8 78:12 wanting 64:9 95:5 wants 5:16 16:8 23:11 45:9 59:9 59:12 60:21 61:19 62:13 69:12 70:22 71:1,11 87:1 ward 73:1 wards 61:11 wasn't 69:2 95:16 watching 9:24</p>	<p>Waxman 2:1 4:3,7 4:16,16,22 5:2 7:14,16,20 8:14 8:19 9:14,23 10:17,22 11:7,14 11:23 12:4,24 13:4,9,16 14:1,5 15:4,6 19:22 20:12 21:8,10 28:17 32:13 34:1 35:9 37:7 38:15 39:13 42:5 43:8 47:22 48:5 53:18 56:8 57:8 58:13 61:16 62:20 64:18 65:8,15,19,24 66:2,9,18,21 67:4 68:21 69:5 71:4 71:20 73:17 74:7 74:12 77:4 79:20 79:24 81:11 82:1 82:17,20,23 83:2 83:7,12 85:6,20 86:24 87:5,19 88:14 89:8,17 90:6 91:7,10,16 92:13 93:11 95:8 95:23 97:3 98:2 98:11 99:6 100:5 101:9 102:15,23 103:2,7,11,18,23 104:9,14 way 9:6,19 14:11 20:4 21:14 25:23 29:1 30:15 32:6 40:23 47:4 53:17 55:21 59:13 61:20 75:17,19 76:7 81:7,8,10 85:12 86:13 87:21 88:14 92:14 93:20 94:21 101:6 ways 28:8 30:24 32:11 95:6 weight 17:11 weighted 16:15 17:18 weighting 17:10 weights 16:17 welcome 66:17 well 6:1 15:16 18:19 20:9,21 25:1,21 27:9 28:6 29:2,8 29:11,16 34:8 39:12 42:6 46:7 50:15 54:16,20 55:12 57:2 60:7</p>	<p>62:21 63:23 68:1 70:21 71:8 73:15 74:12 84:8 90:6 94:4 103:18 went 13:18 82:24 100:4 were 7:6 27:22 37:10,11,19,24 38:4,7 47:17 49:6 60:12,19 67:4 71:7,15 72:23 83:6,10,16 86:22 93:17,18,23 94:13 95:2,17 97:13 99:12,13 105:6 west 1:3 34:23 we'll 4:8 5:7,8,15,20 30:3 31:3 32:18 41:22 54:17 91:12 91:12 102:13,22 103:19 104:4,14 we're 5:18 6:24 7:21,22 10:2,3 11:10 13:13,22 15:7,8 18:4 20:23 25:22 27:9,18 28:2 33:5 40:2,12 41:18 43:8,21 44:5,15,15 45:2,3 46:9,14 49:8,10 50:5,6,10,16 51:7 51:8,20,21 52:23 52:24 53:7,11,21 59:24 61:3,13 63:20 67:9,12 68:2,4,5 71:3 72:14,24 73:9,10 73:11,12,12,16 74:22 75:14 76:4 80:5 81:19,19,20 81:20,22 83:12 85:3,13,15,18,22 85:24 86:1,5,16 86:19 88:9,23 89:2,4,19 92:9 94:23 101:12 we've 4:24 8:7 20:17 23:17 40:24 53:1 54:4 55:10 63:8 65:12 66:5 67:8 68:15 72:15 75:18 77:1,19,20 83:17 92:9,14 101:9,14 102:5 whatnot 5:18 6:16 wheels 57:23 while 5:18 12:15</p>	<p>30:22 34:22 38:13 60:6 67:12 white 63:4 whole 24:2 53:20 54:10 67:9 69:24 71:23,24 90:14 96:12 102:1 wide 60:13,17 widely 18:10 wiggle 22:22 willing 10:14 69:20 75:4 willy-nilly 88:13 wish 66:3 wishes 36:15 wondered 23:18 wonderful 88:3 wondering 58:1 word 31:11 words 30:17 44:1 work 4:7 5:20 51:17 55:13 60:22 66:11 66:12 72:20 77:1 81:23 91:14 worked 42:9 84:14 working 18:13 33:13 53:12 73:10 78:14 84:5 86:22 works 11:17 13:10 29:16 worse 56:11 100:21 worth 70:11 wouldn't 7:17 66:19 77:6 102:18 Wow 98:11 wrapped 68:18 write 9:18,21 writing 89:15,21,23 90:1,2 105:7 written 59:13 61:20 64:10 78:16 101:6 101:19 wrong 59:3,4 94:10</p> <hr/> <p style="text-align: center;"><b>Y</b></p> <p>yeah 62:18 72:17 78:10 95:13 96:6 year 23:6 25:11 42:16 68:9,19 72:15 76:20 77:8 86:8 100:14 years 21:12,14,14 21:22 25:5 31:9,9 37:24 39:24 40:9 48:16 60:8 64:6 67:21 68:21 69:1 69:10,20 71:3,22</p>	<p>76:13,20 86:9 98:21 100:1 young 57:8</p> <hr/> <p style="text-align: center;"><b>Z</b></p> <p>zero 16:24 17:1 zoning 60:3</p> <hr/> <p style="text-align: center;"><b>\$</b></p> <p>\$15 12:1 \$28 11:14</p> <hr/> <p style="text-align: center;"><b>1</b></p> <p>1 3:3 1,000 37:15 49:24 1:50 104:20 10 3:13 16:1 21:22 40:13 48:16 69:10 69:20 71:3 78:20 79:1,1,5,5 86:8 97:17,20 10,000 37:12 54:9 10-day 48:19 10-year 21:15 74:20 74:24 10:30 1:16 4:1 100 32:17 37:14 46:15,23 47:14 50:16 100-bed 78:7 11 3:5 1100.510 29:23 12 97:17 12th 7:24 120 100:24 120-foot 60:14 15 40:9,13 41:2 16-bed 64:7 160 32:17,18 19 68:21 1979 33:3 39:9 1997 37:15</p> <hr/> <p style="text-align: center;"><b>2</b></p> <p>2 3:4 48:16 2nd 1:3 20 18:4 48:16 49:2,6 49:23 63:19 78:20 20,000 44:1 54:8 70:15,16 20-bed 79:1,6 97:5 20-plus 71:22 200 25:13 47:24 200,000 39:6 2000 22:13 2011 1:15 3:5 217-782-3516 1:5</p>
---	---	--	---	--

<p>24 1:15                  24th 6:1                  25 63:19                  26th 11:16,18 13:1                  27th 104:10,10                  29th 104:10,11</p> <hr/> <p style="text-align: center;"><b>3</b></p> <p>3 3:5                  30 24:14 40:14 41:4                  70:20 89:9,10,13                  30-bed 63:19                  30-mile 51:12                  30-minute 38:20,23                  39:13,23 40:2,3,7                  40:8 51:13 52:6                  39,000 25:5</p> <hr/> <p style="text-align: center;"><b>4</b></p> <p>4 3:6                  4th 11:4                  4-bed 73:1                  401 2:23                  411 1:16                  42,000 25:11</p> <hr/> <p style="text-align: center;"><b>5</b></p> <p>5 3:7 18:3                  5,000 49:24 72:16                  50 20:21 78:24                  525 1:3</p> <hr/> <p style="text-align: center;"><b>6</b></p> <p>6 3:8                  60 20:21,24 32:17                  32:17,18 89:8                  600 25:15,16,19                  60611 2:23                  62761 1:4                  64 16:24 17:1                  65 16:24 17:1,6 18:1                  18:5,9,9</p> <hr/> <p style="text-align: center;"><b>7</b></p> <p>7 3:9 97:17                  7:30 87:6                  74 16:24 17:1                  75 16:24 17:2,12,17                  18:14,19 21:4                  78:7                  77 30:5                  78 37:20                  79 34:5 37:20</p> <hr/> <p style="text-align: center;"><b>8</b></p> <p>8 3:11 60:13,17 67:2                  97:17</p>	<p>80 43:23 52:22                  84 16:24 21:4                  85 16:24 18:14                  22:19 23:3 46:10                  47:16 48:2 49:13                  85:14</p> <hr/> <p style="text-align: center;"><b>9</b></p> <p>9 3:12 37:14                  90 25:6,12 27:8                  42:19 43:22 44:8                  44:19 46:3,15                  47:11,12 48:15,24                  49:3,14,18 79:4                  90's 39:1                  93 23:5,8 49:1,3                  95 27:8 47:15 48:1,2                  50:7,16                  97 22:19 23:3 37:20                  46:10 49:13</p>			
---	---	--	--	--