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

LONG-TERM CARE ADVISORY SUBCOMMITTEE

MEETING

APRIL 3, 2012

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 SUBCOMITTEE
MEETING

The meeting of the State of Illinois Health Facilities and Services Review Board, Long-Term Care Advisory Subcommittee was held on April 3, 2012, scheduled to begin at the hour of 10:00 a.m., at Bolingbrook Golf Club, 2001 Rodeo Drive, Bolingbrook, Illinois.

1 MEMBERS PRESENT:

2 Michael Waxman - Chairman
Eli Pick - Vice-Chair
3 Greg Will (for Dave Lowitzki)
Phyllis Mitzen
4 Timothy Phillippe
Michael Scavotto
5 Judy Amiano
Patricia O'Dea Evans
6 Toni Colon (for Rick Dees)

7
8 ALSO PRESENT:

9 Frank Urso - HFSRB Legal Counsel
10 Cathy Clarke - Assistant to HFSRB Administrator
11 Claire Burman - HFSRB Staff
12 Alexis Kendrick - HFSRB Staff
13 Michael Constantino - IDPH
14 Bill Dart - IDPH
15 Charles Foley
16 Cathy Nelson
17 Terry Sullivan

18
19 Reported by:

20 Karen K. Keim
21 CRR, RPR, CSR-IL, CRR-MO
22 Midwest Litigation Services
23 401 N. Michigan Avenue
24 Chicago, IL 60611

- 1 AGENDA
- 2
- 3 CALL TO ORDER
- 4 1. Welcome New Subcommittee Member
- 5 2. Roll Call
- 6 3. Approval of Agenda
- 7 4. Approval of January 31, 2012 Minutes
- 8 5. Review of the LTC CON Application
- 9 6. Long-Term Care Representatives (HCCI - Illinois
- 10 Healthcare Association and Illinois Council on Long-Term
- 11 Care; and Life Services Network)
- 12 7. Open Meeting Act and Ethics Training Update
- 13 8. Work Group Report and Discussion
- 14 9. Bed Transfer Issues with Other States
- 15 10. Legislative Update
- 16 11. Other Business
- 17 12. Next Meeting
- 18 13. Adjournment
- 19
- 20
- 21
- 22
- 23
- 24

1 START TIME: 10:03 a.m.

2

3 MR. PICK: Why don't we get started. Mike is
4 very close by. He'll jump in when he gets here.

5 So, we'll call the meeting to order, and
6 perhaps we can start with introductions. Mike?

7 MR. CONSTANTINO: Mike Constantino, Illinois
8 Department of Public Health.

9 MR. DART: Bill Dart, also IDPH.

10 MS. COLON: Toni Colon, IDPH.

11 MR. PICK: Eli Pick, Vice-Chair.

12 MR. SCAVOTTO: Mike Scavotto, Management
13 Performance Associates.

14 MR. PHILLIPPE: Tim Phillippe, Christian
15 Homes.

16 MS. BURMAN: Claire Burman, Review Board.

17 MR. URSO: Frank Urso, with the Board.

18 MS. KENDRICK: Alexis Kendrick, with the
19 Board.

20 MR. FOLEY: Charles Foley, consultant.

21 MS. NELSON: Cathy Nelson, Director of
22 Clinical Services for Life Services Network, here on Jason
23 Speaks' behalf.

24 MR. PICK: Welcome. Our Chair, Mr. Waxman,

1 called me three minutes ago. He is very close by, so he'll
2 join us shortly, but he asked me to get things started. We
3 clearly don't have a quorum, so we will not be able to
4 execute the approval of an agenda or minutes, but we can
5 certainly continue to do discussion and other business.

6 So, the next item on the agenda is review of
7 the CON application, and, Mike, I know you were
8 spearheading that initiative. Can you give us a report?

9 MR. SCAVOTTO: I have -- I am pleased to
10 report that we have no report.

11 (Laughter)

12 MR. SCAVOTTO: Claire got the application back
13 to me last week. We've got the conference calls going,
14 probably next week. I do have a couple of questions,
15 though, if I can ask.

16 MR. PICK: Yes, please do.

17 MR. SCAVOTTO: Mike, let me ask you a
18 question. So, in the last application that Claire
19 provided, there's a requirement in there for a financial
20 feasibility study.

21 MR. CONSTANTINO: Yeah. We've run into
22 problems with some applicants not meeting their commitments
23 as expressed to the Board. They had told us they were
24 going to get financing, and it fell through. We expect

1 when you go to the Board that what you tell the Board is
2 correct and you have a good idea you're going to get that
3 financing. So, we no longer accept letters of interest to
4 fund a project as meeting the requirements of financial
5 feasibility. We're requesting more documentation as
6 additional information.

7 MR. SCAVOTTO: Okay. So, let's -- can we talk
8 about this a little bit?

9 MR. PICK: Yeah.

10 MR. SCAVOTTO: So -- and I'm asking. I'm not
11 trying to draw any judgments on this at all. I've been
12 involved in a number of financial transactions, and many of
13 them require a feasibility study and some do not. So,
14 the -- there's two issues that I would want to explore with
15 you. Number one is, what type of financial feasibility
16 study -- let me rephrase that. What are you looking for in
17 a financial feasibility study? And number two -- which
18 probably is probably more important -- is, why do we need
19 the requirement in the first place? It sounds to me like
20 financing is your big bugaboo. People come forward and get
21 a Certificate of Need and can't get financing.

22 MR. CONSTANTINO: Yes, or just giving the
23 Board more information which they have requested that we
24 provide them. We will no longer accept a letter from the

1 bank saying that "we've got an interest in financing this
2 project". That's no longer acceptable. We were accepting
3 that for a long period of time. We won't do that anymore.

4 MR. SCAVOTTO: I guess my issue with that
5 would be that it would be entirely possible for me to give
6 you an extremely well-documented and detailed feasibility
7 study and still not be able to get financing.

8 MR. CONSTANTINO: That could be, but what we
9 have in front of us then would be more documentation for
10 the Board, that you're expressing here, "We think we have
11 the ability to -- we're financial feasible to fund this
12 project," and if you get turned down from one borrower,
13 then you could go to another one. As it sits now, all
14 you're providing us with is a letter from a bank, which I
15 can get, which my project reviewer could get. So, we no
16 longer will accept that, Mike. That's the only thing we're
17 asking for, for additional information, which is our right
18 as a project reviewer for the --

19 MR. SCAVOTTO: I don't mean to imply that I'm
20 questioning that.

21 MR. CONSTANTINO: No, no, no, no.

22 MR. SCAVOTTO: You should be -- to me, being
23 able to get financing is the sine qua non of this whole
24 process. If you can't come up with the bucks, you

1 shouldn't be at the table and shouldn't be wasting
2 everybody's time. So, we're with you on that one.

3 MR. PHILLIPPE: It ties up the community. I
4 know of a place where -- I can remember this -- a few years
5 ago a group got approval and don't have it open yet, and
6 it's been years now, and it's like they tie up those beds.

7 MR. CONSTANTINO: Right, that's the other
8 issue here.

9 MR. PHILLIPPE: It kind of locks up the market
10 and nobody else can do anything, and it goes on for years.

11 MR. CONSTANTINO: That's correct.

12 MR. SCAVOTTO: Having been through this
13 process a number of times, I can't think of a bank or an
14 underwriter who will give you a commitment to finance
15 without having a feasibility study or the equivalent of a
16 feasibility study.

17 MR. CONSTANTINO: We're not --

18 MR. SCAVOTTO: So, if you've got the
19 commitment to finance, you know, de facto you've got a
20 feasibility study requirement met, and it seems to me it
21 would get you where you want to go.

22 MR. CONSTANTINO: We haven't been asking for
23 that feasibility study, and now we are asking for it.

24 MR. SCAVOTTO: I guess my -- would you be

1 further ahead -- and I think you would be -- if you just
2 insisted on having a commitment to finance it rather than
3 the feasibility study, rather than two things, the
4 feasibility study and the commitment to finance? Because
5 in my experience -- and maybe you can back me up on this --
6 if you've got the commitment to finance, these guys have
7 already combed the numbers and the demand analysis. And
8 you're there. They're not going to finance it unless they
9 are willing to take a risk.

10 MR. CONSTANTINO: Mike, what we're getting is,
11 they won't provide us with that commitment letter until the
12 CON approves it.

13 MR. SCAVOTTO: They won't say the final
14 condition --

15 MR. CONSTANTINO: They won't even say that.

16 MR. SCAVOTTO: Why are you going forward with
17 it?

18 MR. CONSTANTINO: That's been our concern. We
19 accepted this to move forward under the assumption that
20 what they were telling us, that they would have the
21 financing. But we will no longer accept that from the
22 applicant.

23 MR. SCAVOTTO: I don't blame you. You're
24 wasting time.

1 MR. PICK: Even a feasibility study doesn't
2 necessarily get you there.

3 MR. SCAVOTTO: You can get the study, but you
4 don't have the financial commitment.

5 MR. PICK: I think the issue for the Board
6 really is you want to know, once you approve it, it's going
7 to go ahead.

8 MR. CONSTANTINO: That's correct.

9 MR. PICK: And the steps that are being put in
10 place -- going back historically, when financing was more
11 readily available, a letter of interest was adequate. In
12 today's environment, that's not the case.

13 MR. CONSTANTINO: That's correct.

14 MR. PICK: So I think the -- as the conditions
15 are changing -- and it will loosen up eventually, but as
16 the conditions are changing, the Board's process remains
17 static, and I think that's part of the challenge, is that
18 as you raise the bar, because we need to have projects
19 moving forward, then as the -- as finances become more
20 readily available and the ability to move forward loosens
21 up, the Board's expectations and requirements are still
22 going to remain the same, once you change your process.
23 So, I think the challenge becomes how do we establish a
24 process that's mindful of the conditions and the

1 environment, because a letter of interest two years from
2 now may become adequate again to move projects forward, but
3 once you change the process, that's the way it's going to
4 stay.

5 MR. SCAVOTTO: I'm not with you on that.

6 MR. PICK: Okay.

7 MR. SCAVOTTO: That's fair game for
8 discussion. I think there's a significant amount of
9 resources that get committed to putting a CON together. A
10 lot of people are going to spend time reviewing it, and
11 I -- if you can't finance it, you shouldn't be at the
12 table.

13 MR. PICK: I don't -- well, I don't disagree
14 with you, but I think you have a situation today that three
15 years ago was very different in that --

16 MR. SCAVOTTO: In terms of money.

17 MR. PICK: Right, in terms of money.

18 MR. SCAVOTTO: Right. It's harder to get.

19 MR. PICK: And that's the issue, and I think
20 in a couple of years, it's going to be easier to get money.
21 So then what's the litmus test? Whether a request for a
22 feasibility study gets you closer, we don't know. I mean,
23 I think that's -- the Staff's position is that always gives
24 you a higher degree of confidence that something is going

1 to move forward based on the feasibility study. So, I
2 think that's the challenge. How do we establish a level of
3 confidence that by the time the Board's completed its task,
4 that a project will move forward, not that the Board's a --
5 one more rung in the ladder and then it gets hung up for
6 external issues. We need to know that at the time a
7 project is approved, it's moving forward.

8 MR. SCAVOTTO: And what triggered the question
9 in my mind is the request for a feasibility study -- not
10 that it's a bad request, but it says to me, wait a minute.
11 Why are we asking for a feasibility study when we should --
12 are we really asking for proof of financial capability? If
13 they can finance it -- they're not going to be able to
14 finance it if they haven't demonstrated financial
15 feasibility to the bankers, the underwriters or whoever.
16 So, I'm saying, is it an extra step that we don't need?
17 That's the question. It's not that financial feasibility
18 should be ignored.

19 MR. PICK: Mike, I'm in full agreement with
20 you. The central question is, will the project move
21 forward?

22 MR. SCAVOTTO: I agree.

23 MR. PICK: That's the central question. So
24 the step that is being taken in requesting a feasibility

1 study, does it actually achieve that objective, or are we
2 just adding another layer?

3 MR. SCAVOTTO: Cost.

4 MR. PICK: Cost in a project process that does
5 or does not.

6 MR. SCAVOTTO: These things are not cheap.

7 MR. PICK: Chuck?

8 MR. FOLEY: I've got to agree with Mike in
9 terms of where he is coming from, in that there should be a
10 mechanism in place to assure the Board that somebody does,
11 in fact, have the financial wherewithal to fund a project.
12 There's no question about that. However, I think our
13 process already includes a step whereby -- even at
14 obligation. The project needs to be obligated after a
15 certain period of time, and I think at that point in time,
16 whether it's a year down the road, we could always ask that
17 magic question, "Have you secured financing?" If the
18 answer is no, then I think the Board then has the
19 opportunity to say, "Okay, we're going to give you three
20 more months." Or, "No, we're not. You had twelve months.
21 If you can't get it, that's too bad," that sort of thing.
22 I think what is in an application already, in terms of cash
23 flows, in terms of historical, if there is historical, your
24 projections, I think everything is already in the

1 application that a lending institution would, in fact, ask
2 for in order to give you that quote commitment. Now, I
3 agree that this loose letter that has been accepted in the
4 past should be a little bit stronger than what was
5 indicated. I don't have a problem with that. The only
6 problem that we are seeing is that to get that letter, to
7 get -- how much would it cost to do a financial study, I
8 guess, is the important question. Mike, Tim would you guys
9 know that?

10 MR. SCAVOTTO: Just in long-term care -- I
11 would throw in a ballpark guess for all sorts of projects,
12 between forty and sixty thousand, if it's a certified.

13 MR. PHILLIPPE: That's what I get, because we
14 have to do it for bond finances, and so it has to be, you
15 know, a select group of accounting firms. It can't be just
16 any CPA, and it's in that range.

17 MR. SCAVOTTO: If you're going to do a CON,
18 you're going to attach that study to it anyway.

19 MR. PHILLIPPE: But I'm not doing the study
20 before the CON, because you're trying to limit the amount
21 of money you spend, in case it doesn't work out. That's
22 the problem. It can be a fairly expensive process.

23 MR. CONSTANTINO: The problem for the Board,
24 they can no longer accept letters we're receiving from

1 these banks and institutions. They express an interest.
2 That's not fair to the Board members, to make a decision
3 based upon that letter. That's not telling the Board that
4 they have financing. There's no way, shape, or form. In
5 fact, the last -- the Board approved three projects. Two
6 of them have not been able to get financing and have
7 already asked for permit renewals. One has been withdrawn.
8 So, this is a real issue that has sprung up here in the
9 last year and a half, two years.

10 MR. SCAVOTTO: So, real issue; it's not just
11 one or two; it's far more complicated.

12 MR. PICK: It's clearly a change in pattern.

13 MR. CONSTANTINO: Yes, it is.

14 MR. PICK: Which sparks this discussion to
15 revisit the process, because with a change of pattern, we
16 need to revisit how the whole process evolves.

17 MR. FOLEY: Doesn't the process also give the
18 Board the opportunity to deny an extension if one is so
19 requested.

20 MR. CONSTANTINO: Permit renewal? Yes, it
21 does, Chuck.

22 MR. FOLEY: Okay. I guess one has to
23 understand, when one gets a permit, what is the next step
24 for an applicant? Most times you have to go for zoning.

1 Zoning has not yet been approved. That process could take,
2 you know, three, six, nine months, up to a year. Okay?
3 And that's before -- that's why a bank will not give you
4 any firm commitment, because in that firm commitment, they
5 want to know a firmer dollar figure, and then you have to
6 go through the expense of getting the architectural
7 drawings all finalized.

8 MR. CONSTANTINO: Those costs are all supposed
9 to be included in the --

10 MR. FOLEY: Application?

11 MR. CONSTANTINO: Right. All of those costs
12 are supposed to be included in that application and you
13 certify to that.

14 MR. FOLEY: That is absolutely correct.
15 That's my point.

16 MR. CONSTANTINO: All we're saying, we can no
17 longer accept those letters as submitted, that the bank
18 will show an interest in financing this project with the
19 information you're currently giving us. We went round and
20 round with you and John about this.

21 MR. FOLEY: I understand.

22 MR. CONSTANTINO: We will no longer do that,
23 Charlie. We won't accept that.

24 MR. FOLEY: I guess what we're trying to do

1 here, if I understand this correctly, is get some kind of a
2 happy medium, because we know, Mike -- and we agree with
3 you. I guess what we're trying to say is that somebody
4 most generally -- not always, most generally someone is not
5 going to file a CON application unless they feel they have
6 the financial wherewithal. We have a financial statement.
7 We have financial projections. We have letters from the
8 banks indicating that they do, in fact, you know, have
9 cash. Okay? But it's still not a financial commitment
10 that they could get financing. That's absolutely correct.

11 MR. CONSTANTINO: In the past we've accepted
12 projections not from an independent source. We accepted
13 them from the applicant. Okay. You can make projections
14 read anything you want.

15 MR. FOLEY: You're absolutely correct.

16 MR. CONSTANTINO: We also required this letter
17 from the bank. Those banks have gotten into the habit of
18 saying, "We express an interest." All I'm saying is we
19 will no longer accept that.

20 MR. FOLEY: I understand that.

21 MR. CONSTANTINO: We can't go forward like
22 this.

23 MR. PICK: If I may, I think we need to
24 establish -- from a management standpoint, we want to hit a

1 performance measure. So, the Staff -- the time for the
2 Board to review and approve an application is valuable time
3 on the part of the Departments. So, we need to know that a
4 certain threshold of the number of projects are going to
5 move ahead, as we said, beds are not tied up, that prevent
6 others from being able to move forward when there is a
7 need. So, we need to establish -- so, historically,
8 projects were approved based on these assurances and they
9 would move forward. Now we're experiencing a different
10 outcome. So, what we need to do is establish a performance
11 measure that a certain percentage of projects that are
12 presented to the Board and approved have to move ahead.
13 And what is it? Eighty percent, ninety percent? I don't
14 know what it is. I think we need to establish some type of
15 a performance measure that says this is the goal, and if
16 what we're experiencing to date is that financing is the
17 reason these things are not moving forward, then we need to
18 revisit that element of the process to redefine what's
19 acceptable. So, what I'm hearing is that's kind of what's
20 happening, but it's being done on a less formal basis,
21 based on experience.

22 Frank?

23 MR. URSO: I just want to mention that what
24 drives this discussion, I think, from the Board's

1 perspective is, statutorily projects have to move along
2 with due diligence and, you know, that's --

3 MR. PICK: Right.

4 MR. URSO: -- an area where we closely
5 monitor. That's why there are annual reports that are
6 required and things along that nature and people have an
7 opportunity to submit alternatives or renewals or things
8 along that nature. So, due diligence is a key factor. And
9 also the financial ability, of course, is one of the main
10 underpinnings of the statute, that whomever comes before
11 the Board and applies to develop a healthcare facility has
12 the financial wherewithal and resources to complete that
13 project.

14 And, you know, Tim, your point comes into the
15 mix too in terms of your tying up beds and whatnot. But
16 the two underpinnings are that due diligence has to be
17 first and foremost and somebody must have the financial
18 resources to complete this project, not start it and stop
19 in the middle, but complete it, and I think that's what the
20 Board Staff tries to ascertain from all of the documents
21 that it receives.

22 And the other thing I wanted to mention, I
23 think we need to correct the record to make sure we have
24 all of the new members listed.

1 MR. PICK: Right. So, if individuals who
2 joined us since we introduced ourselves could introduce.

3 MS. AMIANO: Judy Amiano.

4 MS. O'DEA EVANS: I apologize for being late.
5 Pat O'Dea Evans.

6 MS. MITZEN: Phyllis Mitzen.

7 CHAIRMAN WAXMAN: Mike Waxman.

8 MR. PICK: Anybody else?

9 MR. WILL: Greg Will, SEIU Healthcare
10 Illinois.

11 MR. PICK: Welcome, Greg.

12 MR. URSO: We still don't have a quorum.
13 We're getting closer.

14 CHAIRMAN WAXMAN: We're one down?

15 MR. URSO: According to my count.

16 CHAIRMAN WAXMAN: Well, someone else count.

17 (Laughter)

18 MR. PICK: So if I could just continue on this
19 same thought pattern. How difficult would it be for us to
20 look at, from previous experience based on the number of
21 applications that have been submitted, how many were
22 approved and actually went to completion as compared to
23 what we're -- as compared to what's happening in the
24 contemporary, where you're having projects approved and

1 they're not getting financing? Would it be too difficult
2 to gather that kind of data?

3 MR. CONSTANTINO: No.

4 MR. PICK: From my perspective --

5 MS. AMIANO: What impact would you have over
6 the end process of the actual security permit financing,
7 because I've been involved in a number of situations where
8 you have letters of intent, you have everything, and then
9 at the thirteenth hour, when the financing sources is
10 giving their final reviews, because the external
11 environment has changed, everyone is pulling the plug. So
12 I don't think there is anything the Board could do to help
13 with that process, frankly. So I'm trying to understand
14 your question.

15 MR. PICK: Well, I guess where I'm headed is,
16 let's establish a performance measure that reinforces for
17 us whether this is an episodic issue, whether there are
18 kind of just -- that they're unique to what's going on at
19 the time, or is it a pattern. Because when you're in the
20 middle of things, it's very hard to step back and get a
21 broader perspective to how the process is working.

22 MR. SCAVOTTO: How many projects failed over
23 the past three years, five years, et cetera, because of
24 inability to finance over the past three, five, and -- can

1 you get the stats for that? .

2 MR. CONSTANTINO: Yeah, we can get that, but I
3 don't know if we'll be able to identify which failed
4 because of financing, the reason being we don't ask for
5 that when they abandon or withdraw a project. All they
6 have to do is submit a letter that they're abandoning the
7 project.

8 MR. PICK: So even if we know how many
9 projects fail, then we can at least establish a goal that
10 says we want to hit X percent of applicants that actually
11 are successful in implementing the project and then look --
12 because the challenge and the temptation -- when you see
13 two or three in a short period of time having a problem
14 because of financing, then the knee-jerk response is we're
15 going to change the requirements for financing, even though
16 it may just be a very short-term kind of issue as a result
17 of contemporary conditions which, as I said, could change.
18 But once we change -- it's human nature. Once we change
19 our pattern, it's changed. There's no going back, because
20 you always remember that, you know, we had this problem
21 and, therefore, this change is perceived to have corrected
22 the issue and, therefore, we don't want to go back, as
23 opposed to let's use the data to drive decisions and then
24 the decisions become more -- they're more sound because

1 they're based on not just experience in a short period of
2 time, but over a longer period, and then you take more time
3 to evaluate what your decision impact has had and whether
4 it's achieving the desired result. So, it's human nature
5 to respond to experience and use that to drive decision
6 making, and it's not always the best way to do problem
7 solving.

8 I'm a process-oriented person, so that's why I
9 believe we need to look at this as a process, and then
10 follow up is critically important, that as a Board,
11 statutorily, as Frank points out, there are conditions that
12 are required to be met with follow-up and reports. Those
13 are the kinds of things that allow us to make sure that the
14 data supports our decisions.

15 MR. SCAVOTTO: Well, I'm having trouble
16 reconciling your process with the goal of making sure that
17 everybody that comes before the Board has financial
18 capability, because if we're assured everybody coming
19 before the Board has financial capability, that's one
20 hundred percent on that standard. I agree you don't get
21 hundred percent, 99.9.

22 MR. PICK: Separate from the hundred percent,
23 I guess the question is whether the individuals who are
24 presenting applications -- they may be just as financially

1 capable today as they were five years ago. It's that the
2 conditions have changed. So, we don't know why the most
3 recent projects are not moving forward. What we know is
4 the banks -- that the project applicants are coming back
5 and saying they're not able to secure financing. That's
6 been the most contemporary experience. So, that's what is
7 driving the decision. It doesn't necessarily mean that the
8 qualifications of the applicants have changed.

9 MR. SCAVOTTO: That's not what I said. I
10 didn't mean to imply that, but that's not what I'm getting
11 at. Going back to the position of the Board, "can you
12 finance this" -- I mean, actually, "can you finance it" is
13 a yes or no question.

14 MR. PICK: No disagreement there. I guess the
15 question is -- the Board's reaction to several projects
16 failing as a result of financing, which is now to require
17 more documentation to support the ability of the applicant
18 to successfully move forward. The question is whether that
19 will yield the result or whether it's just creating more
20 expense and work. We don't know.

21 MR. PHILLIPPE: I think we need more
22 information, like you said. I think that would be wise.
23 We don't know exactly. Really, I've not been in the
24 situation, but do we really know they fail because of

1 financing? People could also have changed their mind
2 because the climate is not as positive over the last couple
3 years, and they may use that as an excuse. So, the
4 question is, you know, are there alternate ways you can
5 use? One is the financial feasibility, which makes some
6 sense, I think, actually. Another one actually is, you
7 know, you could have people be liable for so much money if
8 they don't go through with the project. We could have a
9 fine of \$20,000 or \$40,000, and you put that money up,
10 assuming it's cost time and money to the State to go
11 through this process, and if it fails even for financing,
12 you lose your money.

13 MS. AMIANO: But, quite frankly, we put fees
14 then on the front end, so --

15 MR. PHILLIPPE: It's not a lot of money,
16 though.

17 MS. O'DEA EVANS: I think that it's very
18 important to be a good steward of making sure projects are
19 financially viable. I mean, we have projects right now
20 that are operating that have filed for bankruptcy. We have
21 several in the state that were very high-end, luxury-type
22 places that took cash from seniors up-front to finance, to
23 help finance their projects, and this is serious. I mean,
24 they really -- we really do want to make sure they have as

1 much financial viability as possible in the planning
2 stages, because these are places -- yeah, they got them
3 built, but they couldn't maintain operations. And we also
4 have a state that isn't that quick in paying their, you
5 know, portion. So, they have to be able to manage that.
6 That is the climate we're in right now. So, I don't know
7 how we could, you know, side-step that and make it, you
8 know -- I think it's more stringent now than it would be
9 before because of the climate.

10 MR. PICK: If I may react, I think one of the
11 things we have to be mindful of is the economic conditions.
12 Projects that would have been very successful under normal
13 conditions, because of the economics didn't make it.

14 MS. O'DEA EVANS: Agreed.

15 MR. PICK: And that's not because of poor
16 planning or because the project wasn't sound. It was that
17 the conditions changed, and I -- and regardless of the
18 process improvement we make, we aren't going to be able to
19 account for that, because you operate based on certain
20 assumptions, that conditions that have historically been
21 present will continue to be present moving forward.

22 So, again, the reason I think it's extremely
23 important to take the time to review and evaluate
24 procedures is because once you change the procedure, it is

1 changed. Going back is extremely difficult, and conditions
2 will improve and deteriorate. That's just the nature of
3 things. Things get better, things get worse. So we just
4 need to validate that the perception that projects are
5 failing due to a lack of access to financing and the
6 response as a result of that perception is, indeed,
7 validated by the experience, the data, and that the new
8 requirement as a result of that experience is not overly
9 burdensome when conditions start to improve. We don't want
10 to make it more difficult.

11 MR. SCAVOTTO: Okay. I've got enough to work
12 with Mike on this, to get my group together. There are a
13 few other issues that we want to talk about. We won't do
14 it now, about where you might be getting -- why you might
15 be having difficulty getting good information on the
16 application. The referrals are one, but we'll take care of
17 that in conversation and get back with you.

18 MR. PICK: I read your report. I thought
19 there were several very good points in there about, again,
20 the aspect of the application being unique to long-term
21 care and not kind of just being adapted from the hospital
22 application.

23 MR. SCAVOTTO: Right. I remembered that from
24 one of the first meetings. We wanted to get away from

1 that.

2 MR. PICK: That's really our charge. Our
3 charge is, we wanted to create a specific process for
4 long-term care applications that are not what had
5 historically been a hospital application that was just
6 being applied. So, have you gotten any feedback on the
7 list of your comments?

8 MR. SCAVOTTO: I haven't heard a peep. I got
9 something from Claire. But we'll solve that.

10 MR. PICK: That would seem to me to be the
11 next step. Let's look at the aspects of the application
12 that are still kind of the hospital-borrowed model and for
13 us to be able to continue to move forward to make it more
14 unique to long-term care.

15 Chuck?

16 MR. FOLEY: Is there a way we could approve
17 the application as is right now and still continue, because
18 we do have -- the rule is already in place, 1125, and
19 current applicants are still using the old application
20 form.

21 MR. PICK: Existing, yes.

22 MR. FOLEY: So, I guess I'm just asking the
23 question. Could we approve this new one and still work on
24 the process and change it a month down the road or six

1 months down the road?

2 MR. PICK: We can't take any action. That's
3 the first thing. Here's my question: What new one? Do we
4 have a new application? I thought --

5 MR. FOLEY: We have a draft application form,
6 a new one, which is what Mr. Scavotto, I think, is talking
7 about.

8 MR. PICK: So I would have two problems. One
9 is, given the restrictions of comments that Mr. Scavotto
10 put forward, I think the draft still needs some revisions.
11 There are still some core issues there that have to be
12 addressed. And then the second is, we don't have a quorum
13 to approve it anyway. So, that would be my reaction.

14 Okay. Does anybody have any questions for
15 Mr. Scavotto or the other Mike?

16 MS. BURMAN: In addressing the issues that
17 Mike Scavotto brought up, we addressed all of the different
18 points, and I thought that had been sent out to everybody.

19 MR. SCAVOTTO: Well, they may have been
20 distributed here, but we haven't -- I'm sitting at this --
21 I'm coming at this from the standpoint that there was a
22 subcommittee assembled to work on this, and we haven't had
23 a chance to get to that yet.

24 MS. BURMAN: Right, but my point being that

1 there are some that I did point out as cannot be changed in
2 the application because it requires a rule change.

3 MR. PICK: Right, that's correct.

4 MS. BURMAN: One of the goals of what we're
5 trying to do is get something that we could use sooner than
6 later. Obviously the rule change will have to come at a
7 later point, when we start doing amendments to 1125.

8 MR. PICK: But aren't there portions that can
9 be changed without rule change, based on the review?

10 MS. BURMAN: Well, what we were just talking
11 about, the financial feasibility report, that's an example
12 of something that we can do something about without a rule
13 change.

14 MR. PICK: Okay. I thought -- Mike Scavotto,
15 correct me if I'm wrong. I thought there were aspects in
16 the application -- I'm trying to pull it back up -- that
17 are specific to hospitals that are not relevant.

18 MR. SCAVOTTO: That was my reaction. And --

19 MR. PICK: So I guess I'm trying to separate.
20 Are those rule-change governed?

21 MR. SCAVOTTO: I think in some cases yes, and,
22 Claire, I need your help on this one. We keep going back
23 and forth on the safety net issue and the charity care
24 issue. One of those is hospital and doesn't need to be

1 addressed, and the other --

2 MS. BURMAN: That was pulled out.

3 MR. SCAVOTTO: Is that safety care or charity
4 care?

5 MS. BURMAN: Both right now. Eventually
6 charity care will be included. It was inadvertently left
7 out of the rules, 1125. That's for all facilities. They
8 all have to submit charity care information. But because
9 it's not currently in 1125, it doesn't appear anymore in
10 the draft application.

11 MR. SCAVOTTO: Another issue I think I had was
12 this whole categorization of square footage, clinical and
13 non-clinical. It strikes me that that's really a hospital
14 term.

15 MS. BURMAN: I would defer to Mike.

16 MR. CONSTANTINO: That's what's in the
17 statute, Mike. That's why we're presenting it in that
18 fashion. We can only review clinical portions.

19 MR. SCAVOTTO: Well, maybe we've got an
20 opportunity to redefine "clinical".

21 MR. PHILLIPPE: There you go.

22 MR. CONSTANTINO: That would be great.

23 MR. PICK: So, I think -- that was my sense.
24 I think we do have the ability to modify the application

1 that are not necessarily governed in the rule, that the --

2 MR. SCAVOTTO: I think we can fulfill the
3 intent of the rules.

4 MR. PICK: Yes, but I think there are going to
5 be opportunities that are embedded in the rules because
6 they're hospital oriented that we can get to at the next
7 iteration, but I do think we do have an opportunity at this
8 stage to improve the application, to make it more long-term
9 specific. It won't be a hundred percent, but it will be
10 better.

11 MR. PHILLIPPE: Can I ask about the specific
12 one on the charity care? It's not in the rules yet, but it
13 will be?

14 MS. BURMAN: It will be, because the statute
15 requires that all facilities provide that information, all
16 healthcare facilities that are under the jurisdiction of
17 the Board.

18 MR. PHILLIPPE: That is -- I mean, if that's
19 in the statute, it's in the statute. It's one of the
20 things that it makes sense for a hospital. It doesn't make
21 sense for long-term care. It doesn't make any sense.

22 MR. PICK: Yeah, there's no Hill-Burton for
23 nursing homes.

24 MR. PHILLIPPE: What are you going to do?

1 Maybe the only thing you could do is admit foreigners.

2 That happens occasionally, someone that doesn't have
3 benefits.

4 MR. PICK: Again, from my own experience,
5 that's who I reported as my charity care, were non-citizens
6 that had no benefits that I ended up admitting for one
7 reason or another. That was free care. You're not
8 supposed to be reporting uncollected bad debt because
9 that's not charity care. Charity care is care given away.

10 MS. BURMAN: The other thing to know, however,
11 with that requirement is that it's just the reporting of
12 the data. There's no standard to measure it against right
13 now.

14 MR. PICK: It's self-reported.

15 MS. BURMAN: You submit it.

16 MR. PICK: It's whatever you say.

17 MR. PHILLIPPE: From the provider
18 perspective -- I know I heard this from several people.
19 It's not my own personal opinion. There's a certain
20 suspiciousness about the gathering of data that will be
21 used sometime later that will make us do something that
22 people won't like. They don't know what it is, but they
23 worry about it. But if it's in the statute, it's in the
24 statute.

1 MS. BURMAN: It's in the statute and,
2 therefore, it has to appear in the rule and the
3 application.

4 MR. PICK: I think that's an example of once
5 we have an opportunity to kind of sift through the whole
6 application as a subcommittee, we can recommend to the
7 Board that this is not relevant for long-term care, it
8 should be removed from the Statute as it applies to
9 long-term care, and then the Board decides what the next
10 appropriate step is.

11 MR. PHILLIPPE: Right.

12 MR. SCAVOTTO: Use another example -- Mike, I
13 want to go back to a conversation we had some time back
14 about self -- all of the requirements for getting referral
15 information in the application as it's written now. My
16 recollection is that you were having difficulty getting
17 that information.

18 MR. CONSTANTINO: Definitely. We have
19 difficulty from all healthcare facilities.

20 MR. SCAVOTTO: I think that's only natural.
21 It's going to be difficult to get that. I know, Claire,
22 that that's in the Act and we've got -- you're going to say
23 we've got to collect that, but I think we ought to think a
24 little more broadly. Why do we want to institutionalize

1 collecting bad data?

2 (Laughter)

3 MR. SCAVOTTO: Even though it's in the Act,
4 all we're doing is chasing our tails and we're not
5 advancing anything.

6 MR. CONSTANTINO: There's a requirement for
7 referrals in the Act.

8 MR. SCAVOTTO: I hear it's in the Act. I know
9 it's in the application.

10 MR. CONSTANTINO: It's in the application,
11 yes.

12 MS. BURMAN: It's in the rules.

13 MR. CONSTANTINO: But it's not in the Act, no,
14 no, not in the statute.

15 MR. SCAVOTTO: So do we have the flexibility
16 to do something with that criteria?

17 MR. CONSTANTINO: Yes. We'd have to go
18 through Claire and Rule Making to change that. What I'm
19 trying to get across is ESRD and ASTC's all have the same
20 issues that long-term care has with these referral letters.
21 The hospitals do, too. So it's --

22 MR. SCAVOTTO: I would think -- you're asking
23 the impossible, to have that -- that's not really going to
24 be an accurate database, useful to anybody.

1 MR. PICK: It's not reliable, I agree.

2 MR. CONSTANTINO: Claire would have to do the
3 rule making to change that.

4 MR. SCAVOTTO: I think we have an opportunity
5 to do some good work here.

6 MR. FOLEY: I guess the alternative then -- to
7 help Staff then, what would be a good alternative to ask
8 for rather than referrals that would be meaningful data
9 that we can then collect? And I believe that would be the
10 purpose of this committee.

11 MR. SCAVOTTO: What's the purpose of
12 collecting the referral data in the first place?

13 MR. CONSTANTINO: We're trying to get an
14 estimate of how many patient days will be there at your
15 facility.

16 MR. PICK: Other than the applicant reporting
17 what they think it's going to be.

18 MR. SCAVOTTO: I would -- one option that
19 comes to mind is to provide a specific market analysis as
20 opposed to your bed-need formula.

21 MR. CONSTANTINO: That was the other option I
22 was going to bring up today as part of the application,
23 that you ask for a market feasibility study where we could
24 identify the -- have the applicant identify all other

1 healthcare providers, such as home health, supportive
2 living, assisted living in that planning area.

3 MR. SCAVOTTO: It's possible that could be in
4 your financial feasibility study, if you wanted to make it
5 that comprehensive. So there's a lot of room to maneuver.

6 MR. CONSTANTINO: I know supportive living
7 asks for a market feasibility study. You could do the same
8 here.

9 MR. FOLEY: Because the Act does, in fact,
10 ask -- correct me if I'm wrong. The Act does, in fact, ask
11 for this specifically in terms of the other alternatives
12 that are in the long-term care community. So my question
13 is, is there a data source out there that one could tap
14 into that would identify home health agencies, that would
15 identify all the other alternatives? I know we have
16 assisted living and supported living, but there's no data
17 out there to identify, really, anything else specifically
18 within a geographic area, right?

19 MS. O'DEA EVANS: There's Medicare licensed --

20 MR. PICK: Medicare certified.

21 MS. O'DEA EVANS: Medicare-certified home
22 health providers, and then we do licensed care agencies now
23 in the state.

24 MR. PICK: You also have home and

1 community-based inventory, and there's a list of --

2 MS. MITZEN: There's a list of providers.

3 MS. O'DEA EVANS: And hopefully a list of
4 recipients of services.

5 MR. PICK: There's data available. There's --
6 the Department on Aging does maintain a list of home and
7 community-based services providers. They're not all
8 necessarily licensed and/or certified, because there are
9 categories of services that don't require that, but there
10 is a database available to access that information.

11 MR. FOLEY: We tried to contact, I know a
12 couple times, the area advocacy groups and was hoping that
13 they would be able to provide some of that information, and
14 they were not. At first they were very reluctant to
15 provide that information, and I thought the information
16 would be public information, but then we did get some, but
17 it was not a complete listing, is what I found out. So I
18 don't know --

19 MS. O'DEA EVANS: I don't think there is a
20 complete listing anywhere.

21 MR. FOLEY: That's my point.

22 MS. MITZEN: When you say "advocacy groups,"
23 what are you talking about?

24 MR. FOLEY: The Area Agency on Aging, people

1 like that is who we tried to contact.

2 MR. PICK: That is the appropriate source of
3 information, because there's where seniors are being
4 directed to contact when they need service.

5 MS. MITZEN: And they are working on bringing
6 that information together under one roof. The ADRC, the
7 Aging and Disability Resource Center, will be providing
8 that information, but it's a process also. So they are a
9 source, but not an absolute -- they're not there yet, but
10 it is a source.

11 MS. O'DEA EVANS: With the case coordination
12 units, too, they have to prescreen applicants prior to an
13 admission into a skilled facility and, of course, some of
14 those persons are also screened just prior to using
15 services. So I would think that, you know, there is
16 information. But as Phyllis said, gathering that
17 information specific to a specific location where you're
18 trying to build a facility is a little different slice of
19 the pie, and I'm not sure if it's readily available in any
20 kind of format.

21 MS. AMIANO: And it's a further layer of what
22 percentage of population would access those services versus
23 a facility-based type of services. So, it becomes kind of
24 burdensome.

1 MS. O'DEA EVANS: It is still required even if
2 someone is under 65. So, if anybody is going to have an
3 admission, they have to have a prescreen.

4 MS. AMIANO: No, I understand that, but in
5 terms of an application for --

6 MR. PICK: Well, yeah. I think as we're
7 talking about trying to determine a full, comprehensive
8 identification of services that are available in the
9 geographic area, it's possible. It doesn't mean it's
10 readily available, and I think there's an important
11 distinction.

12 MS. MITZEN: It's complicated to get. I
13 think at our last meeting we identified the fact that the
14 geographic area is defined by the nursing homes in terms
15 of --

16 MS. O'DEA EVANS: Right, but you could require
17 that whatever agency is servicing the location where you're
18 proposing a project is going to be built, that that
19 agency -- that you gather information from that agency as
20 far as how many people they serve and what their geographic
21 pattern is who they're serving, that that type of
22 information is included in their feasibility study.

23 MR. PICK: I think one of the things we have
24 to be cautious of is, before we require individuals to

1 provide the information, we need to validate that it's
2 really available. We can say, "You got to contact the
3 agency," and the agency says, "You're not a senior. I'm
4 not providing services to you. I'm not giving you any
5 information."

6 MR. PHILLIPPE: Could I ask why? Why do we
7 want to require this in the application? How does it help
8 you make a better decision?

9 MR. CONSTANTINO: I think it flows with what
10 you're doing with the bed need inventory, that you're
11 asking for the need inventory to identify these other types
12 of services being provided, home health, assisted living,
13 supported living. That's been -- my impression anyway,
14 that's been all part of that discussion, and until we reach
15 some type of conclusion on how we want to proceed with the
16 bed inventory calculation, this would be a step where they
17 would be identified in the application.

18 MR. PHILLIPPE: Because it does -- I
19 understand there's overlap. That's what we're talking
20 about, really. Long-term care is much bigger than skilled
21 care. There's an overlap, and that's clear. The question
22 is, if I do an application for one area, and I go out and
23 people are willing to give me the information and there's
24 lots of options for home and community-based services,

1 assisted living, and then I do another one in another
2 location, maybe there's much less available. Okay. Would
3 that change the process at all of the application? How --
4 I'm trying to get to how it would change -- everything we
5 do here costs money and takes time, really, and people are
6 not -- like you say, people are not always as willing to
7 give you the information if they think it's supporting some
8 competitor.

9 MR. CONSTANTINO: These are the concerns that
10 have been expressed to me, that all of these other services
11 are out there and taking away from the long-term care
12 services being provided, and this was an opportunity as
13 part of the application material where we didn't have to go
14 through the rules process, where they would -- could
15 provide us with a market feasibility study and identify
16 these other services being provided in that planning area.
17 That was my thinking behind it.

18 MR. PHILLIPPE: We talked about it in my work
19 group. We talked about the issue. The question is, how
20 does it feed into the decision? Because say I -- we do an
21 application one place; we have several supportive living,
22 assisted living in that area. Maybe they have high census,
23 maybe some don't have high census. The question is -- it's
24 useful, but the question is, how would we use it? If we

1 don't use it, is it worth the money to do it?

2 MR. SCAVOTTO: I think the only way it factors
3 into the decision is it drops the days per thousand in
4 skilled nursing.

5 MR. PICK: I think it also integrates with the
6 referral question. If you're running around asking
7 hospitals "How many skilled referrals are you making and
8 will you refer to this new project as a result of it," I
9 think the same question addresses what services are being
10 used in that community, which would include supportive
11 living, assisted, home care, and how do all these pieces
12 fit together? So, I think the pre-existing model that
13 said, well, we want -- "How many projected referrals are
14 you going to get from the surrounding hospitals for this
15 project" -- and that's been the historic basis for the
16 decision for utilization moving forward -- that now that
17 decision has to be incorporated in a broader context that
18 looks at what are all of the community services that are
19 being made available to that same client base, and how does
20 this project determine its projection and validate its
21 projection that its utilization will hit its target, given
22 these services being available in the same service area.
23 So, I don't see one replacing the other. I think it
24 becomes a more robust evaluation of where are services

1 being consumed, how do they all fit together, and how do we
2 validate that a 200-bed facility can be viable when you
3 also take a look at all of these alternatives.

4 MR. PHILLIPPE: So, if you have the 200-bed
5 facility you're wanting and you do a good job -- because I
6 think before you build, you've got -- you should know that
7 anyway. Every provider that is doing their job is going to
8 know that information anyway, because you're part of a
9 system, and you want to do it well. So that part makes
10 sense to me logically. The question is for the
11 application. If you have a lot of assisted living or none
12 in a market, does that make a difference?

13 MR. PICK: I think it does.

14 MR. PHILLIPPE: In terms of the decision
15 that's made?

16 MR. SCAVOTTO: The decision that's made where?

17 MR. PHILLIPPE: At the CON process. That's
18 all we do here.

19 MR. FOLEY: The other question is, even if
20 we're able to identify all of the assisted living and
21 supportive living facilities within the applicant's market
22 area and even if we could go as far as getting their
23 utilization for each facility, which, by the way, is also
24 difficult to obtain --

1 MR. PHILLIPPE: Very difficult.

2 MR. FOLEY: Okay. So now we have it. What
3 does it mean? We can't use it as part of the review
4 process, because assisted living and supportive living is
5 excluded from the Act in the first place. So, either we
6 have it or we don't have it.

7 MR. PICK: You're mixing two things together.

8 MR. FOLEY: I understand that, and I'm doing
9 it intentionally.

10 MR. PICK: They're not part of Planning, but
11 the skilled nursing is part of Planning, and they're in the
12 market.

13 MR. FOLEY: That's absolutely correct. So
14 what are they going to do with it if we do have it? What
15 can Staff do with it, if we do have it, to help them out?

16 MR. PICK: No, no, no. This is not a Staff --
17 it's ultimately a Staff issue, but it's a provider issue.
18 I think Tim's comment is right on target. It's an
19 appropriate aspect of how to determine whether a project
20 should move forward.

21 MR. FOLEY: I agree.

22 MR. PICK: Again, I think fundamentally, the
23 issue really it comes back to is, if the service is
24 essentially the same, if the skilled nursing provider is

1 planning to provide the same level of chronic supportive
2 care at a chronic level that an assisted living facility is
3 also doing, there's something wrong in the planning process
4 for that provider, because they're not going to be
5 successful. So, it forces, as it should, for the skilled
6 nursing provider to really think about what am I
7 introducing to this market? If all I'm doing is offering a
8 different place to sleep and eat, it's not going to be
9 successful, and the Board shouldn't be approving it to
10 begin with. It's got to go back to "As a skilled nursing
11 provider, I'm providing a service that's needed by
12 individuals in this community, that is revolving around a
13 very well-defined niche. I'm here to rehab; I'm here to
14 provide recuperative services for people after the
15 hospital, and these are not services that are easily
16 accessible in the assisted living process, and, therefore,
17 there's a need that's not currently being met." If what
18 they are doing is providing exactly the same thing, that's
19 a problem, and there's going to be a problem with that
20 project whether the CON Board approves it or not.

21 So, I think it goes back to that's why it's in
22 the Act that you have to consider the alternative services,
23 because in years past, you didn't need to. Skilled nursing
24 was an environment that provided chronic care, was a place

1 for people to live because they didn't have anyplace else
2 to be. Now they do. So, it has to be incorporated into
3 the planning process from the project stage, that when the
4 provider comes forward and says, "We feel there's a need,
5 there's a bed need based on the Planning Board's
6 calculation, and we want to be able to build X number of
7 beds; we can serve that population" -- well, maybe that was
8 true in the 1980's but we're now in the 2010's.

9 MR. FOLEY: How do you draw that line in an
10 assisted living or supportive living facility as to whether
11 or not they are both providing the same level of service on
12 the DON score?

13 MR. PICK: It goes back to what the project
14 originator is saying they're going to be using this for. I
15 don't think it's -- the DON screen is used to determine
16 eligibility through different --

17 MR. FOLEY: For level of care.

18 MR. PICK: For level of care, right. The DON
19 screen as a tool -- if the skilled provider is saying,
20 "Well, I'm going to only position myself for people higher
21 than a 26 on the DON," you're still going to end up with a
22 very small number, and, in fact, if you do look at the
23 reports that are coming at the Department on Aging, the
24 community services can handle people with much higher

1 scores than a 26. So that by itself isn't going to make
2 the project viable in and of itself.

3 MR. FOLEY: So is it that -- we need to find
4 out how to document that, and that's the problem out there,
5 because that need is not known.

6 MS. AMIANO: I think it's all over the board,
7 just as you can provide skilled level services in someone's
8 home. You -- if you've seen one assisted living, you've
9 seen one assisted living. Some may have a social approach.
10 Some may have nurses on staff. Some may have more than one
11 nurse for ten hours a day. So, it's all over the board.
12 So, I think the process needs to be mindful that you can
13 care for anyone in virtually any setting.

14 CHAIRMAN WAXMAN: The other issue that is
15 involved is not only what information you can find
16 statistically, but it's the perception of the purchaser, of
17 the consumer, as to who is providing what services. So, we
18 can define, this is skilled, this is assisted living, this
19 is supportive, but that may be totally different than how,
20 when I'm looking for a place to put my favorite aunt or my
21 least favorite aunt, where I'm going to put them. So the
22 perception of the consumer is also part of this definition
23 piece that is going to be different than how we legislate
24 it out.

1 MS. O'DEA EVANS: Also, the hospitals are
2 trying to create medical home, and that's a whole new area
3 that we really haven't discussed here. Medical home by
4 definition is to create an environment in the home that can
5 handle the most complex medical needs of the patient and to
6 treat them in that environment.

7 MR. FOLEY: Have we looked at the cost of that
8 to see if the cost of home care is much higher than it is
9 in the nursing home?

10 MS. O'DEA EVANS: It may be higher, but that
11 is one -- it might be less. So they're looking at that as
12 their model, and what's happening is --

13 MR. PICK: It's not about cost. It's
14 effectiveness.

15 MS. O'DEA EVANS: It keeps them out of the
16 hospital, basically is the motivation, but it's also where
17 the client prefers to have treatment, and it can be managed
18 very effectively with case management.

19 MS. MITZEN: And nursing homes are partnering
20 with hospitals to provide an aspect of the medical home
21 environment.

22 MR. PHILLIPPE: That's true. There's two
23 issues I think are getting confused, in my mind at least.
24 One is what Eli said in terms of if you want the

1 application to require people to do an assessment of the
2 community just because it's good for the provider, it won't
3 change the CON decision. It's not used in a formula, what
4 you're talking about. It would be good for the provider
5 discipline for them to look at that, because if they're
6 doing their job, they should be doing it anyway. That
7 makes sense. But the second part of that is how we include
8 that in the CON process, and that's kind of what's being
9 talked about here, and, you know, when I go to meetings --
10 and I've been to some outside of the state, like some of
11 you have, too -- everyone says we are moving quickly,
12 dramatically, to home and alternate settings to skilled
13 nursing for kind of routine care. I mean, it's happening
14 more dramatically in some states than it has in Illinois,
15 but it's across the board. So that causes some of us, when
16 we're having a discussion about the bed-need formula, to
17 say how do we include it, because the other side of the
18 question is, it is important because some of the people
19 that would have been in a nursing facility 10, 15 years ago
20 are now at home, they're in assisted living, they're at a
21 variety of locations. But we're using the same formula.
22 It's difficult to figure out how to change it, because
23 other states are actually trying to downsize the number of
24 beds in their state because they feel like they're less

1 needed than they used to be. So both of those issues, I
2 think, we're talking about.

3 MR. PICK: As Mike just pointed out, it's
4 happening in Illinois as well. Utilization is dropping for
5 a very specific reason.

6 But I think if I can recap our decision, I'm
7 sensitive to Chuck, who is in the business of helping
8 people put applications together, trying to understand how
9 do I put all of these pieces together to help the client
10 who is trying to put a project together, which, you know,
11 we have an existing process, and we have this entity, which
12 is us, the subcommittee, who has been charged with
13 redesigning the process, because there's been acceptance
14 from a public policy standpoint that the existing system
15 has to change. Right? We've gotten input from the
16 industry that says we've got to change the application
17 because it's a hospital application, it's not a nursing
18 home application. We have input from the community that
19 says we're using all kind of other services other than
20 skilled nursing and that's not being taken into account in
21 this planning process and needs to be.

22 And that's our charge. Our charge is to bring
23 those things together and integrate them so that as the new
24 process moves forward, it's more responsive to these two

1 constituencies. That's what we're here to do.

2 MS. MITZEN: I don't know whether this is
3 redundant or not, but I think it even goes beyond that,
4 Eli. I think it's -- the medical home that Pat just talked
5 about is only the tip of the iceberg in terms of the
6 changes that are going on in both medical care as well as
7 chronic care, and the world is going to be extraordinarily
8 different. I mean, I live in the aging world, but aging
9 and disabilities is rapidly moving together, and I don't
10 know how that happens then at Mike's desk in terms of how
11 you decide what's then needed in the community. But I
12 think unless we can provide some more flexible guidelines
13 in this process, I think five years from now we're going to
14 be -- we're -- the process is antiquated right now, and
15 five years from now, we don't want an antiquated process
16 because of what we've done.

17 MR. PICK: As a concluding comment, I think
18 one of things we have to be careful about is not running
19 too far ahead of our charge and actually being able to
20 implement it.

21 MR. SCAVOTTO: Or my committee.

22 (Laughter)

23 MR. PICK: Change has to occur in stages, that
24 we can't kind of leap frog from the system that we have now

1 to being well positioned for where the future is going to
2 take us.

3 MS. MITZEN: I agree with you.

4 MR. PICK: We have to incorporate that lens
5 when we're looking at this, that our goal needs to be that
6 not -- that we need to move where we are today to be more
7 sensitive and incorporate those contemporary dynamics that
8 are occurring. We have to try and be sensitive to making
9 sure that we're on the right path, where as things continue
10 to evolve, that we don't have to go through a monumental
11 effort to redesign again, but we also have to be sensitive
12 to the fact that we're part of a political process, that if
13 we come back with a model that we're proposing that has --
14 that we've run into resistance on the part of -- whether
15 it's the skilled nursing community, the home and
16 community-based community or the hospital, the medical
17 community, the reality is it's dead in the water anyway.
18 So, all of our efforts won't yield any improvement. So we
19 have to somehow integrate all of these different dynamics
20 so that we end up with some progress. And some progress is
21 better than no progress, and that's an important aspect we
22 have to keep in mind. We want to move, but we need to
23 evolve. We don't want to transform, because transforming
24 means that it won't go anywhere, and I think that's just

1 the harsh reality of our environment.

2 I think we've well discussed this topic. I
3 think the direction to Mike Scavotto, as Chair of the
4 application committee, is that those things that are in the
5 rules we have the ability to modify. Those things that are
6 statutory, we have to then make recommendations to the
7 Board, to seek their approval, to then move forward to
8 request a statutory change and go through that process, and
9 those are the things that we're trying to get done. So, I
10 think that's kind of my read of the general consensus.

11 MS. O'DEA EVANS: You know, I think also part
12 of this isn't just -- I know we're talking about the
13 application, but I just want to bring into play the process
14 itself. It sounds like Staff really wanted to have
15 concrete data to make decisions on, and we're talking
16 about -- you know, when we talk about market feasibility
17 and all of that, that's not necessarily a concrete
18 summation. It's more subjective in some ways, and so I
19 think I'm hearing -- often there's this issue about is this
20 data something we can hang our hat on or is it something
21 that we're just discussing? So I'm not sure enough about
22 the process itself. You know, how do applications -- you
23 know, when they do come in and they're reviewed by Staff
24 for consent, you know, then where does it go from that

1 point? And then who is able to make the decisions about
2 the actual application?

3 MR. PICK: I think that's the charge of the
4 work group.

5 MS. O'DEA EVANS: So we really don't have that
6 process at all?

7 MR. PICK: There's a process, an established
8 process, and what we've asked the work group to do is look
9 at the established process and make recommendations to us
10 as a subcommittee on how that can be improved, and what
11 we've heard discussed this morning is one issue that is
12 going on right now.

13 MS. O'DEA EVANS: Is that charge under the
14 application subgroup?

15 MR. PICK: I think so.

16 MS. O'DEA EVANS: All right. Thank you.

17 MR. PICK: So, with that, I'll turn it over to
18 Mike as the Chair.

19 CHAIRMAN WAXMAN: I was enjoying sitting here
20 minding my business. You know, please don't take the
21 following comment in the wrong way, but I was sitting here
22 and really for the first time not having to be concerned
23 about making sure I recognized everybody and run a meeting.
24 Thank you; you did an incredible job. But I now recognize

1 how much talent is in this room, how much experience and
2 professionalism is sitting around this table, and I'm
3 really grateful that this group is working on these
4 questions, because they're really, really difficult
5 questions. But it was interesting to sit here as a
6 bystander, if you will -- although I was thinking -- but to
7 see that. So, again, thank you all for participating.

8 To get back to Pat's question, Mike, can you
9 give us a quick summary and explain the process of what
10 Staff goes through on an application?

11 Is that what you're looking for?

12 MS. O'DEA EVANS: I'm hearing there is a
13 process already.

14 CHAIRMAN WAXMAN: Mike lives it every day, so
15 if you want him to take 30 seconds and explain it to you --

16 MS. O'DEA EVANS: That would be helpful.

17 MR. CONSTANTINO: Applications are submitted
18 with a required fee, Pat, and we review for completeness
19 whether or not the applicant has addressed all of the
20 relevant criteria. We then have, in most cases, 60 days to
21 review an application and write a report. Sometimes a
22 public hearing is called for, sometimes not. The report,
23 we go through each relevant rule in the 1125 Section and
24 determine whether or not the applicant has met the

1 requirements of the rule. That's essentially what we do on
2 all of the applications.

3 Right now we're accepting referral letters, as
4 Mike pointed out, to get some idea for demand of the
5 project. Personally, I've always thought maybe a market
6 feasibility study would be helpful, but I always assumed
7 that all applicants had already prepared one and wouldn't
8 be additional work for them to provide it to us. So,
9 it's -- essentially it's the same for all of the
10 applications we receive.

11 Then we do ask for additional information, if
12 we feel that -- especially with financial -- the financial
13 issues that we've -- that has been coming up the last
14 couple of years.

15 MS. O'DEA EVANS: Just a question. For
16 example, if someone submitted -- is there a minimum number
17 amount of referral letters?

18 MR. CONSTANTINO: They have to justify the 90
19 percent within two years, 90 percent occupancy within two
20 years.

21 MS. O'DEA EVANS: So the referral letters, how
22 is that measured then?

23 MR. CONSTANTINO: They identify the numbers of
24 individuals that would be referred to their long-term care

1 facility within the next two years, and those referral
2 letters are generally from hospitals, and then we do a
3 calculation.

4 MS. O'DEA EVANS: I mean I have read some of
5 the letters and so forth, so I know what the content looks
6 like, but -- so, actually, you're measuring -- so this CEO
7 of this hospital says he's going to refer X amount of
8 patients, and you're actually using that as data?

9 MR. CONSTANTINO: Yes.

10 MS. O'DEA EVANS: Wow. That's very
11 interesting. Okay.

12 MR. PHILLIPPE: Just one point. I wondered --
13 just in terms of the application process, the Staff has to
14 do a lot of work, it looks to me like, in reviewing the
15 applications and coming up with an analysis. So, just as
16 your work group is looking at this, are there things that
17 are creating work for the Staff that aren't necessary?

18 CHAIRMAN WAXMAN: Aren't necessary?

19 MR. PHILLIPPE: Yeah. There may be some
20 things in here that are creating work for Staff that we can
21 find are not useful. So, I want to ask the work group to
22 consider that. That's all.

23 MR. SCAVOTTO: The work group is tuned in to
24 that.

1 CHAIRMAN WAXMAN: Mr. Foley?

2 MR. FOLEY: I was just going to make a comment
3 to substantiate what Mike was saying, quite honestly, that
4 a market study is normally required anyway when you go to a
5 lending institution. So, having it up-front in the CON
6 process really does, in fact, make sense, and it does give
7 an applicant more of the desire to determine whether or not
8 he wants to proceed with the project or not. So, I think a
9 market study is good.

10 MS. AMIANO: I would just remind you, there's
11 a big difference between doing a market study that gives
12 you a flavor of "I think this is a good idea, let me test
13 the market" versus a market study for financing purposes,
14 two totally different things. So, again, there's a lot of
15 cost wrapped up, because you have architectural fees, you
16 have a lot of costs wrapped up in getting that CON
17 application to the Board. So, back to Eli's point
18 originally, I think everyone wants projects that are good
19 to move forward, but it has to be the right balance of cost
20 at the right time in the process. Any good provider does
21 the full market study but not necessarily that early in the
22 game, because if you don't get the CON, why would you spend
23 50 grand doing that? Really? I know the consultants love
24 that, but, you know --

1 CHAIRMAN WAXMAN: Okay. So, Mike, it's back
2 to you, with some input of your group, back in your court a
3 little more longer.

4 MR. PICK: Mr. Chair, could you remind us who
5 is on the work group?

6 MR. SCAVOTTO: Carolyn Handler and Cece.

7 CHAIRMAN WAXMAN: Right, and Cece had an
8 emergency family issue, so she's not here today, and
9 Carolyn has a State audit going on.

10 MS. O'DEA EVANS: I just have a -- right now
11 we're not able to function right as a --

12 CHAIRMAN WAXMAN: We can't vote.

13 MS. O'DEA EVANS: As a voting body. So, is
14 there any effort being made to locate people that -- do we
15 know where all of the absences are, or is there someone
16 outstanding that we still might be expecting?

17 CHAIRMAN WAXMAN: I don't know the answer to
18 that question.

19 MR. CONSTANTINO: The last I heard last night,
20 there were seven that responded to Courtney's e-mail that
21 were going to attend.

22 CHAIRMAN WAXMAN: To be perfectly honest with
23 you, judging from the number of people that are on the
24 phone call with the work group, I assumed the meeting would

1 be packed. I'm amazed that --

2 MS. O'DEA EVANS: So, those who are absent,
3 can we reach out to them and inquire what their status is?

4 CHAIRMAN WAXMAN: They're not here.

5 (Laughter)

6 MS. O'DEA EVANS: We all have cell phones
7 so --

8 MR. PICK: There are seven voting members
9 here.

10 MS. O'DEA EVANS: Are we okay then?

11 CHAIRMAN WAXMAN: We need ten, right, Frank?

12 MR. URSO: Yes.

13 CHAIRMAN WAXMAN: And two had emergencies
14 that I'm aware of.

15 MR. PICK: I think, going back to your
16 question, Pat, it's -- we have several members who have not
17 attended for the last four or five meetings. So --

18 CHAIRMAN WAXMAN: And we have one
19 resignation.

20 MR. PICK: That is --

21 MS. O'DEA EVANS: Does the resignation change
22 our committee size?

23 CHAIRMAN WAXMAN: No. Unless the Mother
24 Board allows us to reduce the size of the committee, it is

1 an open position.

2 MS. MITZEN: Who resigned?

3 CHAIRMAN WAXMAN: Stephanie.

4 MR. PICK: Mike and I met with Dale, the Chair
5 of the Board, and raised this exact issue, that we're
6 hampered because there are people who are not participating
7 and we still have to meet the same quorum requirements.
8 So, it's been raised and it's being discussed.

9 MS. O'DEA EVANS: So our procedure then is
10 we're going to -- are we going to address the agenda items
11 and just not vote or -- is that our plan of operation?

12 MR. PICK: That's right, and we'll vote when
13 we have a quorum.

14 CHAIRMAN WAXMAN: We certainly can reach
15 consensus of the group, but we can't make an official vote
16 unless we get the last remaining.

17 MR. PICK: To your point, given the number of
18 people that were on the conference call, I think with a
19 phone call, we'll have a quorum.

20 CHAIRMAN WAXMAN: I'm amazed there aren't
21 tons of people here, because there certainly were a lot
22 more on the phone call than this. So, therefore, I assume
23 the subject of -- the topics of the agenda were -- had such
24 pull, if you will, that I figured the place would be packed

1 and we'd have open galleries and all that stuff.

2 MR. PHILLIPPE: The work group just keeps
3 getting bigger. We'll eventually have twenty.

4 But the other side is really technical. The
5 issue is probably travel. I mean, somebody can stay at
6 their job and take an hour or an hour and a half off and
7 attend a work group. If they live farther away, it's the
8 travel time. They have to take the whole day off and
9 travel.

10 MR. PICK: I think that's part of it. I think
11 the other part is, if I said my piece on the work group and
12 the work group has reached a consensus that I'm okay with,
13 why do I need to come to the sub-committee meeting, if it's
14 just going to be a repeat of the same.

15 MR. PHILLIPPE: That's encouraging. You think
16 that the work group I was involved in reached a consensus.
17 I would take that as success then.

18 (Laughter)

19 CHAIRMAN WAXMAN: I think your work group was
20 tremendously successful. I really do. I think it was.

21 I'd like to ask the group if I can move Item 6
22 to a later time frame today, because the people who are
23 invited --

24 MR. PICK: Well, one of them is here.

1 CHAIRMAN WAXMAN: Okay. Thank you.

2 MR. PICK: Mr. Sullivan called and asked me --
3 he'll be here by one, so if that presentation could be held
4 until after lunch.

5 CHAIRMAN WAXMAN: Okay. In that case, Frank,
6 we're at Open Meetings and --

7 MR. URSO: Okay. Thank you. At our last
8 meeting, which I think -- well, at least I have a memo
9 dated January 31st -- I submitted an Open Meetings Act
10 comment and said everybody needs to do their Open Meetings
11 Act training and that their certificate needed to be in by
12 March 20th, which was the tentative meeting for this group.
13 So, we're meeting today instead of March 20th. I would
14 just like to please ask everyone who hasn't done the Open
15 Meeting Act training requirement that's now a requirement
16 to please do that, and if anybody needs the instruction
17 sheet -- because you have to go to the AG's web site to do
18 this training. If anybody needs that, please let me know
19 and I'll make sure you get the instructions on how to get
20 in to that particular web site, and if you can complete
21 that and get the certificate of completion form back to
22 myself or, you know, one of the offices, then we'll --
23 either the Springfield office or the Chicago office, then
24 we'll make sure that we all comply with that particular

1 statutory requirement.

2 MR. PICK: Can I ask how many you did get?

3 MR. URSO: We'll get --

4 MR. PICK: Approximately.

5 MR. URSO: Maybe four or five.

6 MR. PICK: So, do we need to provide some
7 stimulation on the part of the Chair and Vice-Chair to
8 follow up and encourage people to get these in?

9 MS. AMIANO: Could you send out an e-mail with
10 a link? That would be great. I promise to do that.

11 MR. URSO: We can send out an e-mail to
12 everybody.

13 MS. MITZEN: To remind those of us who might
14 not have done it.

15 MR. URSO: We can send everybody a reminder
16 e-mail.

17 MS. AMIANO: We apologize. Nothing worse than
18 having to chase professionals down.

19 MR. URSO: If there are no questions on the
20 Open Meetings Act training requirement, there's the ethics
21 training that's another annual, statutory requirement, and
22 I have that with me. It's a paper copy. We will provide
23 this to everybody. There's a number of documents you have
24 to read and then sign off on the certificate of

1 participation. If you can get that certificate to me or
2 send it to our offices in Springfield, then we'll mark you
3 off on the list. So, before everybody leaves -- unless you
4 want me to do it right now, Mike, I can hand it out.

5 CHAIRMAN WAXMAN: Sure.

6 (Pause)

7 MR. URSO: Cathy, can you answer the question
8 about how many people did the Open Meetings Act training?
9 I thought it was about four or five maybe.

10 MS. CLARKE: Four or five.

11 (Discussion held off the record.)

12 (Recess)

13 CHAIRMAN WAXMAN: Frank, do you need to say
14 anything else on these two subjects?

15 MR. URSO: The only thing I wanted to mention,
16 in case it wasn't clear on the paper that we handed out,
17 the certificate of participation is the last page. So the
18 expectation is you will go through everything and you'll
19 get to the last page --

20 CHAIRMAN WAXMAN: That you'll read it and not
21 just go through.

22 MR. PICK: Unless you're on other State boards
23 who have the same training.

24 MR. URSO: But it's the last page that you

1 need to return to myself.

2 CHAIRMAN WAXMAN: Okay. Did we lose anybody?
3 I don't see any new faces. I think we're still in the same
4 spot. Okay. Thank you for agreeing to move 6 to a little
5 later time.

6 Tim, I think we're at your work group.

7 MR. PHILLIPPE: We've had a busy work group
8 since last meeting. As I said, we started with the idea of
9 a work group to have a smaller group that would focus, and
10 our last call had at least 13 people on it.

11 MR. WAXMAN: That's why I didn't think we'd
12 have a problem having a quorum at this meeting.

13 MR. PHILLIPPE: I think we had two good
14 discussions. I wrote about it.

15 MR. CONSTANTINO: I have copies, if someone
16 wants it.

17 MR. PHILLIPPE: Judy needs one at least.

18 (Pause)

19 MR. PICK: I don't have it.

20 MR. PHILLIPPE: Anyway, we basically focused
21 on the two topics. One is operational beds versus licensed
22 beds in the bed-need formula and trying to deal with the
23 issue of licensed beds that are not in use, and it's very
24 complicated, as we can all imagine. It was very helpful --

1 Mr. Green provided the report that -- his analysis based on
2 the annual questionnaire that is filled out. That was
3 actually very helpful in understanding peak beds and beds
4 in use on December 31st and that whole list, and Eli made a
5 proposal that was very, very limited, to try to get a first
6 step -- that's the way I perceived it -- of just really
7 taking that into account, actually, for new facilities
8 after they're built, and even that ran into a number of
9 questions that were identified.

10 MR. PICK: I thought there was enough
11 controversy. I didn't want to add any more.

12 MR. PHILLIPPE: It shows how difficult the
13 issue is. The proposal was very, very limited, and it
14 still had numerous issues to consider, and they're real
15 issues that people brought up.

16 And then the second one was looking at bed
17 transfers, buying and selling beds or transferring or
18 whatever, and I think all we've accomplished there so far
19 is looking at the positives, why we might look at that, and
20 then identifying the major themes to talk about, to
21 discuss, and then we prioritized -- the people who chose to
22 vote, we had a priority of which themes we should talk
23 about when.

24 The idea -- my idea from the work group, I

1 didn't think we could decide and make a proposal, kind of,
2 ready to go to the full subcommittee. The idea was, if we
3 can eliminate the issues and organize the information about
4 each of the individual issues, then we could provide that
5 to the full subcommittee. So that's where we started, and
6 we've had good discussions.

7 CHAIRMAN WAXMAN: Had excellent discussions.
8 Does anyone have any questions for Tim?

9 MS. AMIANO: So what is the recommendation to
10 the full committee?

11 MR. PHILLIPPE: There is none. I don't think
12 we're at the point to make a recommendation. You guys were
13 in all of the meetings. Is that fair?

14 CHAIRMAN WAXMAN: Yeah. I guess my gut
15 feeling at this point -- and I really want to thank Tim,
16 because he really walked into a lot of work, probably more
17 than I realized and probably more than Tim realized, and I
18 think he did an incredible job of organizing it, and as
19 Chair, I'd like to thank him publicly and privately for
20 what he's done.

21 What's clear to me is, because there is so
22 much discussion going on at the work group level, that I
23 think it needs to come back to this group and be handled in
24 the large group setting, because some of these people

1 really want to partake in the discussions and have very
2 strong opinions about it. I think it has to come back to
3 the full work group or full subcommittee as a subject for
4 us to deal with. Now, the good news is that a lot of the
5 issues have been discussed and understanding, I think, has
6 been increased. Eli's memo, I think, helped a lot. Tim's
7 work has helped a lot. Claire's work has been really very,
8 very useful. So, I think the people who participated,
9 which is larger than the work group itself, certainly have
10 a better understanding, and I think for our next meeting,
11 we can tackle that problem or tackle that question as a
12 full group.

13 And, Judy, glad to see you back, by the way.

14 MS. AMIANO: Thank you.

15 CHAIRMAN WAXMAN: I think it's not an easy
16 topic. It's not an easy subject, and it's probably more
17 controversial than I ever thought it was, just as -- you
18 know, it's worse than the Cubs versus the Sox.

19 MR. PHILLIPPE: It's tough.

20 CHAIRMAN WAXMAN: It's tough. Or do I have
21 to say St. Louis, Mike?

22 MR. SCAVOTTO: You don't have to. You can if
23 you want.

24 (Laughter)

1 CHAIRMAN WAXMAN: Anyway, I think back at
2 this meeting, when we -- I don't think we have a scheduled
3 date for our next meeting, do we? Does Staff know? Do we
4 have --

5 MR. CONSTANTINO: I don't know, Mike.

6 CHAIRMAN WAXMAN: Courtney went on vacation.
7 We need to talk about that.

8 MR. URSO: We did have a list of proposed
9 dates, if I can find them.

10 CHAIRMAN WAXMAN: That's right, we did. But
11 probably not -- anyway, I think it has to be the topic of
12 our next.

13 MR. PHILLIPPE: I would agree. I think we
14 scratched the surface a little bit, but it's clearly too
15 complex to talk about it in one-hour conference calls, and
16 even outside the committee, like Chuck or Terry Sullivan,
17 have been very helpful in giving us information, and Jason
18 Speaks did a couple of meetings ago. So, I think we've had
19 other people -- Claire's work was great. It's helped us
20 understand what other states do and what they learn from
21 that. But I think it's time to bring it here. I agree.

22 CHAIRMAN WAXMAN: Tim, I really hope you feel
23 that the fact that I suggest it comes back to this meeting
24 is in no way saying you didn't do a phenomenal job.

1 MR. PHILLIPPE: No. You saved me from
2 resigning. Great leadership.

3 CHAIRMAN WAXMAN: We certainly don't want
4 that to happen. So, I think it will come back, and, again,
5 there's a ton of material out there on the subject that has
6 been disseminated, so we should all be prepared at our next
7 meeting to address that and should probably be the topic of
8 our next gathering.

9 MS. MITZEN: How will we focus that
10 conversation, and what do we want to have come out of it?

11 CHAIRMAN WAXMAN: There you are again, being
12 practical.

13 MS. MITZEN: Sorry. We spent a lot of time
14 on this, and I think we do need to be focused and we do
15 need to have -- perhaps we need to go over -- I don't know.

16 CHAIRMAN WAXMAN: Claire is on the agenda
17 today to go over -- aren't you, Claire?

18 MS. BURMAN: Yes.

19 CHAIRMAN WAXMAN: Yeah. Bed transfer issues
20 of other states. So, I think she is going to go over that
21 today, and I think our two issues are to come up with a set
22 of rules on --

23 MR. PICK: I would say instead of proceeding
24 with the rules, we still need to reach a consensus, because

1 we're still not there.

2 CHAIRMAN WAXMAN: Again, the topic is whether
3 or not we want to propose buying and selling beds and
4 transfer beds, and I agree with you. I made an assumption.
5 We have -- there has to be a consensus, and then the
6 proposed rules of how to buy, sell, and transfer beds, and
7 then the other topic is, you know, what -- that may take
8 the meeting, just that topic, but I think if we can pass it
9 on to the Mother Board after our next meeting, that would
10 be an accomplishment, with our recommendations that this is
11 what we want to propose.

12 MS. MITZEN: So we want to reach a consensus
13 on that and then the process?

14 CHAIRMAN WAXMAN: Absolutely.

15 MR. PHILLIPPE: So you're thinking one
16 meeting? What, a consensus on --

17 CHAIRMAN WAXMAN: That this group wishes to
18 propose a set of rules on the buying and selling and
19 transferring of beds, that there is a consensus, that this
20 subcommittee agrees that we should have in the State of
21 Illinois a process of buying, selling, and transferring of
22 beds. Assuming that we get that consensus or assuming that
23 the group says we don't have a consensus and, therefore, we
24 don't agree that there should be rules, then, of course, we

1 don't have to worry about the rules to make it happen. If
2 there is consensus that we should have in the State of
3 Illinois a process for buying and selling and transferring
4 beds, then I would hope that we could then put a framework
5 in place so we can move that up to the Mother Board for
6 them to act on it.

7 MS. MITZEN: So if we agree on whether or
8 not, then we would then move toward developing the process,
9 which we may or may not get to at the next meeting?

10 CHAIRMAN WAXMAN: Right.

11 MS. AMIANO: If I could make a suggestion,
12 because we have a variety of perspectives in the broader
13 group, that if we could spend -- what might be helpful to
14 get everyone at a common place of understanding, if we
15 could start that day with a framework or some education
16 around it so that -- because we have people who come here
17 that don't know anything about this issue and other people
18 who are well steeped in it. I think if we could all get to
19 a common place of understanding of what is the issue, then
20 a consensus might be a more achievable target.

21 CHAIRMAN WAXMAN: I agree with you, and part
22 of having Cathy and Terry here this afternoon is to make
23 sure that everybody understands where the three
24 organizations were when they addressed some of these

1 subjects, so that everyone who is here will hear that
2 information, and then Claire has certainly laid out what is
3 available in other states. So, I agree with you, I agree
4 with you, totally agree with you.

5 MR. PHILLIPPE: Can I suggest something else?
6 Cathy was not really involved at that point in all of these
7 discussions because -- you may have come on Board after
8 that.

9 MS. NELSON: Yes.

10 MR. PHILLIPPE: But Judy was very involved.
11 We took it from the small group to really one person from
12 each association as a member and one -- she was very
13 involved, and I think she can give you a good background.

14 MR. PICK: We were there.

15 MS. AMIANO: It was painful. That's why I
16 don't want to repeat that pain.

17 CHAIRMAN WAXMAN: Tim, I thought you were the
18 person.

19 MR. PHILLIPPE: At the very end, it was really
20 just Judy and somebody from the associations. She was
21 Chair.

22 CHAIRMAN WAXMAN: Judy, you know, you're
23 always welcome to share.

24 MS. AMIANO: I just -- I know that there are

1 very divergent opinions on this very subject, and trying to
2 think about how we navigate that path so that it's not
3 torturous. We have been having this discussion now for --
4 Tim and I were talking -- four years --

5 MR. PHILLIPPE: At least three.

6 MS. AMIANO: This identical discussion.

7 CHAIRMAN WAXMAN: I understand that from
8 Phyllis --

9 MS. AMIANO: I take Phyllis's comment of how
10 we get there. I'm trying to think that through in terms of
11 what will help folks.

12 MS. MITZEN: I think you've been having those
13 discussions, but we have not. I'm listening to you and I
14 don't know any of these parties, and yet I sit on this
15 committee, and if I'm going to be taking that
16 responsibility, I want my voice to be heard, but I need to
17 have an intelligent voice to enter into this conversation
18 that you guys have been having.

19 CHAIRMAN WAXMAN: This topic has been talked
20 about at other committees that you've been part of, right?

21 MS. MITZEN: Yes, but probably not in
22 terms -- not the way you guys -- not at the level and not
23 with the detail.

24 MR. PICK: For Judy's benefit, at the Older

1 Adult Services Committee, they talked about bed conversion,
2 converting beds to assisted and residential beds. So,
3 while it wasn't for sale or transfer, it was within the
4 same realm of what do we do with excess beds. So, that
5 added a perspective for the other group members here as
6 well, but you, unfortunately, weren't here. But it did add
7 another dimension to the discussion. That wasn't real
8 successful, right, because nursing home beds didn't
9 convert.

10 MR. URSO: I just want to ask a question of
11 maybe Judy and Eli. Was there ever a synopsis or an
12 abstract of the pros and cons that you referred to and the
13 divergent opinions on this?

14 MR. PICK: There was.

15 MR. URSO: Have we seen that?

16 MR. PICK: Terry did provide a recap, that,
17 again, based on my failing memory, did capture the pros and
18 cons, which I tried to repeat again when I wrote the memo.
19 What I remember is we had a pretty exhaustive list when, as
20 a committee, we were going through it, and the issues, the
21 themes that were recurring was innovation and redeploying
22 beds into different areas.

23 MS. AMIANO: It was a whole conversation of
24 the haves and have-not's, frankly, and who has the excess

1 inventory, and there was some general perception that those
2 were provider -- a couple of classifications, so don't take
3 any of these as absolutes. They're broad kind of
4 conversations. There's a group of people who have excess
5 beds because they've taken those beds and made what used to
6 be quad units into double or privates or whatever. That's
7 fantastic. But they held on to their license. That's one
8 category.

9 There's also the category of people who have
10 excess beds because of poor quality and they can't fill
11 them and, you know, the Medicaid mill kind of communities,
12 which, thankfully, are far and few between, but they do
13 exist. So it was thinking of all of these different
14 constituent groups, and then you have your general
15 not-for-profits who at the time -- the universe has changed
16 in the last 24 months, but at the time were at full
17 capacity and trying to get more beds and couldn't get them.
18 So, it was different perspectives and how do you handle
19 that and how do the financing sources look at -- although,
20 you know, a bed -- you don't pay for a bed. Beds are
21 financed, in theory, conceptually, in this state. So, if
22 you took them away from someone, what would that do to
23 them.

24 And so there were all of these consequences,

1 so it was a very hard conversation. I think we got the
2 general issues. I would be happy to bring that list of
3 what they were. I was only referencing that, I think, to
4 get -- I see new faces here. As you know, I've been absent
5 this past year. I apologize. But I think to get everyone
6 to a common level of understanding of just the issues,
7 before we can move forward, would be helpful.

8 MR. PICK: And that was --

9 MS. AMIANO: And my brain gets a little full
10 of cobwebs, too.

11 CHAIRMAN WAXMAN: That's one of the reasons
12 we've invited Terry and Cathy, but even though Cathy didn't
13 partake in it, I'm sure she has heard about it over and
14 over and over again. So that's why we're always grateful
15 when Mr. Foley shows up, because he's sitting on a ton of
16 history, and Terry and their input. So we're trying to
17 find ways to make sure everyone is at a common place.

18 MR. PICK: If I may, I think in all fairness,
19 we want all perspectives. So, that's why Courtney reached
20 out to both LSN and IHCA to make sure we've got the
21 different perspectives for the whole group and the
22 historical, and so it's not just contemporary, but what got
23 us here. I didn't mean to imply that there is no
24 consensus, but I don't want to presume. My perception is

1 that, generally speaking, no one seems to really have a
2 problem with the concept of bed transfers and selling. The
3 issue is how and what, and that's what keeps coming back
4 over and over again.

5 MS. AMIANO: The devil is always in the
6 details.

7 MR. PHILLIPPE: That's what took years.

8 MR. PICK: And it's not done.

9 CHAIRMAN WAXMAN: If you guys would have done
10 your job earlier --

11 (Laughter)

12 MR. PICK: And I think the other component, as
13 Claire did some extensive research about what happened when
14 1125 was introduced and passed, that at that stage, it also
15 got set aside. There was identification of the fact that
16 the topic was discussed, but it wasn't incorporated into
17 the actual bill, and it was left for us to resolve. So, we
18 have -- we're limited by not having any specific direction
19 by virtue of the fact that it isn't in the statute -- it
20 wasn't in the bill. So, again, it's deferred back to us,
21 and we'll hear from Terry and from the associations'
22 perspective as to what happened and why wasn't it more well
23 defined to give us direction on how to deal with it.

24 MR. PHILLIPPE: My understanding of really

1 what happened is that the provider associations could not
2 come to the political world with a clearly defined,
3 specific plan that they could agree to. And if they had,
4 the situation may be different today, but because they
5 could not, that's the major reason it was left out. Is
6 that fair?

7 MR. PICK: I'm not sure.

8 MR. PHILLIPPE: That's what I've been told.

9 MR. PICK: I'm not sure, because I wasn't
10 involved in the discussion with Judy -- the House Rep, and
11 the Senator, Senator Garrett.

12 MR. URSO: You're talking about Lisa Dugan and
13 Susan Garrett.

14 MR. PICK: I think part of the issue was --
15 and I'm not disputing with your thinking, but there was not
16 total consensus on it, but there were so many other issues
17 being presented about having to introduce a unique and
18 specific process for long-term care, the incorporation of
19 community-based services -- there were so many things that
20 were already in the bill that when we got to bed buying,
21 which everybody was interested in, because we couldn't as a
22 group come forth with a specific process, it was, "You
23 know, we've got enough to deal with. Leave it. The
24 concept is okay. Let the committee that we're forming

1 actually work through the issues." So, that's why the only
2 thing I'm not sure is whether -- your words indicate that
3 because we couldn't reach consensus, it was decided we
4 shouldn't move forward. My sense of it was the consensus
5 was conceptually it was okay, but we don't -- they couldn't
6 deal with it at their level, and rather than saying, you
7 know, "We're not going to incorporate something into the
8 bill that we can't put specifics to," it was put aside.

9 MR. PHILLIPPE: And that's my understanding,
10 too. The consensus was there in general, and to some of
11 the major points there was consensus. It was actually the
12 specific concrete plan that was not in place.

13 MR. PICK: We're in agreement.

14 MR. PHILLIPPE: And I think it gets more
15 complicated, as this group is more diverse than the last
16 group.

17 MR. PICK: Right.

18 CHAIRMAN WAXMAN: On some level, I think it's
19 useful that we have the diversification, because it does
20 add perspective that we have not had, but on the other
21 hand, you're right, it does probably add to the more
22 factors that are being considered. So, you're right.

23 Hopefully, to get back to Judy's point, we can
24 reach a common ground of basic understanding and then move

1 forward.

2 MS. AMIANO: Is there -- if I could ask a
3 question. Is there a written report of Bob Green's
4 presentation which talked about those -- the beds, like not
5 being used?

6 MR. URSO: We have the transcript, don't we,
7 Mike?

8 MR. CONSTANTINO: We have the transcript.

9 MR. PHILLIPPE: We have the report. We have a
10 copy of the report.

11 MS. AMIANO: Because that would be very
12 helpful.

13 MR. PICK: There is a transcript as part of
14 the work group, of what he verbally reported.

15 MR. CONSTANTINO: Do you want the transcript
16 and documents?

17 MS. AMIANO: That would be great, because that
18 was one of the core issues, is that we've got enough beds
19 in the state, but we really never, in our group back then,
20 were able to quantify that. There was not a mechanism for
21 looking at and understanding that fundamental data.

22 MR. PICK: In Bob's report, the indication was
23 he couldn't give us the specific number, but a range, which
24 was somewhere between six and twenty thousand of excess

1 beds and --

2 MS. AMIANO: Six and --

3 MR. PICK: Between six thousand and twenty
4 thousand of excess beds, again by virtue of -- and he was
5 the first one to say this based on self-reported
6 information, which he felt was not all that reliable and
7 that you can't tell. So you really don't know. I think
8 that what is accepted is that there are more beds available
9 than people use. I think that's the only definitive
10 element that we have. How much is still not clear.

11 CHAIRMAN WAXMAN: And there's agreement that
12 the empty beds aren't always in the right place.

13 MR. URSO: Or they might not even be set up.

14 MR. PICK: Yep. Because even the concept of
15 peak beds was debated as to what is "peak"? Is peak
16 December 31st? Is it what's reported in the questionnaire
17 as the most beds -- as defined by the provider, who is
18 reporting the most beds that were in use at any given time
19 during the course of the year? You know, even that was
20 going back and forth as to what is peak?

21 MS. O'DEA EVANS: And a hundred percent is
22 never going to be possible in any scenario.

23 MR. PICK: True.

24 MS. O'DEA EVANS: No one could ever reach a

1 hundred percent.

2 MR. WAXMAN: Not unless you really, really get
3 lucky on --

4 MS. O'DEA EVANS: It's statistically
5 impossible.

6 MR. PICK: Just as an anecdote, you know, we
7 operated our facility for 35 years, and my father -- may he
8 rest in peace -- said, "One day I would like to see the
9 census at a hundred percent." It never happened.

10 CHAIRMAN WAXMAN: Anyone ever have a moment
11 of a hundred percent?

12 MR. PHILLIPPE: Yes, and I fuss at them.

13 MS. O'DEA EVANS: For 12 months?

14 MR. PHILLIPPE: Not for 12 months. For days,
15 and then I fuss at them, because that means you don't have
16 access to people coming in for a short stay, and it's a
17 problem when they're full, actually.

18 MR. PICK: Yep. That was something my father
19 could never understand.

20 CHAIRMAN WAXMAN: That's one of the issues
21 with some of the CCRC's around, that they won't fill all of
22 their beds, because they're anticipating need from the
23 community.

24 MR. PHILLIPPE: That's true.

1 CHAIRMAN WAXMAN: So, again, they'll never
2 get a hundred percent, just because their house rules say
3 that they have to hold X number of skilled beds open for
4 community needs.

5 Tim, do you have anything else you want to
6 talk about?

7 MR. PHILLIPPE: No. I guess I'm assuming my
8 work group is finished now.

9 CHAIRMAN WAXMAN: With a great deal of
10 admiration.

11 MR. PHILLIPPE: I appreciate all of the people
12 who did attend, and people brought information for us.
13 Claire did a lot of work. A variety of Staff did work for
14 us, to help make sure we used our time well, and that was
15 very useful that way. So, I appreciate everyone's
16 participation.

17 CHAIRMAN WAXMAN: There were some points
18 learned during your work group. I think an agenda and a
19 limited time frame, I think, all helped, but also maybe we
20 maybe underestimated how many people wanted to be involved
21 in that process.

22 MR. PICK: If I may, I would like to suggest
23 that work groups be restricted to the individuals who have
24 been assigned to work in the group, because --

1 CHAIRMAN WAXMAN: Frank, can we do that?

2 MR. URSO: Sure.

3 MR. PICK: I think by opening it up, it really
4 kind of changed the dynamics of the group and the ability
5 for it to do its charge.

6 MR. URSO: Let me say, you could establish a
7 membership in a work group, and, depending on what the
8 number is, you might have to be an open meeting. So then
9 you have to bump into those requirements, but you can
10 control it as best as you can by agendas and focusing on
11 just the membership having an opportunity to speak and
12 whatnot.

13 MR. PICK: Let me refine my recommendation
14 that work groups be under the number required for Open
15 Meeting Act, so that the work group can do its work and
16 then report to the larger committee to do the job.

17 CHAIRMAN WAXMAN: So that means no more than
18 five?

19 MR. URSO: I believe you're right.

20 MR. PHILLIPPE: And one thing we learned from
21 my group. We said all of that when we started. It was
22 limited to five. It was just going to be the work group,
23 so we would not trigger the Open Meetings law, and the
24 first meeting extra people showed up.

1 CHAIRMAN WAXMAN: Twenty-seven.

2 MR. PHILLIPPE: And then we had to do it --
3 so, that's the one side. The other side, I would just say
4 it actually could be frustrating for the public, like Chuck
5 or Terry Sullivan, who know a lot about something, and
6 we're trying to bring the group, who have no history, like
7 you were saying, in this in the past, and it could be
8 frustrating for both sides, because the person who knows a
9 lot in the public is wanting to explain this, because there
10 is a lot of backgrounds and issues and reasons, and we're
11 trying to bring the members along, a diverse group, who
12 have not talked about this before, and it can be
13 frustrating.

14 MR. PICK: You can invite -- even as a work
15 group, you can invite individuals in the public who have
16 interest to come, present, discuss, and then the work group
17 goes back to doing their work.

18 MS. AMIANO: But the same thing could be said
19 of a subcommittee. I remember the first meeting we had. . .
20 The actual appointed members of the committee were
21 completely overshadowed by the public and the comments by
22 the public. So, from the beginning, it's been difficult
23 for the committee to move this process along. We're now in
24 what, our third year?

1 CHAIRMAN WAXMAN: Second.

2 MR. PHILLIPPE: Seems like three.

3 MR. PICK: And, again, that was, I believe,
4 the purpose of having work groups, was to be able to manage
5 that, right? But if the work group just becomes a mini
6 subcommittee that is overwhelmed by public participation,
7 there is no point in having the work group.

8 MS. AMIANO: I'm not devaluing the public
9 participation. It's just that the work of the committee is
10 difficult then.

11 CHAIRMAN WAXMAN: Right, the size of the
12 group.

13 MR. PHILLIPPE: The one thing we learned is on
14 these complex issues, we will not make any progress if it's
15 just done by what is discussed at the subcommittee and we
16 meet every three or four months. I'll be in retirement.
17 I'm serious. These are complicated issues. There's a lot
18 of information, and so you can't move it fast enough if
19 you're just meeting once every three months, unless
20 somebody organizes work ahead of time, presents a proposal,
21 something to help move it in a more concrete direction.
22 It's not -- you don't meet often enough. You don't.

23 MR. WAXMAN: I totally agree. Who is going to
24 do -- Claire's subject might take a little longer.

1 Legislative Updates. Do you want to do that, and maybe
2 lunch will get here.

3 MS. KENDRICK: Okay. I'm Alexis Kendrick. I
4 work with the Board. I'm the Compliance Manager, as well
5 as the Legislative Affairs Manager. So, I've been keeping
6 track of the legislation that affects the Board in general.
7 But, obviously, there are a couple of bills that are a
8 little more relevant to this subcommittee.

9 First bill, Senate Bill 3614, that was
10 introduced by Senator Sullivan, this was an initiative of
11 the Healthcare Council of Illinois. Right now that bill,
12 it was amended, and the amendment was adopted with some
13 language that was agreed upon between the Board and HCCI.
14 That language says that the subcommittee shall -- I'll
15 directly quote it. "Shall evaluate and make
16 recommendations to the State Board regarding the buying,
17 selling, and exchange of beds between long-term care
18 facilities within a specified geographic area or drive
19 time." So, this bill has made it out of the Senate. It's
20 now in the House. There's not a sponsor for that bill in
21 the House yet, but it's on track, it seems like, to keep on
22 making progress. So, basically, that bill would give this
23 subcommittee authority to evaluate this and make any
24 recommendations to the Board, and that wasn't in the

1 statute before.

2 Another bill that might be relevant to the
3 subcommittee is House bill 4563. This bill originally
4 amended our Act to remove ID/DD facilities from under the
5 jurisdiction of the Board. It now stands that they are
6 still under the jurisdiction of the Board if they want to
7 establish a facility; but if they are to reduce the number
8 of beds, they do not have to come before the Board, and
9 they still have to do the surveying and the reporting to
10 the Board. Right now that bill made it out of the house.
11 That was sponsored by Representative Howard and
12 Representative Davis. It's now sponsored by Senator
13 Steans, Senator Link, and Senator Collins in the Senate.

14 MR. PICK: Can you explain what the practical
15 reality of that bill is? What does it mean?

16 MS. KENDRICK: From my discussions with Mike,
17 it probably won't realistically change much, that if they
18 were reducing beds before, they wouldn't come before the
19 Board. They -- basically, it was a response to the closing
20 of some state facilities, and there was an influx of beds.
21 DHS was concerned about an influx of facilities. They did
22 not want them to not come before the Board. So, this was
23 kind of a -- the compromise and the concern we had. The
24 Governor's office, DHS, Senator Steans, Representative

1 Howard and Mike Bibo and Marie Rucker were all at a table
2 discussing this language. Mike Bibo basically said that
3 it's not their -- well, I guess he spoke on behalf of all
4 ID/DD facilities, that they weren't going to establish any
5 new facilities, that that's not the goal; that they would
6 more likely reduce their beds and move them into being CILA
7 facilities. But that's not how it was presented to us at
8 first. You know, they were basically saying the CON
9 process takes too long, there would be -- I mean, we're
10 talking about, if I remember correctly, around 2,000 people
11 in the -- no, 600 people in the State facilities that would
12 now need to find new homes, and that basically they said
13 the CON process took too long to accommodate this.

14 MR. PICK: As I remember, Mike Bibo's position
15 was that the DD facilities did not fall under the Nursing
16 Home Care Act, and, as a result, the Board had no
17 jurisdiction to determine, you know -- to grant them or to
18 restrict their ability to open or close beds.

19 MS. KENDRICK: Yeah. He wants to continue to
20 make a distinction between the ID/DD facilities and the
21 Nursing Home Care Act facilities, and so this was a
22 continuing of that, wanting to make that distinction.

23 MR. PICK: Okay. So the practical effect of
24 the bill is --

1 MS. KENDRICK: They still have to come before
2 the Board if they're going to establish a new facility.

3 MR. PICK: And for the existing facilities,
4 nothing?

5 MS. KENDRICK: For the -- I mean, if they
6 should reach the threshold, they would still have to come
7 before the Board, but they can reduce the number of beds
8 and they wouldn't have to come before the Board. But if
9 they were going to do a rehabilitation or modernization and
10 if it reached the threshold, then they would still have to
11 come before the Board.

12 MR. PICK: That's the compromise?

13 MS. KENDRICK: Yes.

14 MS. AMIANO: What was that bill number? I'm
15 sorry.

16 MS. KENDRICK: House Bill 4563.

17 That's it.

18 MR. PICK: Thank you.

19 CHAIRMAN WAXMAN: Why don't we pause and grab
20 lunch and let the Court Reporter grab lunch.

21 (Lunch recess)

22 CHAIRMAN WAXMAN: Okay. We'll get back now.

23 Claire, the floor is yours.

24 MS. BURMAN: Okay. I was asked to look at

1 other CON states that do have the selling of beds in place
2 already, and there really aren't that many, but I did my
3 best to track them down. I gave you both a summary of what
4 they have in their rules about this subject, and the last
5 couple of weeks I tried to get a self-assessment from the
6 agencies. There were a couple that gave me no assessment
7 to date. So, there's not much we can do about that.

8 Florida has allowed the sale of beds for a
9 while. I think he said it was 14 years, and he was just
10 picking it out of the air from his memory. It was one of
11 the older reviewers. And they do have a moratorium in
12 place, so the only way that anyone can acquire beds right
13 now is to purchase them from someone who doesn't need them,
14 and he didn't give a formal reply, but I know when we were
15 talking about the actual rules, he thought overall that --
16 he didn't think of any large problems with that arrangement
17 for what they were dealing with. And just as an aside,
18 every state that I did talk to is talking about the same
19 issues and problems that we have been discussing since the
20 first meeting. It's a universal problem.

21 Then what is new is, I do have rules from
22 Maryland, and Maryland was interesting in that they provide
23 a very clearly-stated overview of a couple of different
24 long-term care activities, skilled nursing, I believe, home

1 health and hospice, those three, and they are bold enough,
2 if I may, in their statutes to put very specific, very
3 intelligent and forward-thinking kinds of goals or things
4 they would like to try to achieve. They don't do it in
5 absolute terms like, "By this date you shall have this in
6 place," but they have different points and subjects that
7 they want to try to focus on, and I've appended their rules
8 at the back. I gave you that in total, just because I
9 thought it was better than just giving you a piece out of
10 context.

11 Okay. They do require the seller to delicense
12 beds before they're sold, and the license essentially goes
13 to sleep for a year, and the selling facility has a year to
14 either fill those beds again, and if at the end of the year
15 they don't, then those beds are just totally gone from that
16 selling facility. But they do have an opportunity to meet
17 filling those beds again, if they can do it within a year
18 after they sold them.

19 MR. PICK: I'm confused. So the selling
20 facility has the opportunity to resell those beds? I
21 thought if they were selling them, they're transferring
22 them to another building.

23 MS. BURMAN: They are, but they do have the
24 opportunity to go ahead and try to refill that space, that

1 imaginary space.

2 MR. PICK: So they can sell them and try to
3 refill the beds again?

4 MS. BURMAN: Yes, because they maintain the
5 license for about a year. It goes to sleep.

6 MR. PICK: What happens to the buyer.

7 MS. BURMAN: The buyer has to apply for
8 licensure for new beds.

9 MR. SCAVOTTO: I found that confusing.

10 MR. PICK: I don't get it. So then the buying
11 facility is essentially getting new beds from the selling
12 facility?

13 MS. BURMAN: Yes.

14 MR. PICK: But both parties can end up with
15 additional beds, if the seller refills them and the buyer
16 fills them?

17 MS. BURMAN: Correct. But when they acquire
18 the beds, the buyer applies for licensure for those beds.

19 MS. AMIANO: It's an interesting safety net
20 for the seller in that if something changes in their market
21 for that period of time --

22 MR. PICK: They regained the beds and they
23 sold them.

24 MS. BURMAN: Right. But they have the

1 opportunity -- if they then meet the occupancy target --
2 which, again, in Maryland is in the 90's, I don't remember
3 the exact percentage, but it's in the 90's -- then they can
4 keep the license on those beds.

5 MR. PICK: Is there a moratorium on new beds
6 in Maryland?

7 MS. BURMAN: No.

8 MR. PICK: So there's a pool of beds
9 available?

10 MS. BURMAN: That's correct.

11 MR. DART: And it doesn't say anything about
12 whether they're Medicaid certified beds that they're
13 refilling?

14 MS. BURMAN: No, but that's an interesting
15 point. There are some states, if you go through the
16 material, that do look at that as a requirement. If you
17 look in the rules for establishing a new facility, there
18 are requirements to how many of these beds will address the
19 need for those types of beds.

20 MR. SCAVOTTO: I find that confusing. If
21 you're going to delicense a bed, you've got the risk of not
22 being able to get it licensed again.

23 MS. BURMAN: That's the term I was given,
24 "delicensed," but there is an opportunity before it's

1 totally gone, evidently, if they can admit enough people to
2 the beds that they have the pending license for, the --
3 rather, the sleeping license, if they can meet the
4 occupancy rate, they have an active license on those.

5 MR. PHILLIPPE: Without considering choosing
6 to sell or transfer the beds, does the State do anything to
7 take the delicensed beds, if they don't meet certain
8 occupancy standards on their own, without it being part of
9 the buying and selling process?

10 MS. BURMAN: There is a state that does that.
11 I don't recall which one it is.

12 MR. PHILLIPPE: I was wondering if that was
13 part of it.

14 MR. PICK: I'm sorry, Tim. I didn't really
15 hear.

16 MR. PHILLIPPE: It was kind of an odd
17 structure. I'm wondering if the state already had a
18 process, if you did not hit certain occupancy targets --

19 MS. BURMAN: I think Ohio has something in
20 place to take beds away.

21 MR. PICK: That changes the dynamic in the
22 environment, because if you don't use the bed, you lose it.
23 That's a big factor.

24 MS. AMIANO: When we looked at this a couple

1 of years ago, there were a couple states where there was a
2 two-year window of time. If you didn't use it in two years
3 -- you know, it wasn't a short period of time. So there
4 was opportunity for seasonal fluctuations or market
5 fluctuations.

6 MS. BURMAN: So that would be something else
7 that maybe this group wants to consider.

8 MS. AMIANO: Did who you talked to in
9 Maryland, did they feel that this process of the sleeping
10 beds was a successful model for them?

11 MS. BURMAN: They didn't really give me an
12 assessment. They spent a lot of time talking about the
13 rules, and we talked for at least 20 minutes, but he
14 couldn't go any further in detail. So, this is all I have
15 right now. But I did talk to the head person at the
16 agency. So -- I think his name is Paul Parker.

17 MR. DART: Did you get a sense, Claire,
18 whether they feel they are over bedded in Maryland?

19 MS. BURMAN: Sure. That's one of the reasons
20 they went for the idea of selling the excess beds. They
21 thought it was a very good way to address the distribution
22 issue, which is what most of the states I talked to thought
23 the big plus was, that it might be a good way to
24 redistribute beds as they're needed. Some of them also did

1 bring up the point that has been made here, that this also
2 allows older facilities to have funds to renovate and bring
3 things up to date in their facilities. One of the things
4 that was also brought up about that same idea was that they
5 were not really sure that that's how the monies received
6 were expended, and that was a concern, but they had nothing
7 in place to assure anyone that that's what was happening.
8 So it's another one of those things that you can have a
9 rule, but if you don't have some kind of teeth as part of
10 it, then you are kind of wavering there and not sure about
11 how the outcome is.

12 MS. MITZEN: How long had this been in place
13 in Maryland?

14 MS. BURMAN: In Maryland, that I don't have.
15 I would imagine at least 10 years.

16 MS. MITZEN: So they would have some sense of
17 how it's working?

18 MS. BURMAN: Correct. None of the states that
19 I spoke with were necessarily newcomers to this.

20 MR. URSO: The statute that we have in this
21 packet goes back to 2007, it looks like, so that's just the
22 statute. It could be before that.

23 MS. BURMAN: It was before that, yeah.

24 And then again, we did talk about Michigan a

1 little bit before. Michigan does not allow the sale of
2 licensed beds, period. They do allow the transfer, which
3 may not be as appealing, but they have very specific
4 requirements of the buyer and the seller, and if the buyer
5 or the seller meets all of the requirements, either one,
6 then they can forego meeting the need formula designation.

7 CHAIRMAN WAXMAN: Claire, does the term
8 "transfer" imply there is no money exchanging hands?

9 MS. BURMAN: That's correct.

10 MR. PHILLIPPE: From a practical
11 perspective -- we talked about this earlier, I think.
12 The -- it doesn't make any sense, unless there is some
13 negative reason, for holding on to the beds you want to
14 transfer, or in states that have a large national presence
15 of large multi-site providers -- which Illinois has a very
16 small presence -- it would be a great advantage to a
17 company that had a lot of buildings in the state.

18 MR. PICK: Michigan has a lot of chains.

19 MR. PHILLIPPE: That's what I -- yes, the
20 chains would --

21 MS. BURMAN: I don't know if you all have the
22 document in front of you, but point number 5 on Michigan,
23 "The occupancy of the giving facility is examined. If all
24 the excess beds are not transferred to a facility needing

1 beds, the remaining excess beds are surrendered to State
2 Licensure."

3 MS. O'DEA EVANS: So you have to transfer them
4 or you lose them?

5 MS. BURMAN: Right. It's a way to move them
6 in one direction or the other.

7 CHAIRMAN WAXMAN: I can see a transfer system
8 useful for like Tim or Judy, where they have facilities,
9 multiple ownership -- I mean, multiple facilities, same
10 ownership, in a state, but I can't see how any -- how I, as
11 a private owner, would want to give them to Mike as a
12 private owner. That I don't understand. That's where I
13 think the buying and selling becomes the incentive if
14 you're going to move beds between unrelated parties. But I
15 can see it useful in someone having multiple homes and
16 moving them from north to south, east to west.

17 MS. BURMAN: Sure.

18 MR. PHILLIPPE: It would be fewer in Illinois,
19 because even for mine, if we're talking about the area
20 typically -- like a 30 mile or a county -- as long as it's
21 more limited, I don't have five buildings in that area. So
22 there's very few groups that would have 40, 50, 80
23 buildings in the state. Those are the ones that would have
24 the advantage.

1 MR. CONSTANTINO: You can add beds now, Tim,
2 under the ten percent rule.

3 MR. PHILLIPPE: Right. I mean transferring
4 them.

5 MR. CONSTANTINO: At any facility you could
6 add beds.

7 MR. PHILLIPPE: And I have done that before.

8 MS. AMIANO: It's extremely cost prohibitive,
9 though, to do an addition and only have revenue generating
10 on 10 beds.

11 MR. CONSTANTINO: In this state right now, you
12 can. If you were over the threshold, you wouldn't be able
13 to do that without coming in for a CON, and if you had an
14 excess of the ten percent, or twenty beds, you'd have to
15 come in for a CON.

16 MS. AMIANO: Right, but I'm just saying the
17 every other year, ten percent, it's very cost prohibitive
18 to add beds that way.

19 CHAIRMAN WAXMAN: Is it just letter writing?
20 You don't have to have a certain level of occupancy?

21 MR. CONSTANTINO: No.

22 CHAIRMAN WAXMAN: Just a letter writing
23 process?

24 MR. PICK: You know, I think, as I kind of

1 thought it through, the ten percent of twenty beds is
2 designed if you've got growth of existing activity. If
3 you're expanding your current population, then it's an
4 adequate number to be able to do that without having to go
5 through a protracted process. If you're trying to develop
6 a new program and you need -- ten percent, twenty beds is
7 too small to make it economically feasible. Then you need
8 at least thirty beds to build a program. Now you're over
9 that threshold. So I think the two have different
10 purposes. So the ten percent allows -- if there's an
11 actual growth in the population, I can keep growing and not
12 having to go through a detailed CON process. If I want to
13 add a new program and rededicate a unit, then I need a
14 larger number of beds in order to make it work. So that to
15 me is the difference. It's a different scenario, and it's
16 hard, as you point out, Judy -- you're right, it's not
17 economically feasible to do any kind of real expansion.
18 It's only for natural growth.

19 So I think what I was reading in these other
20 states is that the way organizations are doing it is
21 they're acquiring beds from other providers, and that's how
22 they're doing it.

23 MS. BURMAN: That's correct.

24 MS. O'DEA EVANS: You could technically

1 increase by twenty, plus add ten from another provider?

2 MR. PICK: Well, no, that wouldn't work --
3 well, maybe.

4 MR. FOLEY: Kick in the CON, too, depending on
5 the number of beds.

6 MR. PICK: But even that, again, it's the
7 problem -- there's an example of -- we had a provider in
8 our market area, Glenview, where what they did was they
9 added -- they did a major redesign in their building. So
10 they reoriented a portion of the building for transitional
11 care, added ten percent, which -- it was twenty beds
12 because there were three hundred beds. So they added the
13 twenty beds through the ten percent rule, but what they did
14 is, because they had a bunch of threes, they converted the
15 three-bed wards into two beds and moved those threes over
16 and added them to the ten percent, and that's how they
17 built an addition to make it work. So -- and that's how
18 they made the number work. So what they were able to do
19 was expand their square footage by building an addition,
20 redeploy beds from their three-bed wards and added ten
21 percent. So they ended up in increasing their total
22 capacity by, I think it was, fourteen beds or fifteen beds,
23 but in reality they opened up a hundred bed unit, because
24 they moved eighty beds out of the original building, which

1 were all part of the three-bed wards and made them into new
2 single and doubles.

3 MR. FOLEY: You're doing forty, aren't you,
4 Tim?

5 MR. PHILLIPPE: We're doing something similar
6 in Springfield. My commercial: We have an open house
7 coming up as soon as we get the final inspections and all.
8 But we added twenty-two, but it's to serve the issue that
9 people don't want semi-private anymore. So I added
10 twenty-two private rooms and took twenty-two semi-privates
11 down to privates.

12 MS. O'DEA EVANS: We want to encourage that
13 type of behavior, because we would like to see more private
14 room options for people.

15 MR. PICK: Right. So, I think Tim is a great
16 example, because in your case, you had the beds in the
17 building, so you're redeploying them and moving them
18 around. In an environment where I want to add beds -- so,
19 if I've got a fifty or sixty-bed facility, if I want to add
20 thirty, the only way I can do that is go for a CON based on
21 a bed need to do that, or if there is another facility in
22 the area that has beds, they want to reduce their density
23 but they don't have any real use for the beds they're
24 reducing, if the smaller building can acquire those beds,

1 then they can add -- they can expand to capacity without
2 having to satisfy a bed need, because they're moving beds
3 over.

4 MR. PHILLIPPE: Which is what we are actually
5 in the process of doing right now in the state of Ohio, by
6 the way, a perfect example of how that works, because we
7 manage CCRC's for a related church group, and they have an
8 older CCRC with only a sixty-bed unit, and really,
9 practically speaking, it's not big enough to be viable, and
10 so we actually can remodel an assisted living, but we went
11 out in the market to attorneys who help put people
12 together, and so they buy the beds then, and with a limited
13 process, they can go ahead and expand the capacity of the
14 building so it makes it more viable, because the same
15 thing, we wanted more private rooms in the building. They
16 had sixty beds but all semi-private. It just wasn't
17 competitive. So, you're right. Along with expansion is
18 trying to move toward the model that consumers want that is
19 more healthy.

20 MR. PICK: And it doesn't increase the overall
21 bed inventory, and I think that's the issue we're stuck
22 with. The only way we can add beds is by increasing the
23 overall bed inventory, when we know there is a number of
24 beds that are out there that are just not being used

1 because they're excess.

2 MS. BURMAN: Michigan -- there is a very short
3 summary statement. They said that the relocation of
4 long-term care beds has been helpful in reducing the number
5 of phantom or paper beds in the state, and there are no
6 unstaffed beds. Not too many problems in Michigan with
7 their program, since the beds are not allowed to be sold
8 but are transferred from a facility that needs to downsize
9 to facilities in the same district that have a documented
10 need for more beds. So that goes back to the distribution.

11 Then Missouri --

12 CHAIRMAN WAXMAN: Claire, just a second.

13 Do you have a question, Phyllis?

14 MS. MITZEN: No, I just think a comment.
15 Documenting? Do they have -- did they talk about how they
16 document the need, because that's kind of what we've been
17 talking about. You might want to go back and ask them.

18 MS. O'DEA EVANS: Was just wondering how they
19 would facilitate that process. Does that go through the
20 State, or do these institutions negotiate that amongst
21 themselves?

22 MS. BURMAN: I believe they negotiate -- in
23 Michigan, at any rate, they start talking to one another,
24 and then when they make the decision they want to --

1 MS. O'DEA EVANS: So, what if someone says
2 they're not going to relinquish them but you have a
3 documented need, like you're provider A and you need to
4 expand, and the other provider has paper beds and they say,
5 "Well, we don't want to get rid of them"? I mean,
6 obviously, there's interest that the State would have to
7 have it more evenly distributed, but they're kind of
8 leaving it up to the providers to duke it out themselves?

9 MS. BURMAN: Right. There is nothing in their
10 rules that would require any facility to give up their beds
11 to another facility if they didn't choose to.

12 MS. MITZEN: But are there any mechanisms
13 that they use for that? Is there anything else in there
14 that provides that --

15 MS. BURMAN: Well, there's the fact that if
16 they don't sell them -- they have to do something with
17 these paper beds. If they don't sell them, they're going
18 to lose them.

19 MS. O'DEA EVANS: There is no sale, though,
20 right?

21 MS. MITZEN: They'll either transfer them or
22 lose them?

23 MS. BURMAN: If they don't transfer them to a
24 facility that needs them, they're gone.

1 MR. PHILLIPPE: It does create motivation --
2 I'm trying to think of this practically -- where I may not
3 want somebody building across the street from me. So, if I
4 don't transfer the beds to somebody who lives across town,
5 somebody might go to inventory -- my beds will go to
6 inventory anyway, and somebody might choose to build across
7 the street from me.

8 MS. BURMAN: They wouldn't be able to do that,
9 unless there was a documented need in the same planning or
10 market area. Depends on what the State wants. That's
11 right.

12 MS. MITZEN: So, it gets back to the
13 question. Maybe we need a little more information about
14 what "documented" means.

15 MS. BURMAN: Then you'd have to look at all of
16 those rules. That goes back to the need formula. Michigan
17 does have that, and it's very extensive.

18 MR. PICK: So Michigan and Maryland have in
19 common that if you don't use the bed, you lose them?

20 MS. BURMAN: Right.

21 MR. PICK: And that's the driver.

22 MS. BURMAN: That's correct, and I believe
23 Ohio is another state that --

24 MS. MITZEN: Do we have that here?

1 MR. PICK: No.

2 MS. O'DEA EVANS: We have something sort of in
3 the rules, but we don't enforce it.

4 MR. PICK: No, no, no. Only for brand new
5 projects, but for existing providers, whether you use the
6 bed or not, it's your bed. So, if it's a new project and
7 you're supposed to be hitting a 90 percent target within 24
8 months, if you don't, there's nothing that happens.
9 There's no enforcement.

10 MS. MITZEN: So the three of them have rules
11 that enforce this?

12 MR. PICK: Yep.

13 MS. MITZEN: Okay.

14 MR. PICK: That's a big difference.

15 MS. BURMAN: Okay. Then we're going to look
16 at Missouri. Missouri looks at sort of -- they say they
17 look at need, but it's not like a full CON review. They do
18 look at their bed-need determination, which is based on X
19 number of beds per one thousand population age 65 plus.
20 That's their formula for need, and they have a form that
21 the buyer and seller have to complete. It's not really
22 reviewed, yes or no. It's just informational.

23 MR. PICK: And then that form is provided to
24 the Board?

1 MS. BURMAN: Yes.

2 CHAIRMAN WAXMAN: Do you do any work in
3 Missouri?

4 MR. SCAVOTTO: My daughter is a CON attorney
5 in Missouri. She is quite accomplished, but she doesn't do
6 any work in Illinois.

7 CHAIRMAN WAXMAN: Any comments on Missouri
8 rules?

9 MR. SCAVOTTO: She's done this a few times.
10 She says it works out okay. The beds can be transferred
11 anywhere in the state and no geographical restrictions.

12 MS. BURMAN: It's very wide open, and in their
13 self-assessment -- this was from the Administrator, who is
14 six months on the job, so she told me right away she
15 doesn't have a lot of experience with this. But it's her
16 understanding, in talking with other people who have been
17 in this for a longer period, that as an overall statement,
18 the relocation has worked out very well and that the excess
19 beds are usually relocated to a facility that has high
20 occupancy, and it alleviates their problem as well. So I
21 think they're pleased with the way it's going in Missouri.

22 MR. PHILLIPPE: One of the things we've talked
23 about in the past is that one of the issues is getting
24 people to sell the beds, and when the geographic regions

1 where they can be transferred is so short, they're a
2 competitor, and the advantage in Missouri, really, because
3 it's state-wide, tends to create a bigger market to do that
4 and to move beds from places where they're not needed
5 geographically because of population declines, to areas
6 with population growth.

7 MS. AMIANO: Ohio did the same thing. They
8 started small and expanded.

9 MR. PHILLIPPE: Ohio has contiguous counties.

10 CHAIRMAN WAXMAN: Terry, did you wish to
11 speak?

12 MR. SULLIVAN: No, no, no no. I was going to
13 add something about Missouri. When the three associations
14 were looking at the issue, we had a long conference call
15 with the head of the Planning Board, who had been there for
16 quite a while, and he -- I mean, his attitude was --
17 originally he was against the idea, because he thought it
18 would upset the whole bed-need thing, and he said after
19 several years of experience, he was really surprised at how
20 the market actually evened things out, that generally it
21 was beds that went to the high occupancy facilities and in
22 areas where they were needed. So, without putting a lot of
23 regulations on it, the market system seemed to work in
24 Missouri of putting beds where, in fact, the market was

1 calling for it.

2 MS. AMIANO: With the exception of rural
3 areas.

4 MR. SULLIVAN: Which nobody wanted to go in.

5 MS. AMIANO: Exactly, because there's no
6 buyers. It was just very difficult to get people in rural
7 areas, and this whole notion of the buy-sell didn't work.

8 MR. SCAVOTTO: My daughter has done it a few
9 times, and she says it's all in metro areas, none in the
10 states.

11 MS. O'DEA EVANS: In Ohio there are certain
12 cities that have large metro areas where here in Illinois
13 we have --

14 MR. PHILLIPPE: -- one metro area.

15 (Laughter)

16 CHAIRMAN WAXMAN: Terry, Claire is going
17 through her presentation on other states, and then it's you
18 and Cathy.

19 MS. BURMAN: Now, I don't remember if this was
20 presented to this group or if it was just the work group,
21 but in New Jersey, the person I talked to in New Jersey
22 felt that they, in hindsight, should have been a little bit
23 more thorough in looking at the outcomes of allowing this.
24 What happened in New Jersey is there are a couple of chains

1 that would buy up mom and pop operations, and then they
2 would hold the beds in a holding company, and then when
3 they had a sufficient number for what they wanted, they
4 would open up a brand new facility. There's nothing in the
5 rules to prohibit them from doing that, and this is still
6 causing problems in New Jersey. So, his assessment was
7 that there was no improvement in the distribution of beds.
8 It was sort of a free-for-all, and in New Jersey a transfer
9 of ownership for a facility does not require a CON permit,
10 and the CON agency is not always notified, which is a
11 problem, because then you cannot keep track of the bed
12 count.

13 CHAIRMAN WAXMAN: So, theoretically, I could
14 buy a bed and hold it for 10 years. I don't have to use
15 it.

16 MR. PICK: The example you gave, they bought a
17 whole building?

18 MS. BURMAN: No, they bought -- he said either
19 in part or in total, they would go to the smaller
20 facilities and then buy them, and then the plan, evidently,
21 from what he was saying, is to have a substantial number of
22 them so they can open a new facility.

23 MR. SCAVOTTO: Claire, did that person say how
24 much the price per bed was?

1 MS. BURMAN: No. I don't think they get into
2 that in New Jersey.

3 MR. PICK: I'm sure it's much higher in New
4 Jersey than Missouri.

5 MR. SCAVOTTO: I'm thinking it's pretty high
6 in New Jersey.

7 MR. PICK: New Jersey has a similar problem,
8 because there's a high density area in the northern part of
9 the state. In the southern part of the state, it's rural.
10 But beds are very expensive in the northern part of the
11 state, because they're serving New York, southern New York
12 and northern New Jersey, but when you get into the rural
13 parts of New Jersey, the beds are much cheaper. So that's
14 my guess is that influences this. It was much cheaper for
15 them to buy the rural beds and then bring them into the
16 city and build a whole new building, and CON's are very
17 hard to get in Missouri. So that's their way of getting
18 around it completely.

19 MS. BURMAN: His final comment was that the
20 requirements for relocation need to be tightened to correct
21 these problems. He suggests that the beds being sold
22 should be delicensed immediately, which means they would
23 just go away, and the relocation of beds should take into
24 consideration the impact on the availability and access to

1 Medicare and Medicaid beds. That was a really big issue
2 that he wanted to emphasize, and we've touched on that.
3 We've never really gotten into --

4 CHAIRMAN WAXMAN: One of the things we've
5 heard from day one from primarily the community people is
6 that there aren't enough Medicaid beds in the right area.
7 There may be an over abundance -- I know that's one of your
8 issues, that there's an abundance of Medicaid beds, but
9 they're not exactly where your clients are.

10 MR. PHILLIPPE: And the way the rules work
11 with Medicaid in Illinois, you could say you're going to
12 certify your building for Medicaid, but that doesn't mean
13 you ever have to take anyone on Medicaid.

14 MS. O'DEA EVANS: Exactly.

15 MR. PHILLIPPE: So, we have people who can get
16 buildings approved by talking about that as being improving
17 access, but there's no guarantee they actually have to do
18 it.

19 CHAIRMAN WAXMAN: Really?

20 MS. MITZEN: If people spend down, are they
21 required to keep them, if they're certified for Medicaid?

22 MR. PHILLIPPE: If they are in a certified
23 bed, by law they can't make them leave.

24 MR. PICK: Wait, wait, wait. Slight

1 modification.

2 MR. PHILLIPPE: Go ahead.

3 MR. PICK: If you certify a distinct part of
4 Medicaid beds and those beds are filled when someone spends,
5 down, then they can legally tell them, "We don't have a bed
6 available. We'll put you on a waiting list.

7 MR. PHILLIPPE: But if the bed they are in is
8 certified --

9 MR. PICK: Then you can't tell them to leave.

10 MR. PHILLIPPE: That doesn't mean sometimes
11 people don't encourage it and make them leave anyway.

12 MR. PICK: That's right, but the way it's
13 occurring right now is facilities are certifying a Medicaid
14 distinct part in order to maximize how many beds they're
15 making available for Medicaid -- not maximizing. They're
16 establishing a maximum number of beds that they'll maintain
17 as Medicaid, and then that way they're legally able to say,
18 when those beds are filled, if you're the next person who
19 spent down, we don't have a bed available for you.

20 CHAIRMAN WAXMAN: Mike, in the CON process,
21 in the application process, does it matter or is it taken
22 into account whether the facility --

23 MR. CONSTANTINO: We ask for the payor mix,
24 the anticipated payor mix.

1 CHAIRMAN WAXMAN: And that is one of the
2 factors that is looked at?

3 MR. CONSTANTINO: By the Board members, yes.
4 Do we follow up on it? No. I couldn't.

5 MR. PICK: If I can follow up with a question,
6 based on your memory, do you have applications that are
7 indicating that there will be no Medicaid beds in their
8 building?

9 MR. CONSTANTINO: No.

10 MR. PICK: Never. And we know that that's not
11 the case. There are buildings that are not admitting them.

12 MR. PHILLIPPE: My impression --

13 MR. CONSTANTINO: I take that back. The CCRC
14 facilities, they do not for the most part serve Medicaid
15 patients.

16 MR. PICK: Okay. They're different.

17 MR. CONSTANTINO: Yes.

18 MR. PICK: I was thinking of the skilled
19 nursing.

20 MS. O'DEA EVANS: They do have Medicaid beds
21 reserved for their own residents.

22 MR. CONSTANTINO: I'm sorry. What I'm saying,
23 they don't make that attestation to the Board.

24 MS. O'DEA EVANS: They're not presenting that

1 as their clientele?

2 MR. CONSTANTINO: Right.

3 CHAIRMAN WAXMAN: You have Medicaid in your
4 CCRC's, right?

5 MR. PHILLIPPE: We do. I'm not fortunate
6 enough to have any high-end CCRC's that exclude Medicaid
7 people.

8 CHAIRMAN WAXMAN: A filled bed is better than
9 an empty bed.

10 MR. PHILLIPPE: Our target where we work in
11 the industry is about serving the entire population. There
12 are some days now when I'm waiting for a Medicaid check
13 from the State that I wish that were different.

14 (Laughter)

15 MS. BURMAN: Just as something that might be
16 of interest on this topic, if you look at page 14 of the
17 Maryland rules in the back, they have what they call
18 "Medical Assistance Participation" requirement, and this is
19 for all nursing home projects. It's point number 2, and
20 this is how they address the Medicaid availability.

21 MR. PICK: The reality from a follow-up
22 standpoint is three years from now, if I make a commitment
23 to set aside Medicaid beds and three years from now the
24 economics of the market are such that the State is not

1 paying bills or whatever, I can decertify those beds. So,
2 it's an arbitrary requirement that can't be enforced.

3 MR. URSO: What the Board has done, I think,
4 on this topic -- there have been applicants who declare
5 that they're going to take a high percentage of Medicaid
6 patients, as I recall, and the Board has put conditions on
7 that permit and said, "You've committed to this; we expect
8 you to report back you know annually or semi annually of
9 your fulfillment of that commitment." So the Board has
10 listened to those kinds of things. Now, is that something
11 that the condition will be actively monitored five years
12 from now? Probably not. But the Board has done that.

13 MR. PHILLIPPE: This is something that we need
14 to keep in mind for Illinois, because Illinois is unique.
15 The Medicaid rate --

16 MR. PICK: There have been no Medicaid
17 payments since October. That is unique.

18 MR. PHILLIPPE: July or August was my last
19 payment. Okay. But we have two issues. The rates are
20 very low, really.

21 CHAIRMAN WAXMAN: 50th lowest?

22 MR. PHILLIPPE: Right there near the bottom.

23 MR. PICK: I thought we were 49.

24 MR. PHILLIPPE: But if you compare it to the

1 costs of the State, the average rate in the building in
2 Ohio could be \$160, \$180. It could be 40, 50 percent
3 higher than the same kind of community in the state of
4 Illinois, and it does make a difference, because within the
5 state of Illinois right now, really, nobody builds for
6 anybody except Medicare and private pay, and they don't.
7 They can't afford to. You can't even pay the staff really,
8 let alone pay the debt on the building. So, it is
9 something to discuss. If you keep having more and more
10 building for that one population, it creates more access
11 problems for people who are on Medicaid.

12 MS. O'DEA EVANS: I don't think that our staff
13 costs are lower than other states. I think our staff costs
14 would be higher in Illinois just because of the cost of
15 living and the expectations of professionalism.

16 MR. PHILLIPPE: Chicago is going to be like
17 any big city. Big cities cost. The other communities kind
18 of match Midwestern costs.

19 MS. AMIANO: I can tell you I have communities
20 in Ohio and Chicago and other states, but if I compared the
21 two, Ohio is my highest Medicaid utilization and my most
22 profitable, because I get paid in Ohio for the care and
23 services we provide to people. That doesn't happen in
24 Illinois.

1 CHAIRMAN WAXMAN: Again, when I was on that
2 side of the world, we had homes in Illinois and Ohio and
3 Florida, and Ohio was much better earning-wise and
4 reimbursement-wise than either of those other two states.

5 MS. AMIANO: And I don't operate them
6 differently. I get paid differently.

7 CHAIRMAN WAXMAN: Yeah. A can of peas is a
8 can of peas is a can of peas.

9 MR. CONSTANTINO: Do you think the excess beds
10 have held down the reimbursement for Medicaid in the state,
11 the over abundance of beds in this state has held down the
12 rate?

13 MS. AMIANO: I think there are other political
14 factors on which we haven't even touched upon that.

15 (Laughter)

16 MS. AMIANO: I don't think it's a function of
17 the beds. I know we keep talking about the buying and
18 selling and cash associated with these beds. I'd love for
19 us to diverge from that topic, because this really isn't
20 about money that changes hands. This should be about how
21 do we care for the people in the state of Illinois?

22 MR. PHILLIPPE: Yes, that's right.

23 MS. AMIANO: I think any time you put money
24 into it, whether it's family, friends or business, put

1 money into the equation, the issues get confused, and so, I
2 mean, I love the examples -- Claire, you did a fantastic
3 job on this research. I love the examples of states where
4 it's working where no cash changes hands. It's about how
5 do we provide for the needs of the people in our state and
6 what's the appropriate thing and, sorry, that's my soap box
7 but --

8 MR. PHILLIPPE: The consumers. As a group,
9 the elderly have fewer people speaking for them than
10 perhaps the groups that have money on the table have many
11 people speaking for them, and that makes it more difficult
12 for them.

13 CHAIRMAN WAXMAN: That does make it more
14 difficult.

15 Claire, could I ask you to wind down in a few
16 minutes?

17 MS. BURMAN: Let's go to Virginia. I am going
18 to go to the assessment, because that's really what we're
19 talking about. Virginia, they've had the sale of beds in
20 place for 10, 12 years, and it was assessed as follows.
21 For a long time -- at least a dozen years and probably
22 longer -- Virginia has allowed nursing homes to relocate
23 beds within one of Virginia's 22 planning districts, by
24 agreement between them and subject to COPN -- that's

1 Certificate of Planning Need -- approval. The nursing
2 homes involved can be under the same ownership or not under
3 the same ownership. Makes no fundamental difference,
4 although it might affect the COPN review in some way.

5 When the nursing home to give up the beds and
6 the nursing home to receive the beds are not under the same
7 ownership, they typically enter into a formal forbearance
8 agreement, as it's usually called, whereby the nursing home
9 to give up the beds forbears from maintaining licensure of
10 them if the other party is successful in obtaining a COPN
11 to establish the beds at a new location. The party
12 desiring to receive the beds then files a COPN application,
13 and we review it in the normal way. Since our primary
14 interest in the COPN program with respect to controlling
15 the supply of nursing home beds is to control the supply
16 within the planning district, and since these relocation
17 proposals so far are to relocate beds within the same
18 planning district, we never have denied or even recommended
19 denial of a nursing home bed relocation proposal, as far as
20 I can recall. So, this is, again, the head guy responding
21 to my questions.

22 The primary reason for this is that the
23 relocation proposals have made good sense. They propose to
24 move beds from an over-bedded area of a planning district

1 or from an underutilized, perhaps out of date, perhaps
2 poorly located, perhaps poorly managed, nursing home to a
3 more rapidly growing part of the planning area or to a
4 nursing home experiencing greater occupancy and greater
5 likely future demand. Occasionally, a nursing home
6 provider who feels threatened in some way by a proposed
7 relocation of nursing home beds asserts that these
8 forbearance agreements are just a sale of a COPN, which
9 Virginia law does not allow. We contend these arrangements
10 are not a sale of the COPN, and so far no one has taken the
11 matter to court or even requested a formal opinion from the
12 office of the Attorney General, as far as I know.

13 It would be certainly -- it would certainly be
14 conceptually better for planning if there was competition
15 for bed relocations; i.e., if a nursing home willing to
16 give up some or all of its beds agrees to forebear from
17 maintaining their licensure, if any party obtained a COPN
18 to establish them in another location. However, no nursing
19 home provider is willing just to give up beds into a common
20 pool, as long as there is some prospect of ever being able
21 to improve their occupancy or ever being able to give them
22 up to a particular party in exchange for a forbearance fee.
23 This forbearance or bed transfer fee typically runs from
24 \$5,000 to \$10,000 per bed.

1 In general, I think that as a practical
2 matter, our present situation with respect to relocation of
3 nursing home beds is as good an arrangement as can be
4 expected. It does lead to improvement or a rationalization
5 of the supply and locational distribution of nursing home
6 beds within a planning district.

7 So, they have a couple little different
8 things, but essentially it's --

9 MR. PICK: Very interesting.

10 MS. BURMAN: Yeah. That's how they do it in
11 Virginia.

12 Now, Washington, this one actually answered
13 every specific question, which as you can see, nobody else
14 bothered to do. Her assessment is that -- the question
15 was, what were the key factors that led your state to
16 develop a bed relocation sales program? Answer: In
17 Washington the bed rights are considered the personal
18 property of the licensee, and this is according to an
19 Appellate court ruling. As a result, licensees may sell
20 the bed rights to another nursing home. A CON review is
21 required for the facility adding the beds. Since this
22 ruling, the CON law has changed several times in an effort
23 to reduce the number of licensed nursing home beds in the
24 state. These changes include bed banking for the purpose

1 of providing an alternative service; i.e., assisted living,
2 boarding home, home health, and full facility closure bed
3 banking. Facilities that reduce the number of licensed
4 beds may be eligible for an increase in their Medicaid
5 rate. So that's an incentive they have in Washington.

6 The second question was what other issues
7 became important to consider? The answer, number one, is
8 did the relocation result in increased access to services
9 for residents of the planning area? For example, were the
10 beds being relocated to under-bedded planning area or just
11 to another facility within the same planning area? Two, if
12 the beds were moving between planning areas, what would
13 there be on the existing planning area if the beds were to
14 move? So those are the questions that popped up when they
15 were reviewing this.

16 The third question that they were asked is,
17 what are the best results your state has experienced due to
18 the bed relocation program? And their answer was, existing
19 bed capacity is used to address distribution issues rather
20 than creating new system-wide capacity. It also generally
21 resulted in a marginal quality provider either getting out
22 of the business or at least reducing its bed capacity.

23 What are the worse features or unintended
24 consequences of the bed relocation/sales program. Answer:

1 Cost per bed went very high. At one point, applicant
2 facilities were paying as much as \$15,000 per bed.

3 And then how would you rate your overall
4 satisfaction with the bed relocation/sales program?

5 Answer: I would say overall it's about 60 percent out of
6 one hundred.

7 MR. PHILLIPPE: It's not great.

8 MS. BURMAN: Now the last question was, if you
9 could restart the relocation program all over again, what
10 would you do differently? Answer: If there are particular
11 policy positions the State wants to happen, make it clear
12 in any rules developed. Prepping for any rule development,
13 I would try to identify as many different what-if scenarios
14 as possible and think how they would fit into the proposed
15 rules scheme. That way you could think about the level of
16 variation that would be acceptable.

17 MR. PHILLIPPE: Very good.

18 CHAIRMAN WAXMAN: Claire, thank you very
19 much.

20 Any questions for Claire?

21 MR. URSO: Mike, I have a comment. I'm
22 looking at this Maryland code that's in the document that
23 we received. What's interesting is that they seem to
24 utilize the State health plan when they make their

1 decisions, and so, essentially, their CON board has as its
2 guide a State health plan, which is supposed to assure
3 access, quality and cost effectiveness of the various
4 healthcare services. I can't remember how much we talked
5 about in this group, but, you know, the task force with
6 Senator Garrett and Representative Dugan did put on the
7 table a need for a center for comprehensive health
8 planning, which I think was going to function in the same
9 way that I see Maryland is utilizing it. And so I don't
10 know how that factors into the consensus that you talked
11 about, but that is something that is in the Health
12 Facilities Planning Act as a statutory requirement, and in
13 that Act, the Board is required to collaborate with that
14 center. As we sit here today, that center is not existent.
15 But, it's interesting that Maryland has that and utilizes
16 it.

17 MS. BURMAN: Just as a historical point, all
18 of the CON agencies started out having a state plan and a
19 CON review that worked jointly. So some states have lost
20 the planning part.

21 CHAIRMAN WAXMAN: And we just never created
22 ours.

23 MS. BURMAN: No money.

24 CHAIRMAN WAXMAN: I've heard that a few times

1 today. All right. Thank you very, very much. A lot of
2 hard work. Once again a lot of hard work, and I really
3 appreciate it. You provided a lot of education for us.

4 I want to thank Cathy and Terry for joining us
5 today. Our goal specifically -- Terry has been nice enough
6 to join us many times, but today we, the group, are trying
7 to learn the process and what occurred when the three
8 organizations, IHCA, LSN and Illinois Council, met with the
9 Senate committee, Garrett's committee and Dugan's
10 committee, and presented some ideas of bed needs, bed
11 policy, buying and selling, and some of it didn't appear in
12 the legislation. So that's kind of what we're looking for.
13 Did I say that right?

14 MR. PICK: Um-hum.

15 CHAIRMAN WAXMAN: All right. Terry, Cathy,
16 however you want to start, please.

17 MS. NELSON: I really can't offer any
18 information about that.

19 MR. CONSTANTINO: Terry, could you come up
20 here so the court reporter can see your lovely face?

21 (Pause)

22 MR. SULLIVAN: The legislative task force
23 probably spent 99 percent of its time on overall planning
24 issues and hospital issues. There was one appearance on

1 the part of the -- that the long-term care associations
2 were asked to appear before the task force and give our
3 perspective, and there was Judy Amiano and Dennis Bozzi
4 represented LSN, I was there, and Pat Comstock were all at
5 the table. At the time we had prepared our presentations
6 separately, but, interesting, as we did the two separate
7 presentations, they were very similar, and I think we both
8 had very similar major points.

9 Point number one, that nursing homes are not
10 hospitals and that we needed a separate set of long-term
11 care regulations so that every time you passed a hospital
12 regulation, it didn't automatically apply to long-term
13 care. So, keeping them separate was one of our major
14 points.

15 And then we both supported the idea of a
16 permanent, long-term care advisory committee to both
17 develop a set of regulations and to advise the Board on an
18 ongoing basis. I think all three of those ideas -- namely,
19 that nursing homes are not hospitals, we need a separate
20 set of regulations, and we need a subcommittee -- was
21 pretty much accepted unanimously by the entire task force.
22 That really wasn't an issue.

23 Within our presentations, we also did address
24 more specific issues like bed need, HSA, the impact of home

1 and community-based services, the need for innovation in a
2 changing marketplace, variances, and the bed relocation
3 program. The reaction of the task force was sort of like,
4 well, those are all issues that should be discussed by the
5 Long-Term Care Advisory Committee. So what was put into
6 the legislation was a very clear statement that the nursing
7 home system should be separate from the hospital system,
8 that there should be an advisory board, and that there
9 should be a separate set of regulations, and that the
10 details of what would be in the regulations would be up to
11 the Long-Term Care Advisory committee to recommend to the
12 Health Services Board.

13 So, in a lot of ways, there was a lot of stuff
14 that was not put in legislation and -- but nothing was
15 specifically prohibited. It was more pass it on to the --
16 that's why we're establishing an advisory committee, is to
17 discuss these issues, just as we have been. It was
18 interesting, the task force also recommended that the three
19 associations get together and come up with a set of
20 regulations and recommendations, which, over the following
21 year and a half, Judy and Tim and Eli and Mike Bibo and --
22 we met on a regular basis and did come up with a proposal
23 that we presented to the Advisory Committee back when we
24 first started and had some impact on the regulations that

1 eventually did get put into place.

2 So, that briefly was the history, and we did a
3 lot of discussion about all of the issues of bed need,
4 market area, innovation, variance, and bed relocation, had
5 very similar discussions to what we've been having here,
6 although your work and research has been absolutely
7 fantastic, and we really appreciate it.

8 CHAIRMAN WAXMAN: Was there -- so there
9 wasn't an actual rejection then of the concept of buying
10 and selling and transferring beds by the committee?

11 MR. SULLIVAN: I didn't get any sense of that.
12 Judy?

13 MS. AMIANO: I'm sorry. Sitting here feels
14 like deja vu all over again. I missed your question.
15 Sorry.

16 CHAIRMAN WAXMAN: My question was that there
17 was no rejection by Legislative Committee on the idea of
18 buying selling and transferring beds?

19 MS. AMIANO: I won't say that it got to the
20 level that they contemplated an answer to that question,
21 because there was very divergent opinions about certain
22 aspects of that, you know, pretty much circulating around
23 the financial aspects of it. There's general agreement, I
24 would say, from everyone that change needs to happen.

1 There's no question about that. Providers and advocates
2 and Legislators alike, everyone is on the same page. What
3 people are having a hard time with is, what does that look
4 like? So we're almost at a juncture here where we just
5 need to try something, get off the dime and --

6 CHAIRMAN WAXMAN: That's kind of where we're
7 hoping our next meeting will -- that we can get to that
8 consensus of yes or no, and, if yes, let's propose some
9 regs, some rules, and run it up to the Mother Board.

10 Cathy, anything you want to add?

11 MS. NELSON: No. Judy and Terry -- I mean,
12 LSN's position hasn't changed. So, we still support the
13 concept of bed transfer, bed relocation, but the 'devil is
14 in the details, as Judy said earlier.

15 MS. AMIANO: I think our main stance was
16 wanting to preserve a model or create a model -- because
17 I'm not sure we have -- one, create a model that allows for
18 innovation in the marketplace, because, you know, a
19 marketplace that's down near St. Louis may have a different
20 need than a Chicago metro marketplace, and our rules are
21 very static. So, how do we be smart enough to craft
22 something that provides a framework but allows flexibility
23 and allows the people who are smart enough, making these
24 decisions going along, that it's the right thing in the

1 marketplace. I don't know a single provider out there who
2 wants to put a property in an area to make it fail. I just
3 simply don't know one. But we seem to go at this from an
4 angle of we're assuming that -- we get so knotted up in
5 making sure people are financially viable, dutta-dutta-da.
6 I can assure you from a provider perspective, you don't
7 want to do anything that's going to fail. That's not
8 folks' general intention. So, I think we need to focus on
9 how do we provide service to people? Let's allow the
10 providers to be smart enough to get their financing and do
11 all of the things they're going to need to do, because they
12 have to satisfy a whole bunch of other masters as it
13 relates to that. It shouldn't be the State they're a slave
14 to in terms of the financials.

15 MR. CONSTANTINO: You're asking a nine-member
16 board to make a decision on a home -- and we have to go to
17 the board with information that they can make an adequate
18 decision on. You're asking the Board to make a decision
19 on, say, a 15 or \$20 million investment, and in the past,
20 we've relied on a letter that says, "We have an interest in
21 financing." That no longer will fly, Judy. It won't.
22 That's my fault. I should have corrected that years ago,
23 and I didn't. What I'm saying to you is we can't rely upon
24 what the other financials say. We have to provide these

1 nine Board members what they need to make an adequate
2 decision about whether or not to establish another
3 long-term care facility.

4 MS. AMIANO: And I absolutely respect that.
5 It's probably at a different level that I'm speaking in
6 terms of -- I think all those things are still necessary.
7 I'm not taking anything away from that process. I'm just
8 saying we in this group are getting knotted up in those
9 kinds of things. We should just take those as givens and
10 try to create something different, and how do we do that?
11 And I'll never forget -- I was in a meeting, I think, with
12 Claire, and it was one of those meetings where I had an
13 "aha moment" several years ago, where we were walking
14 through -- Terry, I think you were there as well, and we
15 were trying to make all of these changes, and I think
16 finally Claire said, "You can't change this" -- so we were
17 left with about a 10 percent margin of things that we could
18 really impact, and so that was just an "aha moment". We
19 can talk about them all day long, but if they're statutory,
20 they're off limits. So if we knew what those handful --
21 because they're tiny, guys. There are not very many of
22 them that we can actually impact, and let's focus on those
23 things.

24 CHAIRMAN WAXMAN: Right. I keep thinking of

1 what Mr. Scavotto keeps talking about, which is no one
2 would -- logically speaking, no one would present a CON
3 application that they believe is going to fail and,
4 therefore, you know, the financial projections and some of
5 the stuff seems like it should be automatic. You wouldn't
6 present one saying, "I'm expecting to lose millions, and
7 please give me the right to build a home so I can lose more
8 money." I mean, the logic just isn't there. But I
9 understand why the protection for the State and the
10 community and all of that good stuff has to be there, but
11 the logic is no one would do that. I agree with you. You
12 don't present applications with the expectations of losing
13 money.

14 The other fear I have is -- when I was a
15 participant for a while this morning, hearing that the
16 world is much different the last couple of years because of
17 external things such as financing obligations and the
18 ability to acquire financing is much different in the last
19 three or four years than it was prior, my concern is that
20 we don't want to build regulations based upon what those
21 happenings are now and then hopefully the world will come
22 back together again and will swing the other way. So we
23 don't want to put rules in place that would prevent us from
24 having an easier application five years from now. So that,

1 I think, has to be in there.

2 Frank?

3 MR. URSO: I'm just sitting here, and I just
4 wanted to make a comment. My perspective is, I've been
5 dealing with long-term care for years, different levels,
6 and a lot of my years were prosecuting problems in nursing
7 homes.

8 MR. PICK: I'm glad I just met you.

9 (Laughter)

10 MR. URSO: Judy, you even mentioned this,
11 about there's some people out there that are not the good
12 providers and even you -- that don't fill their beds, but
13 when you want to think about putting a process together and
14 regulations together, you've got to remember that everybody
15 is not playing with the same vein of consciousness and
16 conscientiousness and taking care of the people the way
17 they should be taken care of. I have seen it firsthand,
18 and I know, Toni, in your office and the licensure office,
19 you know what I'm talking about. So you've got to factor
20 that in when we're coming to our consensus, that there are
21 some players out there that would rather -- are more
22 concerned about the dollar bill than the patient and the
23 bed. And I still call them "patients". So, I think you
24 have to think about that and you have to keep that in mind.

1 MR. PHILLIPPE: That's true.

2 MR. PICK: It is true.

3 MS. MITZEN: What this is triggering for me
4 is, what is our goal? And I think you and Judy, a few
5 minutes ago, really hit it. Our real purpose is to assure
6 that the people of Illinois have a place to be when they
7 need the care that they need, and I think that anything
8 that we do should be measured against that goal. I mean, I
9 don't know how we want to frame it. I don't know if we
10 want to have a framing statement, but something that says
11 this is the purpose of doing this. That's why I'm here.
12 That's why I think all of you are here. So, yes, we can
13 talk about money, and we should talk about money.
14 Obviously, people are in the business. But this is a
15 business that is here to meet a need for the people of
16 Illinois.

17 MR. PHILLIPPE: That's true.

18 MR. URSO: Absolutely correct.

19 CHAIRMAN WAXMAN: I don't think anybody would
20 disagree with you.

21 MS. MITZEN: I know they're not going to
22 disagree with me, but I think that we need to remember that
23 that's our purpose.

24 MS. AMIANO: Mike, you have such a long

1 history and you've seen so many things come through and the
2 good and the bad and the ugly, and Tim said it earlier.
3 You sit here in silence so many times. It would be great
4 to hear you say, "This is what I think in terms of how I
5 think this committee could affect change," because you have
6 such a unique perspective in terms of -- you said, "I
7 should have done that a long time ago." If we could
8 understand some more of those kinds of things, that might
9 be really helpful in terms of, boy, if we as a Board had
10 just advised differently this way, the outcome might have
11 been different. So that would be really helpful, because I
12 think you have a treasure chest of those thoughts in your
13 head.

14 CHAIRMAN WAXMAN: I agree. Thank you, Judy.

15 MR. SULLIVAN: I just want to compliment the
16 process. We're talking -- we were saying no provider is
17 going to start a business to fail. I think this whole
18 Planning Act has brought some realism and some
19 responsibility and maturity to that process by asking, "Do
20 you have this, this, this, and this," because I was around
21 long enough, as were you, Eli, before we had the Planning
22 Act in 1977. There were a bunch of idiots who -- and there
23 were a whole bunch of them right after 1965 that got into
24 the business that didn't have a clue about what they were

1 doing either clinically or financially, and in some ways
2 the planning process has brought some order, logic, reason,
3 responsibility to this entire process. So, we'll complain
4 about things being too regulated or whatever, but this
5 Planning Board has done a good job in bringing maturity to
6 that whole process, but also the fact that there isn't much
7 of a bed need around the state, the bed-need formula did
8 serve its purpose in evening things out and targeting areas
9 that needed beds, and I -- overall, when you look at it
10 over the past 25 years, it's been a pretty successful
11 program. Good job, everybody.

12 CHAIRMAN WAXMAN: We're pretty close near our
13 end time, but I would like everyone to take this
14 opportunity -- because, again, we've talked about it at
15 almost every meeting, that we weren't there. What took
16 place? So if you have any questions about what took place
17 with the legislation or to the three organizations that are
18 supporting all the other providers, please do it now so
19 that next week we can begin moving forward on a real
20 project. Terry is here, Cathy is here, Eli is here, Judy
21 is here, Tim is here. So, please, this is your chance to
22 say, you know, "Can you explain X Y Z now?" Otherwise, I'm
23 going to assume everyone has their historical questions
24 answered and their needs resolved.

1 I agree with Judy. Mike, I'd like to hear
2 from you anytime with your suggestions. I think they would
3 be valuable. I think the group would also like to hear
4 from you -- and maybe it's already been asked -- about the
5 failed applications.

6 MR. CONSTANTINO: Approved and abandoned and
7 renewals.

8 CHAIRMAN WAXMAN: Mr. Historian, Chuck, do
9 you have anything you want to say?

10 MR. FOLEY: No. I just echo what Terry said.
11 I think this whole process has really served the purpose
12 well, and I pity the Staff in what they have to put up
13 with, but I think by and large, everybody is doing a great
14 job.

15 CHAIRMAN WAXMAN: Any other business before
16 the Committee?

17 MR. PHILLIPPE: Could I just add on to
18 something about the goal? To have discussions that have
19 been real -- I've not been in a group like this in the
20 state.

21 CHAIRMAN WAXMAN: This is a unique group.

22 MR. PHILLIPPE: It's different in that from
23 most of the places I work on projects, the goals are clear.
24 I do think this is different, at least in my last three

1 years, because people come to it with very different goals,
2 and I read something recently about where regulation could
3 be good to improve, but sometimes regulatory process ends
4 up protecting the current business model of certain people,
5 instead of really being something that serves consumers,
6 because -- and so we have those conflicting things going on
7 in something like this. So anything we can do so we know
8 what we are trying to achieve would be helpful.

9 CHAIRMAN WAXMAN: Phyllis, could I ask you to
10 do a favor for the Committee?

11 MS. AMIANO: This sounds like a job.

12 CHAIRMAN WAXMAN: You know, every
13 organization today has a mission statement. You seem to
14 have one in your mind.

15 MS. MITZEN: I know what I want.

16 CHAIRMAN WAXMAN: Would you be kind enough to
17 put it into a written form and share it with us at the next
18 meeting, and maybe that's the starting point, is that we
19 all agree to a mission statement and then move forward.

20 MS. MITZEN: You know, what I would like to
21 do -- I'm looking at Judy and, actually -- I'm thinking
22 maybe we should have a small subcommittee. I find myself
23 much better when I can bounce things off of other people.
24 Not an open meeting.

1 MS. AMIANO: I'm happy to.

2 MR. PHILLIPPE: The smaller the better.

3 MS. MITZEN: Yes, I agree.

4 CHAIRMAN WAXMAN: I think it would be very,
5 very useful for all of us and again --

6 MR. SULLIVAN: Can I defer to Mr. Pick,
7 because you're good at mission statements. The next two
8 months is going to be a little bit busy for me.

9 MR. PICK: Okay. I'll be happy to do it.

10 MR. SULLIVAN: Until the Legislature adjourns,
11 nobody is safe.

12 CHAIRMAN WAXMAN: Any other new business, old
13 business, any business, monkey business?

14 Frank?

15 MR. URSO: Courtney wanted me to just mention
16 this. There is -- and I don't know how much applicability
17 it has to everybody here, but there's a travel
18 calculator -- because the State is making a much more --
19 trying to make sure people travel the least expensive way
20 when they go to meetings and whatnot. There is a web site
21 that you can use to calculate various ways in which you're
22 traveling from A to B, and so if anybody wants the web
23 site, I have a paper with it listed on there, and if you
24 care to check -- like, for instance, coming to this

1 meeting, you can check rental car, your own car, the train,
2 coming with Mr. Waxman, all of those kinds of things.

3 CHAIRMAN WAXMAN: I called a limo but it
4 didn't work.

5 (Laughter)

6 MR. URSO: So if anybody wants the web site,
7 that -- maybe they want to check their Vegas vacation. I
8 don't know.

9 (Laughter)

10 CHAIRMAN WAXMAN: Frank, I know we've had
11 this discussion many times, but I forgot how we ended it.
12 Our ability to eliminate members who have missed X number
13 of times, we've talked about that, haven't we?

14 MR. URSO: In fact, we have put together a
15 chart of -- an attendance sheet, so to speak, and, in fact,
16 Mike and I were talking about it, and I suggested he put
17 together an attendance sheet effective for this date also
18 and see where we're at with people attending these
19 meetings, and then maybe we should get together and talk
20 about it and see if we're going to talk to the Chair of the
21 Board and maybe we need --

22 MS. O'DEA EVANS: I was under the impression
23 we did create some rules when we first started.

24 MR. PICK: We did.

1 CHAIRMAN WAXMAN: But I didn't know what we
2 were going to do with it, if we were going to take it to
3 the Chair and ask to remove or at least ask what their
4 intent was.

5 MR. URSO: You're going to have to go back to
6 the Chair.

7 CHAIRMAN WAXMAN: It is painful that we did a
8 lot of great work together and not vote on anything, but I
9 think it's been a very productive meeting. We will meet
10 again some time in the future.

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12 END TIME: 2:03 p.m.

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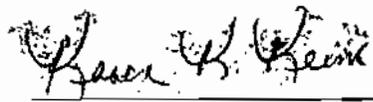
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CERTIFICATE OF REPORTER

I, KAREN K. KEIM, RPR, CRR, a Certified Court Reporter in the States of Illinois and Missouri, do hereby certify that the proceedings in the above-entitled cause were taken by me to the best of my ability and thereafter reduced to typewriting under my direction; 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

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