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SERVICES REVIEW BOARD

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

LONG-TERM CARE ADVISORY SUBCOMMITTEE MEETING

DECEMBER 3, 2012

NATIONWIDE SCHEDULING

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761
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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 December 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 Eli Pick - Vice-Chairman
3 Phyllis Mitzen
4 Michael Scavotto
5 Carolyn Handler
David Raikes
6 Cece Credille
Neyna Johnson
7 Toni Colon
Tim Phillippe
8 Greg Will (proxy for Dave Lowitzki)
Peter Vaughn (proxy for Kelly Cunningham)
9 Matt Hartman (proxy for Terry Sullivan)

10

11 ALSO PRESENT:

- Courtney Avery - HFSRB Administrator
12 Frank Urso - Legal Counsel
Juan Morado - HFSRB Staff
13 Cathy Clarke - HFSRB Staff
Claire Burman - HFSRB Staff
14 George Roate - IDPH

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20 Reported by:

Karen K. Keim

- 21 CRR, RPR, CSR-IL, CRR-MO
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- 1 AGENDA
- 2 CALL TO ORDER
- 3 1. Roll Call
- 4 2. Approval of Proxy
- 5 3. Approval of Agenda
- 6 4. Approval of October 9, 2012 Meeting Minutes
- 7 5. Approval of Revised Bylaws
- 8 6. CON Application Workgroup Update
- 9 7. Bed Sell/Exchange Program Discussion
- 10 8. Other Business
- 11 9. Next Meeting
- 12 10. Adjournment
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1 START TIME: 10:12 a.m.

2

3 VICE-CHAIRMAN PICK: Okay. I'd like to try
4 and get things started, if we can. So, if -- why don't we
5 begin with introductions, and then I know we have a proxy
6 here for Kelly, and then we'll do a motion to officially
7 approve you, so you can vote.

8 Okay. Claire, do you want to start?

9 MS. BURMAN: Sure. I'm Claire Burman, and I'm
10 Staff with the Planning Board.

11 MR. RAIKES: David Raikes -- good morning --
12 with Laborers Local Union in Marseilles.

13 MR. SCAVOTTO: Mike Scavotto, committee
14 member.

15 MS. CREDILLE: Cece Credille, committee
16 member, Illinois Health Care Association.

17 MS. JOHNSON: Neyna Johnson, Long-Term Care.

18 MR. HARTMAN: Matt Hartman; I'm serving as a
19 proxy for Terry Sullivan.

20 MR. ROATE: George Roate, Board Staff.

21 MR. VAUGHN: Pete Vaughn, Healthcare and
22 Family Services, for Kelly Cunningham.

23 MR. PHILLIPPE: Tim Phillippe, Christian
24 Homes, myself.

1 MR. MORADO: Juan Morado, Board Staff.

2 MS. AVERY: Courtney Avery, Board Staff.

3 VICE-CHAIRMAN PICK: Eli Pick, Vice-Chair, and
4 serving as Chair today for Michael Waxman, who is absent.

5 MR. URSO: Frank Urso.

6 VICE-CHAIRMAN PICK: Very important person
7 who is present.

8 So, if I may, the first order of business is
9 approval of proxy, and, actually, I think we've got two,
10 because we have -- for the present time, you're a proxy
11 also.

12 MR. HARTMAN: Yes.

13 VICE-CHAIRMAN PICK: I forgot your name.

14 MR. WILL: Greg Will.

15 VICE-CHAIRMAN PICK: Are you serving as a
16 proxy?

17 MR. WILL: I was asked to put together a short
18 bio. I did. I don't know if it's been sent along, because
19 I just did that this morning. So, I don't know if I can.
20 If that's resolved, then I am.

21 VICE-CHAIRMAN PICK: Okay. Frank, what's the
22 official word?

23 MR. URSO: We've dealt with him before.

24 VICE-CHAIRMAN PICK: It's okay, right? So,

1 let's do all three. So, let's start with Peter.

2 Peter, perhaps you can introduce yourself via
3 background to everyone.

4 MR. VAUGHN: Sure. I wasn't aware I needed to
5 bring a bio, but I'd be happy to send it out to the group
6 afterwards. As I said, I'm a proxy for Kelly Cunningham,
7 Healthcare and Family Services. I have been with HFS since
8 August of 2011, after 'getting my MPA at the University of
9 Illinois. I serve as a Long-Term Care Program Specialist,
10 with the focus on policy analysis. I work closely with
11 several long-term care rebalancing programs as well --
12 "Money Follows the Person" -- and do a lot of work with our
13 program director on that. So that's a brief background.

14 VICE-CHAIRMAN PICK: That's good, sufficient.
15 Thank you. We don't need your whole life history.

16 MR. VAUGHN: All right. Sounds good.

17 VICE-CHAIRMAN PICK: Okay. Do we have a
18 motion to approve Peter as a proxy?

19 MR. PHILLIPPE: (indicating)

20 MR. RAIKES: (indicating)

21 VICE-CHAIRMAN PICK: Tim; and David, second.

22 Thank you.

23 All in favor?

24 ("Ayes" heard)

1 VICE-CHAIRMAN PICK: Opposed?

2 (No response)

3 VICE-CHAIRMAN PICK: Abstentions?

4 (No response)

5 VICE-CHAIRMAN PICK: Carries.

6 Greg, your turn.

7 MR. WILL: Hi, everyone. I'm Greg Will. I
8 hope to be serving as a proxy for Dave Lowitzki, who is
9 Policy Director at SEIU Healthcare Illinois/Indiana. My
10 job there is as a Research Lead, responsible for research
11 on nursing homes and facility-based long-term care, and a
12 lot of you know my face because I've been subbing for Dave
13 over, you know, most of the life of this committee.

14 VICE-CHAIRMAN PICK: Motion to approve Greg?

15 MR. SCAVOTTO: (indicating)

16 MS. JOHNSON: (indicating).

17 VICE-CHAIRMAN PICK: Mike; second by Neyna.

18 All in favor?

19 ("Ayes" heard)

20 VICE-CHAIRMAN PICK: Opposed?

21 (No response)

22 VICE-CHAIRMAN PICK: Abstentions?

23 (No response)

24 VICE-CHAIRMAN PICK: Motion carries. Thank

1 you.

2 Matt, your turn.

3 MR. HARTMAN: Can I just have Karen copy and
4 paste from the last transcript?

5 I'm Matt. I've worked for the long-term care
6 profession for about the last 9 years as a lobbyist in
7 another role, for the trade associations -- first with the
8 Illinois Healthcare Association; then the Healthcare
9 Council of Illinois. I'm now back working with the
10 Illinois Healthcare Association. I work on regulatory
11 compliance issues.

12 VICE-CHAIRMAN PICK: Thank you. And, Matt,
13 your last name?

14 MR. HARTMAN: Hartman.

15 VICE-CHAIRMAN PICK: Thank you.

16 Motion to approve Matt?

17 MR. PHILLIPPE: (indicating).

18 MS. HANDLER: (indicating).

19 VICE-CHAIRMAN PICK: Tim; Carolyn.

20 All in favor?

21 ("Ayes" heard)

22 VICE-CHAIRMAN PICK: Opposed?

23 (No response)

24 VICE-CHAIRMAN PICK: Abstentions?

1 (No response)

2 VICE-CHAIRMAN PICK: Motion carries.

3 We've already done introductions, but perhaps
4 we can go with you.

5 MS. HANDLER: Carolyn Handler. I'm with
6 Rainbow Hospice and Palliative Care.

7 MS. MITZEN: Phyllis Mitzen, Health and
8 Medicine Policy Research Group.

9 VICE-CHAIRMAN PICK: Thank you.

10 So, we have completed our roll call and
11 approval of proxies. I believe we have a sufficient
12 quorum, more now. Thank you.

13 And I guess we can move on to approval of
14 agenda. Are there any other agenda items that anyone
15 wanted to add before we approve the agenda; or
16 modifications?

17 (Pause)

18 VICE-CHAIRMAN PICK: Seeing none, motion to
19 approve the agenda?

20 MR. RAIKES: Motion.

21 MR. PHILLIPPE: Second.

22 VICE-CHAIRMAN PICK: All in favor?

23 ("Ayes" heard)

24 VICE-CHAIRMAN PICK: Opposed?

1 (No response)

2 VICE-CHAIRMAN PICK: Abstentions?

3 (No response)

4 VICE-CHAIRMAN PICK: Thank you.

5 Okay. October 9th minutes; any revisions or
6 corrections to the minutes from the October 9th meeting?

7 (Pause)

8 VICE-CHAIRMAN PICK: Seeing none, motion to
9 approve?

10 MR. SCAVOTTO: So moved.

11 MS. CREDILLE: Second.

12 VICE-CHAIRMAN PICK: Thank you.

13 All in favor?

14 ("Ayes" heard)

15 VICE-CHAIRMAN PICK: Opposed?

16 (No response)

17 VICE-CHAIRMAN PICK: Abstentions?

18 (No response)

19 VICE-CHAIRMAN PICK: Motion carries. Thank
20 you.

21 Okay. Revised bylaws. I hope everyone has
22 had a chance to read the 188 pages. Okay. We had a bit of
23 discussion. Are there any revisions or corrections or
24 issues that want to be raised again before we approve?

1 (Pause)

2 VICE-CHAIRMAN PICK: Okay. Good. Motion to
3 approve?

4 MR. URSO: Mr. Chair, you need three-fifths
5 vote for the bylaws to be revised. That would be 12
6 people. I don't know if we have 12.

7 (Pause)

8 MR. URSO: I think we're just short.

9 VICE-CHAIRMAN PICK: I don't count? Isn't it
10 12 with me?

11 (Pause)

12 VICE-CHAIRMAN PICK: No, we're one short.
13 Sorry. Well, we can't approve it.

14 MR. URSO: Can't approve it, but you can talk
15 about it.

16 MR. SCAVOTTO: And these bylaws require the
17 quorum requirement?

18 MS. AVERY: We have one coming, so maybe when
19 she gets here, we can come back to it.

20 MR. URSO: We need three-fifths of the total
21 membership to approve the bylaws.

22 VICE-CHAIRMAN PICK: So are there any
23 discussion items? We talked about it quite a bit at the
24 last meeting.

1 No?

2 Okay. So why don't we set that agenda item
3 aside and move right on to the application workgroup
4 update. Mr. Scavotto?

5 MR. SCAVOTTO: We had a thrilling conference
6 call, Eli and Cece and members of the Staff. We have
7 another one coming up on Wednesday. This stuff is in your
8 attachments. If you, some night, are suffering from
9 insomnia, this is the stuff that you pick up.

10 I'm going to go to Attachment 2, governs the
11 nature of the conference call. What we're doing is going
12 right through the application, section by section, and
13 we're very cognizant of the fact that most of this
14 application is taken verbatim out of the rules that have
15 been approved by JCAR. There are some things that we think
16 are going to require a rule change. We're just not going
17 to know the extent of all of this until we get further into
18 it.

19 The hot buttons that came up on the first
20 call: Usefulness of the physician referral data that is
21 required in the application. The Staff tells us that it's
22 difficult to get, in most cases. So we're waiting for an
23 examination of the current data from Staff, and then we'll
24 revisit that topic at a later date.

1 Also, we had an agreement that we will examine
2 usefulness of the "Alternative" section. That's something
3 that's required by rule but which we're not really sure
4 that there's any reason for the requirement. No one really
5 examines the "Alternative" section, from what we
6 understand. The only way you get dinged on the
7 alternatives is if you don't even complete it. So, you
8 could say -- and I guess you could take this to extremes
9 and say even an outlandish alternative gets credit. So, it
10 makes you wonder the usefulness of that section. That will
11 be getting revisited.

12 And we also seem to have agreement that the
13 Primary Service Area definition should not be 50 percent of
14 your cases. If you're really going to look at a PSA
15 definition, it ought to be 70 to 75.

16 And we ended our conversation at that point,
17 and will pick it up again on Wednesday. We'll keep you
18 posted on this thrilling saga with complete updates in the
19 minutes. But it's an important piece of work. It's dull
20 and it's tedious, but, you know, when you fill out a CON,
21 you all got to go through this stuff, and it's very
22 informative to see how much of this is tied to the rules.
23 That was Claire's idea and has been a very helpful
24 exercise -- to me, anyway -- to go through that, how much

1 of this is basically legislative prescribed, and we want to
2 unlock the handcuffs. We have to change that prescription.

3 Anything you want to add?

4 MS. CREDILLE: There's really a need to change
5 the application, given the change in the healthcare
6 environment, what's happening in our industry and the
7 hospital industry. So, the backdrop to that is, there are
8 a lot of moving parts, and this application has been in the
9 legislation for quite some time, but the healthcare
10 environment has so markedly changed that we need to look at
11 the application process.

12 MR. SCAVOTTO: Do you want to add anything?

13 MR. PICK: The only thing I would add is, we
14 talked about MedPAR data, other swatches of activity over
15 and above physician referral letters, because that -- right
16 now, that section is -- according to Staff, that's what
17 they rely on exclusively, are physician letters of support
18 of the project. So, I think it's important for us to
19 reemphasize the use of data to support the need for a
20 project, rather than something as soft as some sense of
21 whether they need it or not.

22 MR. SCAVOTTO: Right. That was discussed.

23 Claire, did you have anything you wanted to
24 add?

1 MS. BURMAN: Yeah. In the rules, it's not
2 just physicians that act as referral. We use the term
3 "referral sources". You define whoever your referral
4 source is. And in MedPAR, we haven't had a chance to look
5 at what the contents are, as far as how it's organized, to
6 see if that's a better tool to use. And then there should
7 be a tie-in to the applicant's facility or proposed site.
8 But, yeah, if it gives us crisper data, of course, it's
9 better.

10 I did have a conversation with Pat O'Dea
11 Evans, since she has a discharge planning background, and
12 those are the folks -- for those who don't know, those are
13 the folks that are hands-on with the disposition of a
14 patient in the hospital, who needs to go somewhere, and the
15 part of the team that determines whether they're all right
16 to go home or if they need to go to nursing or assisted
17 living, whatever. So, they do keep careful track of that;
18 and it's not a big deal for the hospitals, certainly, to
19 have that information.

20 But we should look at any alternatives that
21 are discovered, like MedPAR, and that way we can make it
22 more crisp.

23 MR. PICK: Right. I'm not advocating for
24 MedPAR to replace the items -- the sources. It's just

1 one -- another source of data to help to refine the
2 process.

3 MS. BURMAN: Right.

4 MR. PHILLIPPE: I didn't review all of the
5 transcript in detail, but I did remember a discussion about
6 CCRC and variances, something about keeping the CCRC
7 variance but limiting what they could do. There was a
8 discussion about dropping the variance for special
9 populations.

10 MS. CREDILLE: We didn't get that far.

11 MR. PHILLIPPE: I just know some people that
12 would be interested in that, if you are going to change
13 that.

14 MR. SCAVOTTO: I don't know that that's going
15 to be on a radar screen.

16 MR. PHILLIPPE: It's limited by rule and
17 regulation right now.

18 MR. SCAVOTTO: So we'll start on Wednesday
19 with follow-up. Frank, it's an early morning. Referrals
20 versus origin; looking for the ultimate clarification from
21 you on that one.

22 VICE-CHAIRMAN PICK: Any other questions or
23 comments?

24 (Pause)

1 VICE-CHAIRMAN PICK: Okay. Thank you,
2 Michael.

3 MR. SCAVOTTO: You're welcome.

4 VICE-CHAIRMAN PICK: All right. And so then
5 the next conference call is certainly not going to be the
6 last one.

7 MR. SCAVOTTO: No.

8 VICE-CHAIRMAN PICK: And that's scheduled for
9 two hours?

10 MR. SCAVOTTO: Scheduled for two hours. You
11 can have -- I don't do four-hour conference calls. That's
12 not going to happen.

13 VICE-CHAIRMAN PICK: They kind of sneak up on
14 you.

15 MR. PHILLIPPE: Can I ask a question about the
16 workgroup? Is the focus of the group to make
17 recommendations for change in the application, just to
18 match the current -- within the scope of what's allowed to
19 be changed on the application right now, or is it to note
20 things that are in the rules and the law and then try to
21 step back and make recommendations of how those should be
22 changed, so the application is changed?

23 MR. SCAVOTTO: I would say both, because there
24 were some things that we can change by just reordering

1 stuff, and that would make more sense. That's an easy
2 example. But most of the substantive things are going to
3 involve rule changes.

4 MR. PHILLIPPE: Okay.

5 MR. SCAVOTTO: We're going to have to bring
6 those back here and kick them around.

7 MR. PHILLIPPE: Okay.

8 MS. CREDILLE: Didn't we have a timeline?

9 MS. AVERY: No.

10 VICE-CHAIRMAN PICK: No, we didn't.

11 And I think the other area of interest was
12 looking at alternate services that right now is not
13 evaluated at all. As long as there's some content, it
14 satisfies the requirements. So, I think that's an area
15 that we will be able to have some impact on. It doesn't
16 require a rule change, but it's something that we can help
17 guide the Staff into what to look for.

18 MR. SCAVOTTO: I think the timeline is our
19 sanity. We can only work on this for so long before your
20 brain turns to rubber, and so this stuff can really wear
21 you down, and there's just so much inertia to get stuff
22 done, just because you're dealing with legislation.

23 MS. MITZEN: Actually two things. An end
24 date would be very helpful. It can be two years from now,

1 but I think an end date is useful for a group like that.

2 MR. SCAVOTTO: I can think of three people
3 right here that aren't going to be doing this that much
4 longer.

5 MS. MITZEN: And who is on the group?

6 MR. SCAVOTTO: Eli, Mike, and Cece.

7 MS. MITZEN: And I guess I was just -- Eli
8 really preempted what I was going to suggest. Because
9 there is a larger world out there that long-term care
10 facilities fit into, and it's obvious to me -- or at least
11 I believe it's not -- the old process does not take that
12 into consideration, and we certainly, as a group, should be
13 doing that.

14 MS. AVERY: Are you saying when we get a new
15 application or recommendations for the rules, that they're
16 out there to the larger community?

17 MS. MITZEN: You know, I'm not familiar
18 enough with the process to know the answer to that
19 question. It seems to me -- my world is the long-term care
20 world outside of nursing homes; and I know that there's the
21 areas on aging, which has their own planning component as
22 their responsibility, and other groups looking at how this
23 world should be changing.

24 MR. SCAVOTTO: Well, if I can, let me --

1 you're -- for lack of a better characterization, you're
2 unregulated, which is okay. A lot of us are regulated.
3 So -- and we're dealing with the regulated aspect.

4 MS. MITZEN: I understand.

5 MR. SCAVOTTO: It's very different.

6 MS. MITZEN: Right. Am I misunderstanding
7 then? I mean, I understand that you are very heavily
8 regulated. I do understand that, but we're also talking
9 about beds and need for beds within certain areas, and I
10 think that's where the --

11 MR. SCAVOTTO: Eventually we'll get to that,
12 because a bed-need formula will come up. We will not hack
13 that out in one or two meetings. The whole market demand
14 analysis and the need for beds is huge. With HCBS, about
15 the only place I can think of that it gets addressed is in
16 "Alternatives", and that's questionable as to whether or
17 not there's a realistic assessment of that. So, other
18 than -- this is like driving through a milk bottle, and it
19 doesn't have a lot of clarity yet.

20 VICE-CHAIRMAN PICK: Okay. If I may add, I
21 think the challenge of the interface between the existing
22 established long-term care system that's regulated by the
23 Department of Public Health and the community-based
24 services that are prevalent and growing is a challenge, not

1 only for our group, but even the Department on Aging. This
2 is still an area that requires, and has required, a lot of
3 work; and the market is defining, to a great extent, the
4 consumers' responses through what they're choosing to
5 utilize, the services.

6 So -- but from a public policy standpoint,
7 we're still challenged with how to figure out the interface
8 and, you know, the bill that establishes this group
9 incorporated the need for community-based services to be
10 considered as part of this process, without any real
11 guidance as to how that's done. So, that's our work. So
12 our work is to help the Staff understand it better, how
13 to -- and I think from my perspective, the overarching
14 issue that the application workgroup is encountering, that
15 we as a broader group have a challenge for, is to help the
16 Staff understand what these things are and how to evaluate
17 them in a very concrete manner. The concrete part is
18 what's illusive, because even within our existing system,
19 we have some areas that are soft -- is the way I would
20 describe it, for lack of a better descriptor -- and our
21 ability to tighten those things up and to help the Staff
22 discern between applications that are using softer data
23 sources to help advance their application versus what the
24 real need is in the market is really our charge. It's part

1 of what we're here to do.

2 MS. JOHNSON: At the Governor's Conference on
3 Aging next week, on the 12th, which would be Wednesday, the
4 Long-Term Care Council is hosting a public forum on managed
5 care from 2:30 to 4:30. I would just like to extend the
6 invitation. Because Aging is trying to figure out --
7 because it's left the station, and not only for long-term
8 care, but for home and community-based services, as well.
9 So, if any of you can make it, you're certainly most
10 welcome to join.

11 MR. PHILLIPPE: That's very timely. I was
12 actually thinking about how to bring this up, because I do
13 think it's going to make an impact. It will have a huge
14 impact on what we're doing, and having some knowledge will
15 help us make other recommendations.

16 MS. HANDLER: I think Stephanie presented to a
17 group last -- maybe in the last few weeks. Maybe it's
18 something she should do for us. I heard it was really
19 fabulous, actually, the content was.

20 MR. PHILLIPPE: That would be great.

21 MS. HANDLER: Maybe we can ask her to do that.

22 VICE-CHAIRMAN PICK: There's no question that
23 the changes in the funding stream for Medicaid-funded,
24 long-term care services is going through a tremendous

1 transformation. And the expansion -- I think that's the
2 other aspect of this, that the population of individuals
3 that will be utilizing long-term care services, both at the
4 institutional level and in the community, are going to
5 expand this part of this whole process, and not just the 65
6 and older. I mean, the 65 and older, we know through
7 traditional funding sources; but the under 65 and the
8 expansion groups are individuals who will be needing
9 long-term services. So, this is going to have a tremendous
10 impact, not just from a funding standpoint, but also for
11 persons served; is going to significantly increase.

12 The community care -- the Cook County waiver
13 is expanding the population, the Medicaid population, by
14 around 200,000, and that's already in effect as of November
15 1. The expectation is for the full expansion, under
16 Accountable Care, will be somewhere around 500,000
17 individuals in the state. So that's a significant --
18 that's about a 20 percent, I think, 25 percent increase on
19 the number of Medicaid-covered individuals in the state.
20 That's a huge, huge growth.

21 So, thank you, Neyna. You're absolutely right
22 that it will significantly impact the ability for the
23 system to meet the need of the population, and given the
24 reimbursement and where it's been headed, how our service

1 network can accommodate the number of people that are going
2 to enter the system that have up until now been basically
3 denied, because they've had no benefits.

4 MS. JOHNSON: And let's not forget the Colbert
5 decree, the Williams decree, the Liggett (phonetic) decree,
6 and the closing of the State institutions. You know, we're
7 talking about thousands of people being transitioned into
8 the community. It's a daunting, awesome challenge.

9 VICE-CHAIRMAN PICK: All the more reason why
10 we have to have a sound application process. Right.

11 So, the age-old discussion was, you know, form
12 follows function, and if the system's capacity is oriented
13 towards one versus another, then it's going to drive people
14 into that area. So I think our challenge, as a public
15 policy forum, is to be neutral and to create a sound,
16 objective process that enables individuals to have their
17 needs met in the most efficient and effective manner,
18 without a bias towards one or another, and that's the --
19 the historical reality is, there have been biases, and a
20 need for us to neutralize those kinds of biases is our
21 challenge.

22 Okay.

23 MR. PHILLIPPE: Could I join your workgroup
24 call this week? Is it an open group or is it closed?

1 MR. SCAVOTTO: Always has been, but for you,
2 we'll close it.

3 MS. CREDILLE: It's this Wednesday, Tim.

4 VICE-CHAIRMAN PICK: I'm chairing a board
5 meeting. It's kind of hard to get out of the meeting
6 you're chairing.

7 MS. AVERY: Tim, you did receive the
8 traditional meeting notice for the workgroup, but I did
9 send out a separate e-mail with the agenda.

10 MR. PHILLIPPE: I did receive things. I've
11 gotten things.

12 MR. URSO: That would be four members then?

13 VICE-CHAIRMAN PICK: That would be four
14 members then; that's correct.

15 MS. AVERY: It's posted and everything for the
16 Open Meetings Act. I posted it.

17 MR. PHILLIPPE: I got information about it.

18 MS. AVERY: Okay.

19 MS. MITZEN: So that means that any of us
20 could join and enter the call, if we chose to?

21 VICE-CHAIRMAN PICK: Absolutely. We don't --
22 Frank, we don't need to change anything, because we're
23 already -- it's already posted and it's being recorded.

24 MR. URSO: Well, just when we hit that magic

1 number, we have to abide by the Open Meetings Act. But if
2 we're already abiding by the Open Meetings Act with just
3 three members, then, no, nothing needs to change.

4 VICE-CHAIRMAN PICK: Right. Okay.

5 MR. URSO: We have an agenda, and it's posted.

6 VICE-CHAIRMAN PICK: We're following all of
7 the steps?

8 MR. URSO: Right.

9 VICE-CHAIRMAN PICK: We're good. Golden, as
10 they say.

11 MS. MITZEN: As they used to say.

12 VICE-CHAIRMAN PICK: There's a book -- my wife
13 just got me the book -- "Golden". Quite interesting.

14 Okay. If we're done with the workgroup and
15 other discussion on the application, we can move on to bed
16 buying and selling. "Bed Sell/Exchange Program" is the way
17 it's listed on the agenda. So, we can certainly open that
18 up for discussion this morning.

19 (Pause)

20 VICE-CHAIRMAN PICK: Well, now that that's
21 settled --

22 MR. SCAVOTTO: Who wanted to talk about it?

23 VICE-CHAIRMAN PICK: Everybody.

24 MS. AVERY: And what I did was, there was a

1 request for comments from Cece. So, when you look in your
2 materials, you'll see the excerpt of the meeting minutes,
3 but I wasn't sure exactly which part to pull out. So,
4 everywhere that you spoke, I added it as a separate
5 document in the meeting materials.

6 VICE-CHAIRMAN PICK: Well, we did have --
7 Terry had submitted a significant number of --

8 MR. SCAVOTTO: 116 pages.

9 VICE-CHAIRMAN PICK: I don't think 116 pages
10 were all Terry's, but I do think that there's significant
11 basis for us to have a discussion about the items.

12 Welcome, Toni.

13 MS. COLON: Thank you. Good morning. Sorry
14 I'm late.

15 VICE-CHAIRMAN PICK: We're very happy you're
16 here, because you're our twelfth member, and you allow us
17 to have a quorum to be able to do some business that we had
18 to set aside for the time being. Okay. So should we do
19 that?

20 MS. HANDLER: Just in case we lose somebody.

21 VICE-CHAIRMAN PICK: So let's go back on the
22 agenda to -- Toni, the item is the approval of the revised
23 bylaws, and you're the twelfth voting member who arrived.
24 That allows us to have a quorum to actually affect the

1 adopting or revision of those bylaws.

2 So, going back to the bylaws discussion, does
3 anybody have any revisions or discussions to the bylaws
4 before we vote?

5 (Pause)

6 MS. COLON: I didn't. I reviewed them, and
7 I'm fine.

8 VICE-CHAIRMAN PICK: So we'll entertain a
9 motion to accept the bylaws as drafted.

10 MS. CREDILLE: So moved.

11 MR. SCAVOTTO: Second.

12 VICE-CHAIRMAN PICK: All in favor?

13 ("Ayes" heard)

14 VICE-CHAIRMAN PICK: Opposed?

15 (No response)

16 VICE-CHAIRMAN PICK: Abstentions?

17 (No response)

18 VICE-CHAIRMAN PICK: Motion carries. Thank
19 you very much.

20 Okay. So, we're at the bed sell and exchange
21 document on the attachments for today's agenda and Points
22 for Consideration. I'm not sure it serves our best
23 interests to go item by item, because it will take us quite
24 awhile. So, if I may, what I'm going to ask for are

1 specific items that people want to discuss, before we go
2 through the conclusion of the process. I was about to call
3 on Matt, because I know --

4 MR. HARTMAN: No.

5 VICE-CHAIRMAN PICK: You had some things to
6 discuss at the last meeting.

7 MR. HARTMAN: I have some things to discuss,
8 but I have to wait for some word from on high before I can
9 discuss.

10 VICE-CHAIRMAN PICK: Okay. Well, I can tell
11 you that one of the things that was on my mind and Terry's
12 comments was about the eligibility requirements for
13 organizations that want to participate in buying or selling
14 beds and, in particular, the regulatory component, because
15 my feeling was, the organizations that are out of
16 compliance, particularly when they're in a decertification,
17 are not organizations that I feel should be eligible for
18 buying and selling. To me, it's a mixed carpet bag, that
19 the organizations, as they start to spiral down -- one of
20 the ways to quickly convert an asset to cash as you're
21 about to lose it is to start selling off pieces, and I
22 don't think that's in the public's best interests to
23 facilitate that process, and if we don't establish any
24 criteria for eligibility, I can envision something like

1 that happening, which gives me a great deal of discomfort.

2 What's the pleasure of the group?

3 MR. SCAVOTTO: How would that work? I mean,
4 I'm in trouble, and if I don't pass muster, I'm going to be
5 decertified and tossed from Medicaid and Medicare; so, I
6 sell my beds to you; you're a good operator. Where is the
7 harm?

8 VICE-CHAIRMAN PICK: Well, the question is
9 whether there's a perverse incentive as an operator who is,
10 let's say, reluctant to invest resources to improve the
11 operation. Then the harm is that they know they can just
12 sell the beds instead of trying to improve the operation,
13 just let it continue to spiral. To me that's the harm.

14 MR. SCAVOTTO: I've got to think about that.
15 I think if I'm inclined to be a lousy operator, I'm
16 probably going to keep that inclination.

17 MR. PHILLIPPE: That's kind of the way I think
18 about it too, really. Based -- this is just based on
19 personal experience. It's the operator and the location
20 and the look of the building and all of that stuff. It may
21 just be maybe a building that's not viable anymore, or an
22 operator that's not viable.

23 MR. SCAVOTTO: Just for the record, I'm
24 agnostic on this. I could care less. I don't think -- I

1 mean, I'm not an operator. I don't own anything, and if
2 you want to buy and sell beds, I'm totally neutral on it.
3 I don't think it's going to impact the State positively or
4 negatively. I think it's going to be a neutral. So, I
5 don't care which way it goes.

6 VICE-CHAIRMAN PICK: But I guess -- let me
7 react to that. I think if I have a -- if a building exists
8 in a less desirable community, from an economic standpoint,
9 and the organization is deteriorating, those beds end up in
10 another community by virtue of them being sold, then the
11 harm is that the local residents in that community now have
12 to travel outside of their community in order to access
13 services, by virtue of the ability to take a -- so --

14 MR. SCAVOTTO: Are they not in the same
15 position if I would decertify and am tossed for Medicare
16 and Medicaid? Wouldn't they have the same result?

17 VICE-CHAIRMAN PICK: Not necessarily, because
18 either the -- someone is going to end up assuming --
19 operating that building, at least while there are residents
20 in it, unless the building is empty. If it's empty, then I
21 agree with you; it doesn't really affect anybody.

22 MS. JOHNSON: From an advocacy standpoint, I
23 think we would be concerned if a poor performing facility
24 continues to buy additional beds and they're not providing

1 good service with the beds they have.

2 VICE-CHAIRMAN PICK: Flip side of the coin.

3 MS. JOHNSON: Yeah.

4 MR. PHILLIPPE: That's true.

5 MS. JOHNSON: Just a thought.

6 MR. PHILLIPPE: That makes more sense to me,
7 actually, than the other way.

8 MR. SCAVOTTO: Yeah.

9 MR. PHILLIPPE: It seems like the dilemma
10 is -- I'm thinking downstate, really -- is that there are
11 places that funding is low, because they're primarily
12 Medicaid. The census is lower, because they're in small
13 communities. However, it's also true, if that building
14 closes, if one of those places close, that people have to
15 go a much greater distance to find a place. That's what
16 you're talking about. It's kind of the access versus the
17 quality, going to big cities and all of that.

18 VICE-CHAIRMAN PICK: Right.

19 MS. AVERY: Is there anything currently within
20 the system that would keep an operator such as all of you
21 are describing from doing a change of ownership, even if
22 they are decertified?

23 VICE-CHAIRMAN PICK: No.

24 MS. AVERY: So it's up to that new owner to

1 decide to purchase them while in decertification and then
2 come back into the graces of being able to certify those
3 beds? Is that --

4 VICE-CHAIRMAN PICK: That's my understanding,
5 yes.

6 MR. PHILLIPPE: Um-hum.

7 VICE-CHAIRMAN PICK: To me, again, the
8 question from an operator or a business standpoint, is
9 there enough of a market to support the entity? If there
10 is enough of a market, then -- or if maybe not the
11 non-traditional way, if there is enough of a market that
12 you can access to create a viable organization and the
13 existing operator, either through lack of sophistication or
14 ability, is just not pursuing those other sources of
15 potential utilization, that's a viable organization. If
16 there isn't enough need to support it, to make it viable,
17 then it doesn't matter who is there; it's going to close,
18 and it's appropriate for it to be closed, and in that case,
19 rather than buying or selling the beds, just go back into
20 inventory. Right? Because now it's essentially a
21 nonexistent organization, that the market has determined
22 there's no need for it, by virtue of the fact that there
23 aren't enough individuals utilizing the services you're
24 being offered. So, rather than selling those beds, it

1 would seem to me those beds are better off just going back
2 into the general inventory, for the system to then
3 redistribute, rather than to go through the buy/sell.

4 If there was enough -- and, again, I think
5 what we're trying to do is not preclude an organization's
6 ability to buy or sell; it's at what point is that decision
7 viable? Is it before an organization starts to look in the
8 face of decertification or after? The window -- if the
9 window is open, then it could occur at any time, and,
10 again, I think those are some of the implications of our
11 decision. At what point in time is this no longer a viable
12 option? And that needs to be factored into the planning.
13 If an operator is saying, "Hey, I can't make this work
14 anymore; there isn't enough market," then Option A is,
15 let's think about selling these beds off before we start
16 getting into more serious operational issues. Or there's a
17 point that the window closes, and then the beds just go
18 back in inventory. So, it's the operator's decision, and
19 their processing of the implications of what their
20 decisions are impact what they do. And in some cases, you
21 got operators that don't think that far ahead. Well, then
22 it's up to us, from a policy standpoint, to say that,
23 "Well, sorry; that's not an option for you anymore."

24 So, that's why I think this is a very

1 important issue, and I don't know that we're going to
2 resolve it in one discussion, but there are significant
3 implications to how we proceed, and I think Neyna raises a
4 good point.

5 MR. PHILLIPPE: It seems like we try to strike
6 a balance between sort of letting the market decide, and
7 how do we plan for every possible thing that could happen,
8 every possible problem or misuse of the system that could
9 happen, and you have to figure out where we're going to be
10 in that. It seems like we're kind of over on "let's
11 regulate every possibility" versus some state you shouldn't
12 try to do that, because if we move a little bit farther
13 over on the market, then what happens? We talked about at
14 my last meeting, you move the beds statewide, there's
15 places that are not needed, and it moves beds to areas in
16 the state where it's growing and there is a need for
17 greater beds. At the same time, it allows people, maybe,
18 who have those facilities where they don't need all of
19 those beds to recoup some money that can be used for
20 capital improvements to improve the quality of what they're
21 doing already. If we kind of try to think of every
22 possibility, it gets harder, because every time you try to
23 think of every possibility and build it in, there are
24 always exceptions and things you didn't think about that

1 don't make it work, in an odd sort of way.

2 I guess it's a policy perspective. I think,
3 like I said before -- and I guess I'm preaching to the
4 choir -- for some people here Illinois, it is different,
5 because the payments are so low -- and for me, nonexistent,
6 actually. My last check was in July, from the State.

7 MS. CREDILLE: Ours was May.

8 MS. HANDLER: Ours was July 10th.

9 MR. PHILLIPPE: But it does make a big
10 difference here. I know that some people say they could
11 provide a good quality of care and meet all of the
12 standards with a building running 50 percent, with Medicaid
13 payments, downstate. Okay? But it's hard. It's very,
14 very hard.

15 MS. COLON: I appreciate everybody's feedback,
16 and I think everybody's perspectives are very, very valid.
17 As a regulator, from that perspective, we'll regulate how
18 ever many beds you have? Okay?

19 B, I think that it's important to also note
20 that we do have an aging population. There are projections
21 that by 2020, I believe, one in four are going to be 65
22 years and older within our state. We do have issues
23 currently with quality of care outcomes for nursing home
24 providers. That's a given, I think everybody is fully

1 aware, but on the flip side of that, there are some really
2 good providers that truly have good policies, good
3 protocols, and it's very evident in their outcomes.

4 I think -- as we're talking about purchasing
5 and selling, I think that it's very important to take into
6 consideration that we need to put in some mechanisms when
7 making those decisions. I think quality needs to be a
8 factor. If I'm going to purchase beds from you -- you're
9 selling them because maybe you're decertified, your license
10 has been revoked, you can't operate because of
11 reimbursement or lack of payment, because it's been a
12 year -- correct? You can't sustain yourself. While I
13 think it's appropriate to potentially consider the option
14 to sell to a buyer who has a proven record, I think that
15 we, the Committee, should take into consideration what that
16 would look like. What are those variables? And really
17 drill that down. Is it change of ownership? Is it history
18 of surveys? What is it that we need to look at to make
19 these decisions on the application process?

20 I agree with you. It think it needs to be
21 before, not after.

22 MR. SCAVOTTO: I was listening to what, Tim,
23 you were saying, and I think I want to throw this out:
24 Neyna's comment, good; Tim's comment, good. But how much

1 are we going to be able to advocate for anything if we
2 can't pay for it? And I know that's a real problem, and I
3 agree with you. I forget what the rank is -- 50th or the
4 49th? It doesn't matter. It's too low, and I've dealt
5 with numerous clients who have just had to go out of
6 business because they couldn't make it. Now, fortunately,
7 in Illinois there's always someone willing to come along
8 and do a deal. I don't know whether the deal is a good
9 deal or not. That remains to be seen. We haven't seen
10 that dry up, but we have seen reimbursement dry up, and I
11 don't know how much we can realistically advocate,
12 regardless of how good that -- the need to advocate is.
13 And it's strong -- I agree with that -- but realistically
14 speaking, where is the money to do it? I don't think we
15 can put that in a document and have it last. You'll be
16 changing it every six weeks.

17 VICE-CHAIRMAN PICK: Cece?

18 MS. CREDILLE: I'm looking at the mandates of
19 the subcommittee, and one of our mandates is, again,
20 skilled nursing facility continuum of care with other
21 providers, modernization of nursing homes, establishment of
22 more private rooms, development of alternative services and
23 current trends in the long-term care services.

24 If funding is an issue and you allow buying

1 and selling of beds -- I'll just take an example. You
2 could have an operator who says, "You know what? If I sell
3 ten beds -- I'm not selling my whole building. If I sell
4 ten beds, it will give me X amount of cash that I can now
5 create private rooms for clientele and/or I can modernize
6 my facility and/or I can create a larger therapy
7 department." I can make a choice to sell the ten beds,
8 but there may or may not be a buyer. But if you have a
9 buyer, then you have cash flow to improve your operation,
10 which may prevent it -- the facility from closing in that
11 community.

12 Given limited funding in Illinois -- and it
13 isn't going to change. I don't care if we go managed care
14 or not managed care. The intent of managed care is to be
15 even less than already our 49th or 50th ranking. So this
16 just provides an alternative.

17 I would like to also suggest -- I actually am
18 in receipt of a document related to the buying and selling
19 procedure in Ohio, and I believe Ohio is currently at a
20 point -- I received the document this morning -- where they
21 are now in their window, again, of beds being available,
22 and I would like to submit that for our next committee so
23 people can read it and look at. I don't know -- Ohio -- I
24 don't know if they're in year two or four of this whole

1 process, but they limit the time frame in which people can
2 buy and sell beds. It's not just this open forum for years
3 on end, and if you're a bad provider, I'm going to sell my
4 beds, and if I'm a good provider, I'm going to be out there
5 looking for bad providers so I can have beds. It's very
6 orchestrated and organized. I can see a map where they've
7 mapped it out by county.

8 You're from Ohio. Perhaps you're familiar
9 about how they've mapped it out. So they said, "Okay. Now
10 we have twenty beds in this county available, and we have
11 thirty beds in this county available, and, you know, how
12 do -- how -- is there interest in people buying and selling
13 beds?" But there's a time frame, and then they can't sell
14 or buy outside of that time frame.

15 Just as an example -- I cannot speak -- and I
16 know Claire has presented lots of information, but if our
17 mandate is to look at the long-term care continuum across
18 alternative services, and modernization of nursing homes,
19 this is an option in a state with very limited funding.

20 MR. PHILLIPPE: I agree.

21 VICE-CHAIRMAN PICK: Good.

22 MR. PHILLIPPE: The last time I was at a
23 meeting, I think we talked about starting with a pilot for
24 six months. Let's have a limited period, see how it works,

1 give people plenty of time to prepare ahead of time, see
2 how it works, and then we're not committed to some
3 long-term plan. I like that, because it's what you said --
4 you have a fixed time period, and the market can settle
5 down and you can see the impact.

6 MS. CREDILLE: Ohio built theirs moving
7 forward. So, they set a -- I don't know what it is --
8 nine-month period? Toni, you may know.

9 MS. COLON: I don't know that time frame.

10 MS. CREDILLE: Where there's a time frame.
11 Boom, you can't do it; you have to wait two years. Here we
12 go; here's another time period.

13 MR. SCAVOTTO: Do we have any idea what a bed
14 is worth?

15 MR. PHILLIPPE: 10,000, 8 to 10,000, depends
16 on location.

17 MS. COLON: It does depend on location. I've
18 seen \$15,000 in certain states.

19 MR. PHILLIPPE: We were involved in one in
20 Ohio and it was 10.

21 MR. SCAVOTTO: I'm having a difficult time
22 with get-rich-quick on this.

23 MS. CREDILLE: It's not going to be.

24 MR. SCAVOTTO: I don't see how it works. I

1 think it's a cut your losses and get out of Dodge. If you
2 can get 15 grand in Illinois for a bed like that, maybe;
3 but I'd be surprised.

4 MS. CREDILLE: It's market-driven, because you
5 have to have a buyer and seller. You can't just say, "I'm
6 going to sell" and think that the whole world is going to
7 buy the beds.

8 MR. SCAVOTTO: I don't. How many
9 profitable -- how many people want to sell profitable beds?

10 VICE-CHAIRMAN PICK: No one. You're right.

11 MR. SCAVOTTO: I know I'm right. You're going
12 to sell a profitable bed? I don't think so.

13 MS. CREDILLE: But you're allowed to sell a
14 bed to move it, so that you -- and then that would help in
15 Illinois equalize services, potentially, and create access.
16 So, if it's in a community that is over bedded or under
17 bedded, it's not -- for whatever reason, it's not desirable
18 beds, it allows --

19 MR. SCAVOTTO: It could become desirable
20 someplace else in a new home. It could be a very cool bed.

21 VICE-CHAIRMAN PICK: Frank?

22 MR. URSO: I guess I have just a follow-up,
23 practical question. Do you know if the money that was made
24 or being made in this Ohio system is being put back into

1 the homes in a way that you described it? Does this
2 document reflect that, or do you know that or --

3 MS. CREDILLE: My understanding is it's
4 required that you have to put the money back into the
5 facility. So it's not a get-rich-quick.

6 MR. URSO: So a hundred percent of the funds
7 that you make?

8 MS. CREDILLE: I cannot comment on a hundred
9 percent, but my understanding is that it is required.

10 MS. COLON: Yeah, there is a requirement that
11 you put capital investment back into your home. An
12 example -- I went through a selling of approximately twenty
13 beds. The following year after that was completed, I was
14 able to put a million dollars back into the facility with
15 complete renovations, and it was --

16 MR. PHILLIPPE: 50 thousand a bed?

17 MS. COLON: Well, there was also in my budget
18 some capital. Luckily, I had some money in my budget, but
19 it was not in one year obviously. It was a five-year plan.
20 Because of the projected savings from that sale for that
21 year, you look at it within five years, the money that
22 you're going to save, and then you can develop a capital
23 improvement plan based upon the money saved, and then
24 you're able to invest in your home accordingly. So, I

1 mean, I just want to give a bigger picture, but I was able
2 to actually go through that process.

3 Again, I want to emphasize, the Department has
4 not taken a stance on this. I'm just giving some feedback
5 as far as my other hat experience, if you will. Thank you.

6 MS. AVERY: Something that Cece mentioned
7 about inventory triggered me to think about this, too. One
8 of the discussions that we've had here was regarding the
9 State's inventory for the Planning Board. We hear all the
10 time that there are beds that aren't being used. "I want
11 to establish a facility in this area, but there's no
12 documented need, according to the Board's inventory." So
13 one of the things that we wanted to look at also was how to
14 clean up that inventory, to make it accurate for the entire
15 state, because we do have pockets of the state that have a
16 bed need, and we have some that are over bedded, and we
17 hear it all the time. So, that's one of the steps we
18 wanted to take, also.

19 MS. COLON: I agree. And with emphasizing
20 that and what Cece stated, I think when we're looking at
21 this as a potential option, I think that's the number one,
22 I guess, benefit, would be that it would improve
23 accessibility and services in certain areas throughout the
24 state that have little to none. It does provide that

1 opportunity to meet those needs in those areas, where
2 currently we don't have an established system that even
3 offers that as an option. So, that's important to take
4 into consideration.

5 VICE-CHAIRMAN PICK: Okay. So if I can
6 summarize, what I'm hearing is less concern about
7 restricting operators from selling, but some real concerns
8 about who is eligible to buy, and that there should be some
9 criteria on the buyers, so that it's encouraging and
10 providing bed increases to operators who have a proven
11 record of delivering quality services. And the other I
12 heard is establishing like Ohio, or investigating like
13 Ohio, a time frame where buying and selling would occur in
14 prescribed periods, rather than just being open, so that
15 anytime anybody wants to buy or sell, it can occur.

16 MR. PHILLIPPE: Can I ask a question, because
17 I've been involved in talking about this for a year now. I
18 get confused now from across the time --

19 VICE-CHAIRMAN PICK: That's age, Tim.

20 MR. PHILLIPPE: It probably is my age. I have
21 artificial parts now, so you know I'm officially old, and
22 I'm not the Bionic Man; I just have artificial parts.

23 But the key issue here is -- we started out
24 with the bed need, and I was really working on that bed

1 need workgroup first, because it really has to do with how
2 it fits in the bed-need formula, because if you keep it in
3 the same Planning Area and then you are buying and selling
4 beds, I assume there's no impact, because you're taking it
5 one place and putting it another. If we take them across
6 the state -- which is what we talked about the last time I
7 was here -- then I'm assuming what we're saying here is,
8 you can take beds from an area where you bought them
9 somewhere and you can put them someplace else where there
10 is no bed need according to the formula. Is that what
11 we're saying? You're deciding you want to do it there.
12 You think there's a reason they're in need of a facility.
13 Some group decides they want that facility to grow, but,
14 according to the official calculation, there is no bed
15 need. That's what we're talking about. So, it's a way
16 of --

17 VICE-CHAIRMAN PICK: I think your reflection
18 is accurate.

19 MR. PHILLIPPE: If there is a bed need, you
20 would just do an application. Is that what we're talking
21 about?

22 VICE-CHAIRMAN PICK: Yes, I think that's part
23 of the discussion.

24 Yes, Frank?

1 MR. URSO: If I remember -- and that's
2 doubtful, but at the beginning of the discussion, you
3 started talking about the seller as being a reputable
4 individual, and I don't think you can lose track of that
5 also as a consideration. Am I right that you --

6 VICE-CHAIRMAN PICK: That's exactly where I
7 started.

8 MR. SCAVOTTO: You did get started there.

9 VICE-CHAIRMAN PICK: But I got swayed in the
10 course of the discussion in that perhaps the selling side
11 of the coin is less of a concern, whereas the buying side
12 is much more significant, and that -- I mean, my concern in
13 the beginning of the discussion was that we didn't want to
14 reward operators who were just milking a building and that
15 all they're doing is trying to get out whatever they can to
16 the point where they've stripped it down and now they're
17 selling. And, again, listening to the discussion, I'm less
18 anxious about that now than I was in the beginning, and I
19 think because it may be that it occurs for a reason.

20 I can't tell you how many buildings I walk
21 through where I would see the mechanicals -- I mean, this
22 is where I started in this field, working maintenance --
23 where the mechanicals are just totally neglected and --
24 because it's the last place anybody looks, and that's

1 where, you know -- and it's referred to as "deferred
2 maintenance". But the reality is, they're milking the
3 building and taking out as much as they can, because if
4 it's not viable, then they'll get out and it will be the
5 next person's headache. And it's a real issue. So, I
6 guess it's that kind of a mindset that concerns me, and
7 that's what leads me to -- you know, we have an operator
8 where the mindset is, "I'm going to bleed it as much as I
9 can, because I know it's on its last leg anyway." Then do
10 we reward a system -- you know, a management approach like
11 that, by giving them another option of, "Now, after I have
12 taken it down as far as I can go, I'm going to sell the
13 beds off"? So, that's why I used the term "carpetbagger".
14 That's someone who shows up and is an individual who is
15 trying to, you know, extract every last dime they can out
16 of the asset, with no consideration for anything else, you
17 know, who is being served or not served and the whole
18 process.

19 MR. PHILLIPPE: That's true.

20 VICE-CHAIRMAN PICK: So -- but, again, in
21 listening to the discussion, it may be that this is not a
22 dynamic that we can change at a public policy level, but,
23 rather, how do we try and make lemonade out of lemons?
24 Right? So, if beds aren't going to be better, are

1 providing improved services in a different location, then
2 maybe that was the best thing that could happen, and the
3 operator wasn't going to change the way they were going to
4 do it; they can't sell the beds and they're going to bleed
5 everything else they can. So, it's not going to alter
6 their behavior, and, again, from a policy standpoint, I
7 don't think our mission is to alter behavior. It's how to
8 protect consumers, and how do we -- and the protection may
9 very well be that those beds in another area are going to
10 provide a better outcome than they do in the location
11 they're in.

12 MR. URSO: So my mindset comes from
13 prosecuting bad nursing home operators, and therein lies,
14 many times, repeat offenders, and that's why I don't think
15 you can -- or at least I think you need to consider, this
16 group needs to consider, the seller's demeanor, so to
17 speak, and the seller's operations. I mean, Toni mentioned
18 a seller who, perhaps, was in a revocation action. I mean,
19 from a licensure standpoint, that's the most severe -- one
20 of the most severe licensure sanctions that can occur, and
21 so why would you then want to allow that individual nursing
22 home operator to split off some beds and consider making
23 some money before the big fall comes? And it's kind of
24 parallel to what you're thinking about, but in your

1 summary, I think you have to also consider about that
2 seller's disposition.

3 MR. PHILLIPPE: You've convinced me. I agree
4 with you guys. I mean, I do, because we don't want to
5 create incentive -- the penalty is there for a reason, and
6 so if we make it easier for people to make money instead of
7 suffering the penalty, that's not good for consumers. So I
8 think the question is, just how would we define that on the
9 survey process and licensure process? If there are certain
10 points we could just define, that they can't be sold during
11 these points?

12 MS. COLON: Right. You have to wait a period
13 of time before you are eligible for consideration to sell,
14 you know, your beds. I think that brings up a really good
15 point, because you're right -- decertification and
16 revocation actions are very, very severe, as we're all
17 aware, and you're right. I don't think we should afford
18 them that opportunity to make any exchanges during the
19 period of time, until they can show three -- their
20 following three annual surveys to show, you know, the scope
21 and severity involved, or whatever we decide. I think
22 that's a really, really good point.

23 MS. HANDLER: I was going to ask -- because
24 this is not my field of expertise. Is there such a thing

1 as beds in good standing? Beds in good standing would be
2 fully certified, meeting operational criteria, and only
3 those kinds of beds could be sold, which I think is what
4 you were saying, but I don't know if there is a definition
5 or some kind of --

6 MR. PHILLIPPE: I think you mean in
7 compliance. If you're in survey compliance at that
8 point --

9 VICE-CHAIRMAN PICK: Substantial compliance.

10 MR. PHILLIPPE: Substantial compliance. That
11 would be a criterion, and then it sounds like there is a
12 licensure issue separate from that.

13 MS. COLON: There's licensure violations and
14 then there's federal violations that we would take into
15 consideration, and what we would want to at least take into
16 consideration before a decision is made is, what do we want
17 the outcome to be, from that perspective, and what is the
18 time frame to allow that as an option for the operator?

19 VICE-CHAIRMAN PICK: So, again --

20 MR. SCAVOTTO: So that brings the discussion
21 back to where you started. So, I'm still on the spot where
22 I think you can get a better outcome if you're
23 concentrating on the buyer, which is what we ended up with.
24 But I agree that Frank has got a good point; Toni has got a

1 good point. It seems to me that you condition it. If
2 you're in the soup with IDPH and you can't get clearance
3 with IDPH, you can't sell beds. We can protect that.

4 But I want to go back to your comment on the
5 bed formula, the bed-need formula, and that's one of the
6 things I thought that we had a discussion about when we
7 were talking about a pilot program and -- because this
8 would be a real good way to mess up the bed-need formula.
9 It could make everybody's life miserable. So, I think we
10 shouldn't get away from that idea of putting a pilot out
11 there somewhere.

12 MR. PHILLIPPE: So how do you think it would
13 affect it? Tell me what you're thinking about.

14 MR. SCAVOTTO: Think about what, a pilot?

15 MR. PHILLIPPE: No, the impact on the bed need
16 and the bed-need formula.

17 MR. SCAVOTTO: It's easy if you -- if the
18 transaction is within a Planning Service Area, a county.
19 But if you are bordering two counties, two Planning Service
20 Areas -- and that happens quite a bit -- you're going to
21 end up adjusting the bed-need formula in and out of
22 balance, potentially, and it just calls into question the
23 legitimacy of the formula. So, you put this bed-need
24 method independently out there and then, by the way, we can

1 make these side transactions that make the results of your
2 bed-need formula incorrect.

3 MS. BURMAN: That's one road into the
4 discussion. Another one would be that the planning
5 determination for bed need would be one of the points of
6 governing where the beds come from and where they go. If
7 it's not a designated area of need, it's not going to get
8 beds.

9 MR. PHILLIPPE: That was my original question
10 when I went over this to begin with. Because if there is
11 an official bed need in an area, a Planning Area, why would
12 I buy beds? It would just cost me more money to expand.
13 And I could go through the process and expand without
14 paying for them, right? So the only reason to use them, it
15 sounds like, is if it's an option when there is not a bed
16 need.

17 VICE-CHAIRMAN PICK: Not necessarily. We
18 still got the 10/20 rule, right, 10 percent or 20 beds?
19 That hasn't gone away, but then you have a whole other --

20 MR. PHILLIPPE: Has that gone away?

21 VICE-CHAIRMAN PICK: No, no.

22 MR. PHILLIPPE: No, it's not gone away.
23 That's what I mean.

24 VICE-CHAIRMAN PICK: So why would you buy

1 beds if you can just add 10 percent or 20 beds, whichever
2 is lower? So you don't buy any beds, you just -- you're
3 sending in a notice, saying, "I'm exercising this option to
4 add beds," right? So, you're at the 90 percent threshold.

5 MR. PHILLIPPE: I assumed we're doing it,
6 actually, because it's beyond that criteria. That would be
7 the only reason to buy beds.

8 MR. SCAVOTTO: Right. You need more beds.

9 MR. PHILLIPPE: But if there is a bed need in
10 the market, you just go through the process. Why would you
11 buy them?

12 VICE-CHAIRMAN PICK: So the way I look at it
13 is it's tiers. Right? You have Tier 1, the 10/20. If I
14 can do that, that's the least expensive and the most
15 efficient way for me to add beds. If I need more than that
16 threshold provides me, then I'm going to look at -- from an
17 application process, if I apply for additional beds that
18 are available in the Planning Area, what's it going to cost
19 me to put that package together and go through the process
20 of going before the Board to get an approval?
21 Alternatively, what's it going to cost me to buy some beds?
22 Whatever is lower and more likely to be successful is the
23 way I'm going to go. So I would look at it as those three
24 tiers.

1 MR. PHILLIPPE: That's what I was trying to
2 get to on my original question. So, we're still talking
3 about the idea. Even if you buy the beds and they're above
4 the 10 percent, there would still need to be a bed need in
5 that Planning Area to expand that facility where you bought
6 the beds? Is that what you're saying, or not?

7 MS. BURMAN: Well, ideally you would still
8 have to confirm that there is a need for the beds.

9 VICE-CHAIRMAN PICK: The difficulty with that
10 issue is, if there are beds in the area that are not being
11 used because -- for a whole host of reasons, poor
12 performance, whatever, there's an operator who has the --
13 who is gaining market share because they are meeting
14 consumer needs, but there's no bed need in that area
15 because of those dynamics -- then the bed need negates the
16 ability for that operator to add beds.

17 MS. BURMAN: Well, if everything went strictly
18 according to the rule, no deviations from the rule -- we
19 have numbers of applications that come in and they're able
20 to verify that -- for other circumstances that are not
21 contained within our rules, they can verify that, yeah,
22 there is a real need and we do need these beds. Then they
23 get approved.

24 MS. HANDLER: So some kind of an exception.

1 MS. BURMAN: Yes. The Board has discretion.

2 VICE-CHAIRMAN PICK: But there's a
3 distinction between an exception and a discretion.

4 MS. BURMAN: Yes.

5 VICE-CHAIRMAN PICK: Exception, there are
6 specific criteria. You're talking about discretionary
7 decisions.

8 MS. BURMAN: That's correct.

9 VICE-CHAIRMAN PICK: That go over and above
10 the formula.

11 MS. BURMAN: I don't want to muddy the waters,
12 but if you're talking about that kind of a thing where
13 it's -- you want to go as closely to the rule as you can,
14 then there's the world of variances and, yes, we can talk
15 about and perhaps create some more viable variances than we
16 have in place right now. It's not meant to be a black and
17 white world, because we know, when we put rules together,
18 you can't possibly cover everything that's going to come
19 up. That's why they're written in a more nebulous way than
20 some people would like. But it's for that purpose, so that
21 somehow you can fit your project in and we can review it.

22 VICE-CHAIRMAN PICK: And so if I can add, we
23 never intended the buy/sell to be a work around the Board,
24 because even with an exchange, it would still have to go

1 through the Board, through some type of procedure, right?
2 So it's not an alternative to going to the Board. It would
3 just be expedited or a simplified process.

4 MS. BURMAN: And there would be an assessment
5 of need. There's no way around that Certificate of Need.

6 VICE-CHAIRMAN PICK: So it's not all or none.

7 So, I think -- again, going back, I think
8 we're going to have to think about this. How do the puzzle
9 pieces fit together, given the different pathways? I
10 think, Tim, your point is right on target, given the
11 different pathways that an organization can go through to
12 add beds, that the organization and its leadership is going
13 to have to go through some process of analysis to determine
14 what's the best way, and maybe they're going to -- maybe
15 multiple paths, because they want to make sure that they
16 end up with the beds they need as part of their planning
17 process.

18 MR. PHILLIPPE: I know it sounds like it's a
19 rule issue and it's a legal issue and a law. However, it
20 makes more sense to have the -- some process for
21 transferring beds, if it actually allows -- it moves you
22 out of the bed-need formula process, because one of the
23 things we keep talking about here from the very beginning
24 almost and brought up again today is, what about all of the

1 other long-term care out there? And I was one that has
2 been involved in this bed-need issue for a long time. It's
3 very difficult to build any changes in the market to the
4 bed-need formula. That's what it came down to, it sounds
5 like, and we just go round and round. Claire was very
6 helpful, but it's very difficult to figure out how to build
7 it into the formula.

8 So, the transfer gives you an opportunity just
9 to be more creative in the system and ignore the formula,
10 basically is what it does. Now, if it were -- if we really
11 are concerned about it, personally I would prefer it be
12 more like in Ohio. I think in Ohio, it's your county and
13 contiguous counties, or something like that, where you can
14 actually transfer. But we do something that ties into the
15 Planning Area issue, instead of allowing it statewide, but
16 then be able to exempt from the bed-need formula, because I
17 think -- I like predictable. I don't like going and
18 spending lots of money and not knowing what's going to
19 happen at the Board level. I think most groups do.

20 VICE-CHAIRMAN PICK: That's called a casino.

21 MR. PHILLIPPE: So, I mean, you get the right
22 people, you got the experts, they understand the rules, the
23 laws; they can pretty much predict. That's what you want.
24 You want predictable. That's good for the consumer, too.

1 So, I want to mention that, because once we say we will
2 allow statewide, but you still have to go back to the Board
3 and still looking for the bed-need formula, I'm not sure
4 where the value is, particularly. I just can't see the
5 value, outside of maybe there's a little political value in
6 the fact that, well, I'm taking beds out of this area and,
7 yes, I'm adding them here and they're taking them out of
8 service there.

9 MS. CREDILLE: In Ohio, they're doing the
10 65-plus per thousand, and if I pull out -- I'm looking at
11 data that we discussed as a committee a year ago, six
12 months -- it comes up over and over again. You just look
13 at SNF beds per 1,000 people who are over 65, of the sample
14 size I have, Illinois is the highest -- 64.1 -- and we have
15 variances as low as 19.4 in Nevada. I don't know what --
16 but the number of beds we have per thousand is very high in
17 Illinois. And so in the CON process, as well -- and it
18 came up when we talked about the application, that the 90
19 percent occupancy criteria in the application has become
20 more difficult for operators, as maybe reflected in the
21 number of beds per thousand, as may be reflected in the
22 beds that are appropriate or not appropriate; it may be
23 where they are located. I mean, there's a multitude of
24 reasons. But in the industry, I think -- industry-wide, I

1 think, operates about 85, 86 percent occupancy in skilled
2 beds.

3 VICE-CHAIRMAN PICK: Illinois is 78.

4 MR. PHILLIPPE: It's come up. It was about
5 72. I don't know why it came up.

6 MS. CREDILLE: If Eli's number -- it is
7 somewhere between 72 and 85 -- is the current occupancy in
8 Illinois, buying and selling then, again, allows
9 flexibility for beds to be --

10 MR. PHILLIPPE: And I agree. I think that's
11 what I'm trying to say. Rather than just moving beds
12 around and adding beds, at the same time it would be nice
13 if we can -- that's what you're saying, really. Do we not
14 have enough beds already in the state? And come up with a
15 system that allows us to move the beds around and not keep
16 adding to the system. Does that make sense?

17 MR. SCAVOTTO: It makes sense, as long as your
18 utilization is staying down.

19 MS. AVERY: But I think a lot of the issue is
20 all of the unused, empty beds in our inventory.

21 VICE-CHAIRMAN PICK: It bleeds off the
22 numbers.

23 MR. SCAVOTTO: Dead beds? I got that term
24 from Eli.

1 MS. CREDILLE: I'm going to go back -- some of
2 the dead beds -- let's just be very frank here. There are
3 many facilities in Illinois that have four-bed and
4 three-bed wards. I'm sorry; those need to be dead beds,
5 because no one, whether you're a Public Aid clientele or a
6 private pay or a Medicare or a managed care, wants to live
7 today in a four-bed or three-bed ward.

8 MR. PHILLIPPE: As long as you mention -- our
9 charge is to move towards single rooms. It would be nice
10 if we could just do something to eliminate more than two
11 people in any room. That would be a start toward one,
12 unless you have some unusual kind of situation. You might
13 for some clinical reasons.

14 VICE-CHAIRMAN PICK: That strongly reinforces
15 Cece's comment about four's and three's are certainly not
16 viable in this environment, if we have an option.

17 MR. PHILLIPPE: If we could just take those
18 out, because you're -- one of the issues we kept going
19 around and around in our workgroup is, what are operational
20 beds? We looked at the way you describe them and measure
21 them during the year, and it's really clear, however you do
22 it, we're not using a lot of beds.

23 MS. AVERY: And we're working on trying to get
24 the industry to buy into this, just as we do with

1 healthcare facilities, the hospitals. We were able to
2 remove -- and we didn't see a significant increase in
3 utilization, but it did improve, and we didn't have a lot
4 of the providers saying, well, we're not meeting
5 utilization because of X, Y, and Z. But what we're seeing
6 here is that providers aren't meeting utilization targets
7 because of the inventory. And we're getting ready to do
8 surveys next month.

9 VICE-CHAIRMAN PICK: No, December.

10 MS. CREDILLE: December 31st is when we
11 compile the data.

12 MS. AVERY: I think we're going to try to get
13 them out next month.

14 MR. PHILLIPPE: I think some of us would
15 agree, there's plenty of beds statewide. It looks like the
16 statistics show that. They may not be in the right
17 locations, and then they may be stuck in some buildings,
18 not being used, but -- so, an area may have more beds than
19 it needs, but it's also individual facilities may have more
20 beds than they need. So, just from a policy perspective,
21 my preference is not to create policy that causes more beds
22 in the system. It would be nice -- I think that's where I
23 originally started a few years ago, when we started these
24 discussions with the group. We kind of freeze the beds in

1 the system almost and then try to move them around and have
2 a policy that freezes new beds, and what it will do now, it
3 will make a difference, because it makes the beds worth
4 more, if you've got to buy them to get them; whereas, if we
5 had this whole tiered system and you only buy beds when
6 you're in this weird kind of separate niche, it doesn't do
7 much. But if we freeze the beds in the state -- and I
8 think -- you said something about growth. Everything I see
9 is showing long-term care declining in census. I mean,
10 every study, every place I go, I've seen things predicted
11 in other states --

12 VICE-CHAIRMAN PICK: You mean in-patient,
13 long-term care?

14 MR. PHILLIPPE: Institutional long-term care,
15 not assisted --

16 MS. COLON: I was looking specifically at the
17 aging population.

18 MR. PHILLIPPE: You're absolutely right. It's
19 going to grow other places. We're talking about
20 institutional long-term care, which is what we deal with.
21 It's going to decline in numbers. So, it seemed like this
22 is an opportunity to kind of help call a halt to the
23 growth, because I do think there is some element to if you
24 build it, they will come. If you build more, then people

1 have motivations to go out and fill that building. It's
2 just the nature of things.

3 VICE-CHAIRMAN PICK: I think the other
4 practical reality is, operators in an environment when a
5 new building opens, that's where all of the patients go.

6 MR. PHILLIPPE: They do.

7 VICE-CHAIRMAN PICK: So, if I have the option
8 of going into a brand new, state-of-the-art facility versus
9 an older building, I'm going to be influenced by the new
10 building.

11 MS. MITZEN: Don't we also have to ask
12 ourselves what they going in that building for? Are they
13 going for long-term or short-term? And the turnover rate
14 is very high in many of the facilities. So, I think I
15 heard you say, yes, we're going to have an inventory, but
16 what are we using these long-term --

17 MR. PHILLIPPE: One of the things I noticed in
18 Indiana and not having a Certificate of Need, it is true --
19 people come in town with three, four, five, and they build
20 new, but, boy, it puts pressure on everybody else. The
21 owners can't put that money in their pocket and put off
22 updating their buildings. It puts pressure on everybody to
23 improve what they do, because if they're going to survive,
24 they've got to compete. So there's a balance here. It's

1 true in one way that people go to the new building, but
2 people down the street -- I've seen it happen for us when
3 we remodel in the area. We're the best suddenly.
4 Suddenly, people across town, they remodel also, and that's
5 good for consumer, really. It's good for people.

6 VICE-CHAIRMAN PICK: So, again, going back, I
7 think in trying to remember the genesis of the bill, why it
8 was introduced, again, my recollection -- which is not as
9 good as it used to be -- was that there was a sense in the
10 provider community that going -- trying to get CON's as a
11 way to advance the expansion and development and
12 strategically locate new buildings was viewed as
13 restrictive, and the ability to get private rooms, you
14 know, as part of the plan, in historical instances the
15 Board was not receptive to doing that. So, there were a
16 whole host of issues that were viewed as impediments to
17 advancing the field of institutional long-term care, and so
18 as a result, it turned to the Legislature to say we need to
19 make sure that these elements are incorporated, and that
20 also included formulating this group.

21 So, I think one of the things that was not
22 accounted for or anticipated is that by formulating this
23 group, now it's going to impact the Board's actions.
24 Right? Because, again, part of what we're hearing is --

1 the Board's representatives are part of this process --
2 that there's receptivity to let me understand what are
3 other sources of data to help influence our decisions. If
4 we understand that the consumers' needs are X, Y, and Z
5 compared to what we perceived it to be, then that's going
6 to influence the Board's ultimate decisions about what
7 projects are approved. So, I think it's evolving, and the
8 legislation was a point in time, and by virtue of the
9 legislation passing, it's impacting the way the market is
10 responding, and that includes the Board's interpretation
11 of, you know, how projects fit into what the market needs
12 are.

13 So, I think that's part of what we need to
14 take into consideration, that, you know, in the course of
15 our decision making, that we need to understand and
16 appreciate the fact that the Board is not today what it was
17 two years ago when this bill passed, and that we need to
18 make sure that that's being accounted for in our
19 recommendations for rule changes.

20 So, again, going back to Terry's comments,
21 what I really saw as a common thread was Terry trying to
22 liberalize the options for operators on how services and
23 access could be expanded so that market, really, was the
24 primary driver of where services are available and what

1 services are available and how they're delivered, and what
2 we're trying to deal with is, from a policy standpoint, how
3 we balance -- which is exactly what you were saying, Tim --
4 the benefits and risks, the risk reward associated with
5 going to a really full -- as much free market as we can,
6 versus putting up some protections and making sure that
7 consumers are having those protections in place that limit
8 their ability to be harmed in those negative -- potential
9 negative encounters in the full free market kind of
10 environment. So, I think that's -- in a global standpoint,
11 that's kind of where we're at, and how do we synthesize the
12 specific legislation, which is our charge, with the market
13 as it is today and where we see it progressing and the
14 Board's response to how they process applications, given
15 all these dynamics.

16 So, I think that's one of the difficulties we
17 have, is it's -- it's changing even as we talk about it,
18 and it's clear that the Board is more liberal today than it
19 was two years ago. There's no question in my mind that
20 that's already occurred. So, I think from our planning
21 perspective, how do we make this dynamic as opposed to
22 static? Static is, these are the things we need to
23 accomplish today; we'll get it done; and then we'll revisit
24 it at some point in the future. Dynamic is how we

1 establish the elements that allow for the system to evolve
2 in a way that doesn't require such monumental efforts, like
3 sponsoring legislation, and then going through this long,
4 drawn-out process to reform the whole system. By the time
5 we get to reform, things are pretty bad, right? So that's
6 what we want to avoid. That's my sense of what we're
7 trying to do. We want to avoid circumstances that get us
8 to the point where we say we need to reform the system,
9 because then we're close to gridlock, and, to me, that's
10 really ultimately our charge, is how do we help instill
11 those dynamics that allow the system to evolve and move
12 forward without it having to be reformed.

13 I see some head nodding. That's good.

14 MR. PHILLIPPE: So, can I ask you to summarize
15 then? We report to the Board, and they're the ones that
16 really make the decisions. We make recommendations. I've
17 asked this before. So it's useful to know the Board's view
18 of some of this, because you don't want to spend a lot of
19 time working on something that's in conflict with major
20 issues, that they see it differently because they have a
21 much bigger scope, and so -- but I do think -- going back,
22 I like specifics, like you say, evolving, but I like to see
23 something getting done, too. I don't like working on this
24 bed transfer thing now for three years and nothing happens.

1 I've been talking about this bed transfer thing, I think,
2 for three years at these meetings, and it's because it's
3 got some good ideas. So, I would like to look at a way
4 where we're conservative, but we do something; we recommend
5 something to get the process moving forward, even if it's
6 conservative, to see -- then we can evolve it. Is that
7 what you're saying?

8 VICE-CHAIRMAN PICK: And I think, again,
9 reinforcing what you were saying, is that we need to blend
10 somehow those specifics with the dynamics, the overarching
11 concepts. The fact that Dale came to our meeting reflected
12 the fact that there is a significant interest on the part
13 of the Board.

14 MR. PHILLIPPE: That's what I saw.

15 VICE-CHAIRMAN PICK: So that is a very
16 positive indicator, and one of the things I think I
17 heard -- I'm trying to discern what Dale said here at the
18 group versus when Michael and I met with him on an
19 individual basis -- that the Board did not really
20 understand and appreciate the uniqueness of long-term care.
21 It was historically viewed as a mini acute system. That's
22 changed. So -- but, again, those individuals on the Board
23 change, also. So, we don't know what they're coming in
24 with, as far as their preconceived conceptions. So, again,

1 I think that's part of what we want to do is -- over and
2 above those specific elements that the legislation called
3 for as interventions to liberalize the system, it's how --
4 because this advisory group has no sunset. So there's --

5 MR. SCAVOTTO: No what?

6 VICE-CHAIRMAN PICK: No sunset. There was no
7 end date for our group.

8 MR. PHILLIPPE: We'll never be done.

9 VICE-CHAIRMAN PICK: Right. So -- but I
10 think that's reflective of the fact that there's an
11 acknowledgement at certainly the legislative level.
12 Legislators recognized that there is a need for our input
13 to influence the decisions on -- that impact the long-term
14 care system and, secondarily, there's, you know,
15 receptivity on the part of the Board of, "Okay, now that we
16 know that there's this group, that tells me that there's
17 something we're not understanding that we need to better
18 understand." So, I think the legislation has already
19 accomplished that. That's already a positive outcome. So,
20 really, it's up to us as a group to maximize that
21 opportunity, so that -- and I agree with you, Tim. We need
22 to make sure that we have some finite accomplishments,
23 because there's nothing to say that legislation can't
24 choose to disband this group because it's not doing

1 anything. So we need some finite achievements as part of
2 our charge, but I think we also -- we don't want to lose
3 sight of the broader questions of how do we want -- how do
4 we impact and influence Board decisions that are either
5 positively or negatively affecting the ability for
6 consumers to have maximal benefits from long-term care
7 services availability?

8 MR. SCAVOTTO: Let's see how serious we are.
9 So let's propose buying and selling beds and let's
10 seriously consider eliminating the bed-need formula.

11 VICE-CHAIRMAN PICK: That might be a little
12 heretical at this point.

13 MR. SCAVOTTO: Let's see if we have any
14 takers. I'm looking at this data here, and I say you can
15 have any bed-need formula you want; it's not going to hit
16 these targets. You're going to be significantly over.
17 It's one way to see who is out in the wood pile, if there
18 are any real, sacred precepts that we can't talk about.

19 VICE-CHAIRMAN PICK: It certainly separates
20 the wheat from the chaff.

21 MR. SCAVOTTO: Right. Might as well make a
22 strong-minded suggestion.

23 MS. BURMAN: I think we need to keep in mind,
24 also -- if you go back to the documents that have been

1 distributed earlier about other states and how they handle
2 this issue, the vast majority of them require that they fit
3 within the need concept and within the planning
4 determination.

5 MS. CREDILLE: Some of their need concepts are
6 65/1,000. They're not -- they don't have a complicated
7 formula.

8 MS. BURMAN: Well, good for them.

9 MR. SCAVOTTO: "Good for them" is going to
10 secure Illinois' position as having the most beds that are
11 under utilized. That's good for them. I don't see how you
12 can argue with these statistics.

13 MS. BURMAN: The states are in competition.

14 MR. SCAVOTTO: I don't see how you can argue
15 what's here.

16 MS. BURMAN: But the main idea being that if
17 the unneeded beds go to an area of need, that's what
18 everybody wants, and there is a bed-need determination
19 that's already in place and has been.

20 VICE-CHAIRMAN PICK: So, can I ask then,
21 Claire, if an applicant comes in and says, "There's a bed
22 need in this area, and I want to -- I want beds from
23 inventory as opposed to a transfer "--

24 MS. BURMAN: I see. So we have like a pool?

1 VICE-CHAIRMAN PICK: No, no. I'm just asking
2 the question. So if it's all governed by bed need,
3 inventory, but the option is we transfer some beds versus
4 taking beds out of inventory, how would that be -- how do
5 you discern which beds are being used?

6 MS. BURMAN: Taken out of inventory?
7 Inventory is just an official count of the beds and where
8 they are.

9 VICE-CHAIRMAN PICK: No, no. I'm talking
10 about bed need. So let's say that a Planning Area has a
11 bed need of a thousand beds, or even if it's a hundred.
12 Let's say it's a hundred, and I'm an applicant, and I'm
13 coming in and I'm saying, "I want to build an 80-bed
14 facility in this Planning Area." Where will those beds
15 come from, those 80 beds? Would they be a transfer from
16 another area?

17 MS. BURMAN: There would be a regular
18 application for establishing a skilled nursing facility.
19 It would come from what he calls "Inventory".

20 VICE-CHAIRMAN PICK: What I'm referring to as
21 "available beds" based on the formula?

22 MS. BURMAN: Correct.

23 VICE-CHAIRMAN PICK: So then, when would a
24 transfer be relevant?

1 MS. BURMAN: For an existing facility that's
2 over capacity, you know.

3 VICE-CHAIRMAN PICK: They still have to make
4 an application. If there's no beds available in that
5 Service Area, then those beds are not available.

6 MS. BURMAN: If they found someone who wants
7 to sell beds within the defined --

8 VICE-CHAIRMAN PICK: Wait. What's in
9 conflict is, if someone wants to sell beds to a facility
10 that wants to add beds, and they can only do that if beds
11 are available based on the formula, then why -- when is it
12 a transfer versus when is it beds from what's available
13 based on the formula?

14 MS. AVERY: I don't think it would be. It
15 would be two different processes. It would be our normal
16 CON establishment process, and I think we talked about this
17 before, what this would look like, the application process,
18 how it would look. That would be a different process. So
19 that's a process we don't have in place right now.

20 VICE-CHAIRMAN PICK: No, no. I understand.
21 So, in theory, let's say we've worked out the details of we
22 can transfer beds, and we've already walked through the
23 process of who is eligible, who is not. Let's put that all
24 aside. But where I'm getting to, if it's governed by a

1 Planning Area having to have beds available based on the
2 formula, then what's the point?

3 MS. AVERY: I don't think it will be based on
4 it, if we're transferring. I think transferring would have
5 just a totally different scenario. A transfer will be --
6 if the Committee does it or the Board does it -- within an
7 HSA. So, of course, you shouldn't be able to transfer one
8 bed out of an area that has a need documented into an area
9 that's over saturated.

10 VICE-CHAIRMAN PICK: Oh. So, you're saying
11 that the bed-need formula would be applied, if it's moving
12 from one Service Area to another, but if it's within the
13 same Service Area, then it doesn't matter if there's beds
14 available.

15 MS. AVERY: I wouldn't say it doesn't matter.

16 MR. SCAVOTTO: I didn't hear her say that.

17 (Discussion off the record.)

18 (Lunch recess)

19 VICE-CHAIRMAN PICK: All right folks. We're
20 going to try to restart.

21 So, Michael, I think you were the last one on
22 the discussion, right?

23 MR. SCAVOTTO: Yeah, but in further discussion
24 with Courtney, I misunderstood what she said. So she was

1 right in response to you. I misunderstood her, and she
2 didn't misunderstand you.

3 VICE-CHAIRMAN PICK: No problem. So, if my
4 understanding is correct, then as long as the bed exchange
5 is occurring within an HSA, then there is no -- there would
6 be no need for the Board to determine that there's a bed
7 need for a transfer or sale of beds to occur. If it goes
8 outside of an HSA, then there would be a Board review to
9 determine that there is bed need for the transfer to occur.

10 MS. AVERY: An establishment, until we get the
11 rules in place, and from the discussions that we've had
12 when you all have talked in the past, it has been limited
13 to the current HSA's. We talked about a pilot. We talked
14 about statewide. But if this is to go through then, yes,
15 but if there is an establishment of a new facility, it will
16 be based on the bed need for that area, and if there is a
17 need, that would come through as a regular CON.

18 VICE-CHAIRMAN PICK: In Terry's comments on
19 the draft, if my memory is right, his advocacy was for
20 statewide with no bed need requirement for that -- for an
21 exchange or sale.

22 MS. AVERY: But the way we originally had
23 written it before is based on what I just said, before
24 Terry's input.

1 VICE-CHAIRMAN PICK: Okay. So it's clear now
2 that the Staff's -- the current draft of the bed sell and
3 transfer is that if the transfer is occurring within an
4 HSA, then there is no bed need requirement for that
5 transfer to occur. If it's outside of an HSA, then there
6 would be a review to determine that there is a need for
7 those beds in this incoming HSA area that would be
8 acquiring the beds.

9 MS. AVERY: And there would probably have to
10 be some determination as to whether that transfer would
11 have an impact, a negative impact, on the existing HSA, if
12 it's trying to go outside of it.

13 VICE-CHAIRMAN PICK: I'm sorry. Say that
14 again.

15 MS. AVERY: If it's trying to go outside of an
16 HSA. I don't think there is a cookie cutter that we can
17 say right now, but in my mind, in trying to have a visual
18 of what this would look like, I don't see that the Board --
19 not speaking for what the Board would do -- or we would
20 want rules to say that you can go outside of an HSA and
21 leave your current HSA in the negative impact.

22 VICE-CHAIRMAN PICK: Yeah, so I did
23 understand you correctly then. There's a concern about
24 beds leaving an HSA area and creating an under-bedded

1 condition.

2 MS. AVERY: Those are things that should be
3 taken into consideration.

4 MR. PHILLIPPE: Makes sense. Question: You
5 mentioned the new facility, new building. So, I think we
6 talked about originally in one of the conversations -- I
7 remember this was just to be to add beds to a current
8 location, right? We're still limiting that? We're not
9 talking about buying enough beds to start a new one.

10 MS. AVERY: Right, you should not be able to
11 buy enough beds to establish a new facility.

12 MR. PHILLIPPE: I understand. That makes
13 sense.

14 MR. SCAVOTTO: To you, Tim. The way I
15 remember things, when your workgroup was working on this
16 issue, you basically decided to call it a career and not
17 take -- not make a recommendation, right? Do I recall that
18 correctly?

19 MR. PHILLIPPE: Yes. Our task I identified
20 for our workgroup when it was assigned was just to start
21 illuminating some of the issues and bring those back to the
22 group.

23 MR. SCAVOTTO: Okay. So my first question is,
24 where do you -- how would you think your workgroup would

1 respond to this discussion we're having right now?

2 MR. PHILLIPPE: The same way this group is
3 responding, because my workgroup was as big as this group
4 is. I think that it was running 15 or something. It was
5 such a huge group, 10 to 15 each meeting. It was hard to
6 get anything done because there was a lot of interest in
7 the issue. In fact, at one point I think we had better
8 turnout than we were getting for the full committee,
9 subcommittee meetings, because it was by phone.

10 So, we didn't really -- I think it was diverse
11 in the group. I think what we tried to do was illuminate
12 the issues that are being discussed. Claire provided a lot
13 of information; Terry did. We had some long-term care
14 associations provide input, and I think we're talking about
15 those issues.

16 VICE-CHAIRMAN PICK: Yeah. One thing that I
17 remember from the associations' perspective is there was a
18 significant divergence, where the LSN felt like the general
19 idea was good, but they were very concerned about the
20 details of this and how it would get worked out; whereas,
21 the Council on Illinois Healthcare, there was significant
22 momentum to really push this ahead and get this worked
23 through. And I think that's kind of where we ended.

24 MR. PHILLIPPE: I think that's true.

1 MR. SCAVOTTO: Let me pick up on that for my
2 second issue. I'm looking at this from the perspective of
3 this application workgroup that we're going to have another
4 discussion on Wednesday. I just want to throw this out for
5 discussion. Where are we on this whole idea of a bed-need
6 formula? Because I see this issue with buy and sell not
7 being well accommodated by the bed-need formula, and I
8 don't -- you're welcome to your own opinions as to where we
9 stand on the bed-need formula, but I don't know if we
10 resolve this issue cleanly if we don't get at the bed-need
11 formula.

12 MS. AVERY: Well, if you remember, early on we
13 had set up some priorities. Remember, we had those goal
14 sheets and we kind of sectioned them out?

15 MR. SCAVOTTO: You're asking me a very
16 difficult question when you start off with the word
17 "remember".

18 MS. AVERY: Well, before --

19 MR. SCAVOTTO: That's a better way to phrase
20 it.

21 MS. AVERY: We had maybe four or five
22 priorities, and early on, this group had just kind of put a
23 lot of thing on the parking lot, and you sent Staff back to
24 try to put them in some groups and prioritize them, and the

1 bed-need formula was one of the top, but we kept getting
2 side-tracked by the relocation issue, so we never resolved
3 the bed-need formula.

4 MR. PHILLIPPE: Could I say, I think that was
5 the original task of our task group, workgroup, and I think
6 when you dig into it, there's a lot of inertia or pressure
7 to not change it. It's complicated trying to change it,
8 trying to find valid data. I'm trying to summarize the
9 discussion. We spent a lot of time looking at different
10 kinds of operating beds, how do we account for assisted
11 living and other changes in long-term care much broader
12 than institutional long-term care, and I think what it
13 sounded like to me -- I'm hearing more of a concensus to
14 try to keep the bed-need formula, that even states with a
15 transfer option have a bed-need formula, most of them. Is
16 that a summary from our reading?

17 MS. BURMAN: Yes.

18 MR. PHILLIPPE: So, when you say "the
19 position," I think there are providers who would like to
20 kind of move toward the transfer method as a way to
21 eliminate the bed-need formula or limit its role, from the
22 provider perspective. Is that --

23 VICE-CHAIRMAN PICK: Yes.

24 MR. PHILLIPPE: However, I think a lot of

1 people think it would be difficult to do and the Board
2 would very likely not be open for that limit.

3 MR. SCAVOTTO: What would be difficult?
4 Eliminating the bed need?

5 MR. PHILLIPPE: Yes. I say difficult for
6 political and policy reasons, not necessarily just
7 saying -- it's a dramatic change.

8 VICE-CHAIRMAN PICK: Well, it's in the
9 current rule.

10 MR. PHILLIPPE: So it would take a legal
11 change.

12 MR. SCAVOTTO: That's why I'm bringing this
13 up. We're going to deal with it pretty quickly.

14 VICE-CHAIRMAN PICK: Yes. No, I think this
15 is, as they say, a sticky wicket, because, you know, the
16 battle of -- given the fact that Illinois has one of the
17 highest bed needs per thousand in the country --

18 MR. SCAVOTTO: Beds per thousand.

19 VICE-CHAIRMAN PICK: Beds per thousand --
20 thank you -- beds per thousand in the country, that trying
21 to modify that -- the issue is not -- I don't think we
22 would get pushed back on the need, on the sense that
23 there's a need to adjust it. The push-back is to what?
24 That's -- is it going to be any better than what we have

1 right now?

2 MR. PHILLIPPE: That's right. That's the
3 issue.

4 MS. BURMAN: I think what came out in our
5 discussion and examination of bed-need formula that a lot
6 of people do not like, and still do not like, is that the
7 components that are used are essentially very basic things
8 you have to look at. That's why every other CON state has
9 those same elements in their formula. Okay? "All" doesn't
10 mean it's bad. You have to look at these things. One is
11 the use rate. The use rate is real key. It doesn't matter
12 where everybody is going. That's your marketing concern.
13 But in terms of how many beds do you need for skilled, what
14 you need to know is how many are being used, what rate.
15 That's what we need to look at for this little area that
16 we're dealing with, skilled nursing.

17 VICE-CHAIRMAN PICK: I think that's a very
18 valid point. So, going back to the statewide average, in
19 the 70th percentile somewhere, gives us an indication that
20 the use rate is much lower than the target.

21 MS. BURMAN: Remember, part of the sticky
22 wicket -- a big part of it is at the sale end of the
23 formula, where you subtract existing beds. If you don't
24 have a correct bed count, you're subtracting beds that

1 don't even exist, and you end up with a wrong number.

2 That's the basic problem.

3 MR. SCAVOTTO: And that would be the basic
4 problem in every state that adopts a similar methodology.

5 MS. BURMAN: Unless a state has found a way to
6 eliminate paper beds.

7 VICE-CHAIRMAN PICK: Well, so you have an
8 issue on the plus side and the negative, right; the plus
9 side being the prevalence of beds per thousand; and
10 negative is how many of those beds are actually being used
11 versus just licensed, and that's -- there's a significant
12 divergence there.

13 MS. HANDLER: How do they handle it on the
14 hospital side? Because I don't think we have that same
15 phenomenon on the hospital side, do we?

16 VICE-CHAIRMAN PICK: Used to.

17 MS. BURMAN: We had a rule making. The same
18 point was made clear to the hospital world, that, yeah, we
19 have incorrect numbers. That's why all the need numbers we
20 come up with are skewed and are wrong and they aren't
21 working for you. They're working against you. So, we're
22 going to come up with a set of rules to go through, where
23 you can report what the official beds really are. What are
24 the beds that you really use? And then it's a voluntary --

1 you surrender those beds that you don't need. They haven't
2 existed for years. And I don't remember the number of beds
3 that were eliminated from the inventory.

4 MS. AVERY: I think it was about 6,500.

5 MS. BURMAN: It was a significant number and
6 helped to clear up that issue.

7 MR. SCAVOTTO: So are they still using a
8 bed-need formula?

9 MS. BURMAN: Yes.

10 MS. MITZEN: So what's different in the
11 nursing home side? What would preclude us from doing
12 something like that?

13 VICE-CHAIRMAN PICK: Well, there's
14 significant economic issues, because the -- in the hospital
15 environment, they're using a cap rate to determine -- based
16 on gross revenue, they're determining valuations in bonds,
17 whereas in the long-term care arena, it's based on the
18 number of beds. Now, what's evolved in the last 10 years
19 is cap rates are being used in addition to number of beds.
20 Ten years ago they didn't do that.

21 MR. SCAVOTTO: So, not value per bed; it's
22 what your cash flow is; it's what you can produce
23 revenue-wise.

24 VICE-CHAIRMAN PICK: But it hasn't completely

1 converted. Right now they're using both. The financing
2 environment -- although when you talk to HUD as a lender,
3 occupancy -- number of beds that you have and the number of
4 beds that are occupied has a significant impact on HUD'S
5 approval rate for loan applications. In the non-profit
6 environment it's different.

7 MR. PHILLIPPE: We have both. I have HUD
8 loans and I have bonds. The bond side is -- the financing
9 through tax exempt bonds, what's important is really the
10 cap rate, how the financial -- really, the financial
11 performance of the organization.

12 VICE-CHAIRMAN PICK: So I think part of the
13 disconnect, Phyllis, to answer your question is that in the
14 for-profit environment, there is still a significant
15 reliance on bed count and value per bed to determine
16 valuations, and that's the barrier. That's what's holding
17 things back.

18 MR. PHILLIPPE: Let's be open here. We've
19 been talking about a buy and sell concept for three years.
20 When we talk about that, people are going to hang on to
21 every bed. As long as there is any idea that that might be
22 out there, people don't want to give up beds.

23 VICE-CHAIRMAN PICK: I think that's true, even
24 before the buy/sell. People don't want to give up beds,

1 even though they were paying a bed tax on the dead beds.
2 They don't want to give up the bed because of the concern
3 that the organization's value is defined by the number of
4 beds that it owns and that when it's sold, or other
5 economic processes, loans or anything else, that the bed
6 count is going to impact the ability to access capital.
7 So, I think there's significant resistance in the
8 for-profit environment to surrender beds, and what they're
9 saying is, "I may need them", and what they may mean is
10 "When I sell".

11 MR. SCAVOTTO: Well, the consultant in me says
12 that that's very sloppy thinking, and there's no easy way
13 to say that. But the data is already in. We've got too
14 many beds in the state. And the other shoe in this is with
15 HFS. When I've heard managed care organizations talk,
16 they've been instructed by HFS to empty out the nursing
17 homes, which means we're going to have fewer based per
18 thousand. They're not going to empty them out, but they're
19 coming your way. So you'll get what you --

20 MS. MITZEN: Look at the lawsuits. The
21 lawsuits are sitting here. That, and money follows the
22 person.

23 MR. SCAVOTTO: And the based per thousand is
24 what it's going to come down to, and it just makes me

1 wonder. If you hang on to your beds, they're not going to
2 be worth anything.

3 MS. MITZEN: I have to tell you, about four
4 or five years ago, Stephanie was in the room, and several
5 of us over at Health and Medicine, we brought in somebody
6 from a bank, LaSalle Bank, and we asked him questions about
7 the meaning of those beds, and he said, frankly, as a
8 banker he only cares if you pay the mortgage. That's all
9 he cares about. He didn't care how many beds we had. If
10 you pay the mortgage, if you have the capital to pay the
11 mortgage, it was fine. And so I think -- even Matt
12 reminded me, when we had that long-term care committee, we
13 had two bankers come and talk to us and said the same
14 thing. So I'm not -- all I understand is that I don't
15 understand what the meaning of those beds are to the
16 owners, that they want to hold on to beds that are empty
17 and are not generating revenue -- or I don't think they're
18 generating revenue.

19 MR. SCAVOTTO: Right. I'm with you. What
20 good are the beds if they don't contribute to the value of
21 your business?

22 MS. MITZEN: Right. You're running a
23 business. You should be able to make a profit, but then
24 somehow the value of the beds means something?

1 VICE-CHAIRMAN PICK: Well, if I could ask --
2 I mean, I think in the hospital environment -- it wasn't
3 that long ago -- when you talk to hospital CEO's, it was
4 the same thing. They talked about beds like it was their
5 children. "I have so many beds; that's the measure of my
6 organization." But a transition occurred. So I think
7 although we understand from the Board that it was a painful
8 process, what was the catalyst to really push it forward?
9 Because there has to have been resistance on the part of
10 the hospital industry in giving up those beds. So what
11 pushed it over? Because I think we need to understand that
12 in order to understand the dynamic here, because it's
13 exactly the same. It's identical.

14 MS. MITZEN: Seems to be.

15 MS. BURMAN: I think part of what moved it
16 along was the fact that there were a number of major
17 players in the hospital systems that wanted to add more
18 beds, but they couldn't, because there was no need shown in
19 the bed-need determination, and everybody knew who had
20 significant numbers of paper beds, and that was holding up
21 progress, and that was a big impetus for it going --

22 MS. AVERY: One of the ways we were successful
23 is that we had the backing and support of IHA, and there
24 were like three hospitals, I think, that were wanting to

1 establish new facilities and couldn't.

2 VICE-CHAIRMAN PICK: That's the difference.

3 Here's what my conclusion is: The difference is that in
4 the hospital environment, it's more concentrated, that you
5 have a few players, really big ones that could push the
6 rest of everyone else through. In our environment, it's
7 too divergent.

8 MS. AVERY: Well, it's not as public. It's
9 not as out there. Because I'm sure Mike and George hear it
10 all the time when they're hearing applicants on the
11 application: "Well, we know facility X, Y, and Z are
12 really not using those beds, and we want to get in them,
13 and we want to establish them, because there really is a
14 need," and we hear it sometimes at the table.

15 MR. SCAVOTTO: There's a different twist,
16 though. Hospitals churn them out, and long-term care
17 doesn't. They're much different.

18 MS. MITZEN: Churn what out?

19 VICE-CHAIRMAN PICK: They move patients
20 through.

21 MR. SCAVOTTO: Short stays; length of stays
22 are coming down.

23 MS. MITZEN: But that's also changing in
24 nursing homes.

1 MR. SCAVOTTO: But that's still a much longer
2 stay, if you look at the hospital versus the nursing home.

3 VICE-CHAIRMAN PICK: In the nursing home,
4 there's two distinct populations; where in the hospital,
5 there's no long-term, unless they're stuck with somebody.

6 MS. HANDLER: That's true.

7 VICE-CHAIRMAN PICK: Those are exceptions. I
8 think in the nursing home, you still have two distinct
9 populations: The ones that are moving through and the ones
10 that are staying there on a continuous basis.

11 MS. AVERY: But I don't think, until we hear
12 that from the industries, why they're holding on to these
13 beds, what's the significance of doing so and why are you
14 doing it, we won't be able to get those beds out of the
15 inventory.

16 VICE-CHAIRMAN PICK: No, and I think that's
17 exactly --

18 MR. PHILLIPPE: May I speak to some reasons?
19 First, there may be some competitive issues.

20 VICE-CHAIRMAN PICK: If I give them up,
21 they're going to be across the street.

22 MR. PHILLIPPE: Some people new coming into
23 the market -- it is less concentrated than hospitals. So,
24 you may have five, ten players in a market, and so they're

1 worried -- maybe if they give them up, somebody across the
2 street or down the road a little bit gets the beds and they
3 grow and they build something new that looks nicer than
4 what they have. So, there is concerns about -- because
5 there's a lot of deferred maintenance in the industry here.
6 It's a good term. I think it was like 25 million, in my
7 company when I first started, of maintenance costs that
8 were put off through the years.

9 VICE-CHAIRMAN PICK: It can run up to some
10 big numbers.

11 MR. PHILLIPPE: So you try to catch up. So, I
12 think that's part of it. Part of it is competitiveness.
13 There may be some perceived value, but there's some
14 competitive issue, too, and then, of course, there's a
15 perceived value, as long as anybody has ever talked about
16 selling beds. People want to keep them, because then
17 that's potential value. So, all of that has to be handled,
18 I guess, but it is a huge problem. It is a public policy
19 problem.

20 MS. MITZEN: It is, and we're sitting here
21 for that reason.

22 VICE-CHAIRMAN PICK: The whole buy/sell
23 concept is in some ways connected to the phantom beds that
24 are not being given up, because it's a way -- it's a

1 strategy to try to deal with how you reactivate those beds
2 in a way -- because right now, the option is surrender or
3 hold on. So, I don't want to surrender.

4 MR. SCAVOTTO: I was struck by something Cece
5 said in our charge and anticipating what's going to happen
6 here, and I think we should try to do that. When managed
7 care was really in its heyday, I spent a lot of time in
8 California working with it. I learned a lot about it.
9 And, Tim, I know you spent quite a bit of years with United
10 Healthcare, with managed care, and in my experience, it's
11 the same thing on the hospital side. "I've got a lot of
12 beds; I'm a big man on campus because I have beds." Your
13 thinking can change in five minutes, if you're not paid for
14 those beds, which is exactly what happened in California,
15 and I learned that program was much more important than the
16 number of beds.

17 MR. PHILLIPPE: That's true.

18 MR. SCAVOTTO: And I could make a whole lot
19 more money for my hospital with operating at 50 percent
20 occupancy with one very big outpatient program. And it got
21 so bad in California, we weren't doing open heart surgery
22 in the garage, but we might have been, if we could figure
23 out a way to do it. But we did everything else
24 outpatient-wise, and the program -- the reimbursement

1 forces you into a different program, and I think that's
2 where this is headed; and I think that's one of the
3 dynamics that makes me question the bed-need formula. I
4 think it's -- I think we've got some great assumptions that
5 are built on a lot of historical precedent, and if we don't
6 adjust, we're going to see those assumptions stuck in the
7 sand, and they're still going to be historical precedent
8 for an industry that's about 10 miles down the road. And
9 that's just the way I have seen it play out in my
10 experience. That's all it is, is my experience.

11 MS. MITZEN: Did they eliminate the bed-need
12 formula there?

13 MR. SCAVOTTO: In California? They went one
14 better. They eliminated the Certificate of Need, and I can
15 give you the thought process. There's two sides of it.
16 We're going -- if you're dumb enough to build an
17 institution like a hospital or a nursing home in a managed
18 care environment, go ahead, and then they regulated you at
19 a different level. Like take that picture (indicating).
20 If that picture weighed more than 25 or 35 pounds, it was a
21 seismic event, and you couldn't change the building with
22 any sort of seismic event without having the approval of
23 the State Health Planning Board, which sometimes took a
24 year, and it was -- so, it was just totally burdensome

1 regulations. So, you really had to make it move with your
2 existing facilities and put a program in effect. So, you
3 could -- with outpatient, you could put programs in effect
4 that were off your campus, not connected to the hospital,
5 different set of licensure regulations, same thing. Same
6 thing with long-term care.

7 One of the things we did at our place in order
8 to compete, we built a long-term facility. So, we felt we
9 could be stupid and win, and we did. We were able to do
10 it. But the program is the important thing, because I
11 think what's going to happen when managed care rolls out
12 is, they're not going to care how many beds you've got.
13 They're going to want one available, but --

14 MR. PHILLIPPE: No, I would disagree. Managed
15 care --

16 MR. SCAVOTTO: They may want one available,
17 but -- I may have a bed available, but they may have the
18 services that are more important, so they're going to get
19 the business. Now you can have it.

20 MR. PHILLIPPE: I was just going to say they
21 will care. I used do the hospital contracting way, way,
22 way back, and when you've got a hospital running with 30
23 percent empty beds, those rates come way down, because when
24 managed care is contracting, they're contracting based on

1 the quality of the program, quality of the provider. They
2 do look at that, because they have liability for it. They
3 have legal liability, but they also look at how many empty
4 beds you have and, you know, I used to have this
5 discussion. If it's \$2,000 a day or 5,000, whatever, how
6 much does it cost you really to fill that empty bed? It
7 does not cost \$5,000. I don't know if that will happen in
8 Illinois, but that happened everywhere else where there's a
9 lot of empty beds and they have control of the money. That
10 could happen.

11 MS. HANDLER: But the contracting looks
12 different today. It looks very, very different. Advocate
13 has a huge contract with Blue Cross and Blue Shield, and
14 it's based on savings. They know how much the oncology
15 service line costs Blue Cross/Blue Shield per patient on an
16 average, and they have said to Advocate, "You figure out if
17 you can -- this is what we're going to pay you, and you
18 figure out how to save money, and you will get a portion of
19 the savings." That's how Medicare is contracting today,
20 too. It is a completely different model of paying. It's
21 not paying a fee for service. It's saying, "Cut down
22 the" --

23 MR. SCAVOTTO: That's what I'm used to.

24 MS. HANDLER: -- "expense side." California

1 is an anomaly. Nobody else in the country looks like
2 California. And managed care has never succeeded in
3 Illinois. It hasn't. So what's to say it's going to
4 succeed this time around? I've seen it, like, how many
5 times go around?

6 MR. PHILLIPPE: We are going to have a complex
7 system. You're actually looking at treating more
8 populations, but it's not going to always work like that in
9 every place in the state.

10 MS. JOHNSON: Don't kill the messenger, but
11 aren't the empty beds in long-term care now going to the
12 under 60 population, the MI's and in many instances the
13 identified offenders?

14 VICE-CHAIRMAN PICK: I wouldn't say that
15 that's prevalent as far as industry-wide. There's pockets
16 of that activity and, again, it's an operator stepping into
17 a building, saying, "Look, I have an asset I need to
18 leverage for revenue, and I'll put anybody in a bed in
19 order to generate revenue." But I wouldn't say that that's
20 an industry-wide response. There's also providers who are
21 saying that we're going to leverage beds into different
22 populations, short-term care as opposed to long-term care,
23 and even though occupancy is much lower, we're actually
24 generating more net revenue than we did when we had

1 long-term care patients. So, I think it depends. So, I
2 wouldn't say that that's universally true, but it does
3 exist. There's no question.

4 You know, I think the other aspect of this is
5 going to be the expansion population, that even though
6 there's managed -- it's going to be managed in a different
7 way, because the payor, who used to be HFS, is going to be
8 a managed care entity and is going to be managing those
9 patients as opposed to just paying vouchers. There's an
10 aspect that we haven't accounted for, and that's the
11 expansion. We don't know how many of those are going to
12 need institutional, long-term care, either on a short-term
13 or long-term basis. So, I think part of the dynamic is
14 owners who are saying, "With all of this uncertainty, the
15 last thing I'm going to do is give away a bed." I think
16 that's part of it, because there's so much uncertainty.
17 And, again, they are paying for those empty beds. There is
18 a bed tax, although -- wait. Didn't we in the last bed tax
19 change -- it's occupied beds?

20 MR. HARTMAN: It hasn't changed yet. The
21 original dollar-fifty is still on all licensed beds.

22 VICE-CHAIRMAN PICK: So they're paying some
23 amount on all beds, because I remember I paid on empty beds
24 because I didn't want to give them up either, and as it

1 turned out, I sold every one of my beds. So, it was a good
2 thing I held on to them. So, you know, I think --

3 MS. AVERY: When you sold the facility?

4 VICE-CHAIRMAN PICK: Yeah. When I sold
5 Ballard, they paid for all of those empty beds.

6 MS. AVERY: So there is a movement to make it
7 on occupied beds per day?

8 MR. HARTMAN: It's not a movement. It is the
9 second tax. It was the original dollar-fifty tax on all
10 licensed beds. The second tax is six-oh-seven for occupied
11 beds. That was passed to help staffing increases and so
12 forth.

13 VICE-CHAIRMAN PICK: So the dollar-fifty is
14 still in effect on all licensed beds.

15 MS. AVERY: And then the other is the six
16 dollars --

17 MR. HARTMAN: On occupied beds.

18 MS. AVERY: Okay.

19 VICE-CHAIRMAN PICK: Because -- yeah, there
20 was a tremendous resistance to paying \$6 a bed for licensed
21 beds, because there was so many empty beds.

22 MS. HANDLER: So we're going to be able to get
23 the data on unoccupied beds?

24 VICE-CHAIRMAN PICK: We have that already.

1 The place where the data is questionable is on the
2 long-term questionnaire, because there, you know, they're
3 reporting beds as being set up; they're available, we
4 can -- within 24 hours, we can have those beds in the
5 system. But when it comes to Medicare cost reports,
6 Medicaid cost reports, those are based on occupancy. So,
7 we have the data available.

8 Well, I think this has been a very healthy
9 discussion. I don't know that we've come to any
10 resolution, but I do think -- coming back to this, I think
11 what we have learned is the dynamic in the hospital
12 industry that enabled the ability to get those beds off the
13 shelf are not the same in long-term care. We're not going
14 to be able to do it the same way. I think the buy/sell was
15 an effort on the part of the industry to try to implement
16 some system to begin the process of how to start to get
17 those beds out of the dust pan and create some movement.
18 But, frankly, I don't think in today's environment, with
19 all of the uncertainty, the beds aren't going to move
20 anyway, because nobody knows what's going on, who is paying
21 how much and for how many. So, I think realistically, the
22 reality would be, the operators that are really in a
23 position where they have no other option to raise capital
24 are the only ones that are going to sell any beds, and the

1 buyers are going to be very jittery about expansion at this
2 point, because of the reimbursement uncertainty.

3 So, I think those are the realities of our
4 environment right now and how we craft this thing out,
5 because even today when -- three years ago, we were talking
6 about this, and Healthcare and the Council were strongly
7 behind it. Today? Not so sure. There are elements within
8 the Council and Healthcare really questioning this buy/sell
9 thing. So, if it really came forward, what would be the
10 response on the part of the industry? I don't think it
11 would be the same as it was three years ago, but we won't
12 know that until we get there.

13 MR. PHILLIPPE: When I was looking at the
14 minutes from the last meeting, it looked like there was a
15 discussion about bringing in some outside consultants to
16 actually help bring an objective, non-bias -- even though
17 we all work not to be biased, like you said, you can't
18 help -- you always think about your own experience, really.

19 VICE-CHAIRMAN PICK: Absolutely.

20 MR. PHILLIPPE: And so, I don't know. Is that
21 off the table -- I guess I didn't read to the very end --
22 the idea that you have someone in and they can help with
23 some of the proposals or ideas?

24 VICE-CHAIRMAN PICK: One modification. I

1 thought the consultant was coming in for the valuation
2 component, not for the programmatic elements. How do --
3 was it the value of the bed? That was --

4 MS. AVERY: The value of the beds. We had a
5 couple of questions: The value of the beds; the effect or
6 interest for residents of the state of Illinois; looking at
7 the buyers; trying to get some kind of feedback from those
8 other states that have already implemented, pros and cons,
9 those things; any kind of legislative effect this had; is
10 it working.

11 So, as you were saying that, I was looking
12 back through our bill -- well, HCCI, the bill we worked on
13 last year, and we asked them to change it to evaluate,
14 which is one of the documents that I have given you. In
15 looking at that, we're way ahead of schedule, because it
16 has an effective date of August 21st, 2013. So now I'm
17 thinking that -- how do we get back to what we need in
18 order to present something to the Board and start actually
19 lobbying this around the state to get feedback beyond the
20 16 or 19 members that are here around the table? Because
21 as I said before, there seems to be a divide off the record
22 between those two entities, LSN and the other.

23 VICE-CHAIRMAN PICK: And HCCI?

24 MS. AVERY: Yes.

1 VICE-CHAIRMAN PICK: So then perhaps the next
2 best step is to go through the process of securing a
3 consultant to do this evaluation and produce a report.

4 MS. AVERY: And we -- and I think I
5 misunderstood. I thought in my head that we were supposed
6 to convene a committee to come up with questions, and
7 Claire and I had started to talk about that, and I never
8 convened the committee, and I think the committee was
9 yourself, Chuck Foley, and Matt.

10 MR. HARTMAN: Terry.

11 MS. AVERY: You or Terry.

12 VICE-CHAIRMAN PICK: Terry, Matt.

13 MS. AVERY: I guess the Staff needs more of a
14 direct charge to see what the subcommittee needs and wants
15 us to do.

16 VICE-CHAIRMAN PICK: Okay. So do we need that
17 in the form of a motion?

18 MS. AVERY: Our motion expert?

19 MR. URSO: If you're through discussing it and
20 want to take action on something.

21 MS. CREDILLE: Can I clarify the money issue
22 of this?

23 VICE-CHAIRMAN PICK: Yes.

24 MS. CREDILLE: That is, who is paying for it,

1 and how do we know who is paying for it, and where is the
2 money in a state that is broken?

3 MS. AVERY: Our money doesn't come from the
4 State of Illinois; it comes from the providers. So, right
5 now, today, we're healthy and, again, I will have to check
6 with CMS and Department of Public Health to make sure that
7 we're in line with sending out an RFP and all of the red
8 tape to see exactly what that is; but right now we're
9 sound. I mean, we wouldn't pay billions of dollars for
10 something like this.

11 VICE-CHAIRMAN PICK: I've got a consulting
12 company that's interested in that, if that's --

13 MS. AVERY: But we're reasonable -- have
14 enough money to do something. To me it's a project that
15 will probably cost us --

16 MS. CREDILLE: Who is "we"?

17 MS. AVERY: The Board.

18 MS. CREDILLE: So it's coming from the Mother
19 Board, as we affectionately --

20 MS. AVERY: Yes. It comes from our fund.

21 VICE-CHAIRMAN PICK: It's not general
22 revenue.

23 MR. URSO: There's a dedicated Health Planning
24 Facilities fund that funds the administration of the Board.

1 MR. HARTMAN: Where does the money that goes
2 into that fund come from?

3 MR. URSO: Facility fees and fines and
4 sanctions.

5 MR. HARTMAN: It's not CMP?

6 MR. URSO: CMP is a licensure term. We're
7 talking about the Board.

8 MR. HARTMAN: What fine money?

9 VICE-CHAIRMAN PICK: When an applicant does
10 not follow procedures, they get fined.

11 MR. HARTMAN: Fines from the application
12 process?

13 MR. URSO: Fines from the Board. Licensure is
14 a whole different world.

15 MS. COLON: It's not coming out of my CMP
16 funds.

17 MR. HARTMAN: Somebody misspoke at one of my
18 meetings the other day, and I was clarifying for them,
19 internal meeting.

20 VICE-CHAIRMAN PICK: Does that answer your
21 question, Cece?

22 MS. CREDILLE: Um-hum.

23 MS. AVERY: We sometimes have facilities that
24 are not in compliance with something they were supposed to

1 do, turning in late reports, overcosts.

2 MR. HARTMAN: Right. Personal clarification,
3 that's all.

4 MS. AVERY: Okay.

5 MS. MITZEN: I guess I'm trying to remember
6 the conversation that we had that led us to feel that we
7 needed a consultant, which I think we do, but I don't
8 remember what issues we wanted to have researched.

9 VICE-CHAIRMAN PICK: Courtney, do you want to
10 respond?

11 MS. AVERY: Again, is it good for the state of
12 Illinois? How is it working in other states that are doing
13 this? What kind of evaluation have they done
14 post-implementation? Pros, cons, whatever questions we
15 come up with, those things that we want to have answers.

16 VICE-CHAIRMAN PICK: Didn't come from this
17 group. It came from the Board.

18 MS. MITZEN: Okay. Gotcha.

19 MS. AVERY: Board Staff. We just felt like
20 there needed to be some outside party to validate, if we
21 want to go through this, and probably give us some pros and
22 cons for people sitting at the table, and we wanted to
23 continue to pursue this and, again, we're way ahead of
24 schedule, so that's good.

1 VICE-CHAIRMAN PICK: So have we exhausted
2 this topic from a discussion standpoint, to get to the
3 point of putting forward a motion?

4 (Pause)

5 VICE-CHAIRMAN PICK: I'm seeing heads bobbing.
6 Okay. I haven't seen any no's. Then it would seem to
7 me -- I mean, we've raised a significant amount of
8 questions that are not clear at this point, and we've
9 identified areas of concern that we want to make sure are
10 addressed in the course of moving forward with this kind of
11 initiative. It does seem like the next logical step, since
12 there's a recommendation from the Board Staff about
13 engaging a consultant, that that would be the next logical
14 step, to have the consultant come in -- or to first define
15 the scope of what the consultant would do, and then have
16 consultants bid on that project, and then who would make
17 the final selection -- the Board -- of the consultant?

18 MS. AVERY: I think the Long-Term Care
19 Subcommittee can make recommendations -- one, two, three --
20 and then submit it to the Board.

21 VICE-CHAIRMAN PICK: So, the Subcommittee
22 would review those proposals and then rank order the
23 proposals based on their content and the amount of money
24 that's being requested?

1 MS. AVERY: Experience, do they have a good
2 team put together to address those issues, financial,
3 market, whatever we come up with, are they addressing those
4 in a way that is satisfactory to the Long-Term Care
5 Subcommittee?

6 VICE-CHAIRMAN PICK: Can we have a motion?

7 MS. AVERY: Cece, what was the concern? You
8 just wanted to make sure we were not using monies that
9 would come from --

10 MS. CREDILLE: No. I just wondered if we had
11 money. I live in Illinois.

12 VICE-CHAIRMAN PICK: Well, not having the
13 money never stopped us from doing anything.

14 Okay. So, I think -- it seems to me we're at
15 a point where the Chair will entertain a motion to
16 determine whether the Subcommittee supports or doesn't
17 support this as the next step.

18 MS. MITZEN: I'll move that we move forward
19 on obtaining --

20 VICE-CHAIRMAN PICK: Engaging?

21 MS. MITZEN: -- engaging a consultant.

22 VICE-CHAIRMAN PICK: I don't want to put
23 words in your mouth.

24 MS. MITZEN: You did a good job.

1 VICE-CHAIRMAN PICK: Do we have a second?

2 MR. SCAVOTTO: Second.

3 VICE-CHAIRMAN PICK: All in favor?

4 ("Ayes" heard)

5 MS. CREDILLE: Can I ask -- can you abstain?

6 VICE-CHAIRMAN PICK: Of course. I haven't
7 gotten to the abstentions yet.

8 MR. HARTMAN: Can I say I'm opposed, just for
9 the same reason I articulated in the last meeting? It's
10 just one of a delay that I could see happening. My
11 opposition first came from the money thing, which is
12 settled -- thank you, Courtney -- and from what I see is a
13 potential for greater delay in the whole process.

14 VICE-CHAIRMAN PICK: And then abstentions.

15 MS. CREDILLE: Well, yes, because I'm not
16 comfortable voting on behalf of Illinois Healthcare,
17 although I'm listening to Matt who is here from Illinois
18 Healthcare, so I --

19 VICE-CHAIRMAN PICK: You can oppose.

20 MS. CREDILLE: Then I need to oppose.

21 VICE-CHAIRMAN PICK: Okay. We have two
22 opposed. I would -- it still passes with the number of
23 positive votes.

24 Okay. Well, then --

1 MS. AVERY: Can I clarify one thing, not to
2 change the vote or anything?

3 VICE-CHAIRMAN PICK: You can't change the
4 vote.

5 MS. AVERY: Not to change Matt's mind, but
6 look at the effective date of the legislation that requires
7 us to start evaluating. We are ahead. So that's --
8 hopefully, that will make the Council feel a little more
9 comfortable.

10 VICE-CHAIRMAN PICK: Perhaps one of the
11 things we can do as we start to recommend what we want is,
12 we also can include a deadline that it at least needs to be
13 completed by.

14 MR. HARTMAN: That would certainly create a
15 greater comfort zone for us.

16 VICE-CHAIRMAN PICK: Duly noted, and we'll
17 make sure that's incorporated, that we have not only a
18 scope, but a time frame by when it needs to be completed.
19 This has been going on for years already.

20 MS. HANDLER: When will the Committee get
21 those recommendations from Staff?

22 MS. AVERY: As I'm thinking, Claire and I will
23 work on it, convene the workgroup; we'll do a draft; get
24 the feedback; and then put in some deadlines, you know,

1 give a frame of what we think that the consultant should
2 have, just as a point of discussion, not recommendations,
3 and to build on that.

4 MS. HANDLER: Okay.

5 VICE-CHAIRMAN PICK: So, given those
6 comments, we should -- we need to finish our work
7 relatively quickly, hopefully by the end of the year, that
8 we can have a completed scope of work with --

9 MS. CREDILLE: Like in 30 days?

10 VICE-CHAIRMAN PICK: Something to release --
11 like within 30 days, to release -- and then we'll have a
12 full meeting in January, right?

13 MS. AVERY: We haven't set the date yet.

14 VICE-CHAIRMAN PICK: Okay. Well, I'm thinking
15 steps. So, we need -- as a workgroup, we need to formulate
16 the elements that are going to be within the scope of this
17 RFP that we're going to request. Then once that's
18 completed, it's released, so that consulting groups could
19 then bid, which takes 45 days, 30 to 45 days for that to
20 occur, and then we'd have to review those bids; recommend;
21 the Board has to approve. So, figure another month.
22 That's two and a half months already, and then this
23 consulting group has to do its work. You have to give them
24 at least 60 days to do their work. So, now we're up to

1 what, five and a half months before we've got a report to
2 evaluate? And that's very ambitious. So --

3 MS. AVERY: We'll still be ahead of the August
4 deadline according to the legislation.

5 VICE-CHAIRMAN PICK: Yes. So five, six
6 months from today, right, puts us around May or June, would
7 be a realistic -- well, not realistic -- would be an
8 aggressive time frame, but it's doable.

9 Okay. Then if we are concluded, I think we're
10 up to "Other Business".

11 MS. AVERY: Yeah, and I'll just give a quick
12 update. It goes back to the point of how do we handle the
13 issue of being over-bedded in Illinois. We have not
14 formally submitted this to the Board. It did go to the
15 Governor's office, and my understanding is that the
16 proposed legislation has been circulated, and I didn't want
17 any of you all to get that legislation and think we were
18 trying -- Staff was trying to do something without your
19 permission. We were asked by the Governor's office to give
20 our legislative priorities for 2013, and it was like a
21 quick turnaround time. We did ask the Board to give us
22 permission to do so, and one of the issues was how to clean
23 up the inventory for long-term care beds, and Alexis isn't
24 here, and I don't have the legislation, her draft, right in

1 front of me, but there is some legislation, proposed
2 legislation -- or language, I should say, proposed
3 language, that is circulating. We had an LRP to draft. It
4 is not a final. It has not been agreed upon by the Board,
5 and it will come here first. And I understand that
6 somebody released it and it started to circulate via e-mail
7 on Friday. So, I didn't want any of you all that's in the
8 different networks to get wind of it and think that the
9 Board was trying to clean up this issue of inventory
10 without your input. So, it is not -- doesn't have a
11 sponsor. It's not in bill format. It's just language that
12 we were asked to work on with LRP in order to get it
13 straight and make sure it didn't compete with any other
14 language of our Act.

15 MS. CREDILLE: How did that come from the
16 Governor's office?

17 MS. AVERY: All agencies were asked to submit
18 their priorities, and I think we did that about two months
19 ago, and then we were asked to work with LRP to get
20 language forward. So, I don't know how it got out there in
21 cyberland, but it's out there.

22 MS. CREDILLE: When you say "we", did it come
23 from the Staff that are here? Did it come from the --

24 MS. AVERY: No. It came from Staff. We have

1 a Legislative Affairs Manager, and we tried to clean up our
2 existing rules, Act, issues that we've heard from
3 providers, from this table; and one of our priorities was
4 trying to get our inventory under control and accurate and
5 similar to what we did with the hospital associations, to
6 try and get the bed count right, justifiable, get our
7 inventory cleaned up. So, I did not want anyone to think
8 that we were trying to push it. It was just language that
9 was drafted.

10 VICE-CHAIRMAN PICK: So, two months ago was
11 the phantom beds or the inventory -- was that on the list?

12 MS. AVERY: Yes, as a result of hearing
13 applicants at the table and hearing discussions here. So,
14 we thought maybe we ought to use that as one of our
15 legislative priorities, to clean up the inventory for
16 long-term care beds, and I got a couple calls on Friday
17 that said to me that it's out there. But the Board hasn't
18 said yes, go ahead with this. You all haven't recommended
19 to go ahead with it. So right now, it's just language that
20 we're working on.

21 MS. HANDLER: Is it something you should send
22 to us, so we know what it says?

23 MS. AVERY: I think we should get it okayed
24 from the Governor's office. We also have to talk with HFS

1 and EHS -- and those discussions haven't occurred -- as
2 preliminary, to make sure that everyone at the table agreed
3 on it, and then it will come to you, if it's still an
4 issue. It will come back here. Because the Governor's
5 office hasn't even said that it's something that they would
6 support.

7 VICE-CHAIRMAN PICK: It's got a long way to
8 go.

9 MS. AVERY: It does. Again, I just didn't
10 want you all to think that we were taking these steps on
11 our own.

12 VICE-CHAIRMAN PICK: Any questions about the
13 language?

14 (Pause)

15 VICE-CHAIRMAN PICK: No? All right. Any
16 other --

17 MS. AVERY: One other thing that I heard here
18 today was the communication with the Board, Review Board.
19 One of my thoughts is -- we can look at the future agendas.
20 I think February is kind of -- George does the agenda. Is
21 February filling up?

22 MR. ROATE: We have no meeting in February --
23 well, I take that back. February's agenda is full.

24 MS. AVERY: So, we'll look at future agendas

1 and try to carve in some space and let you all know as a
2 Subcommittee, and then maybe instead of me just giving a
3 report on what the Subcommittee is doing, there can be more
4 of a dialogue between the Board and the Subcommittee. So,
5 maybe we'll look at the spring to do that.

6 VICE-CHAIRMAN PICK: That's good.

7 MS. AVERY: Come personally or a conference
8 call or something.

9 VICE-CHAIRMAN PICK: Anybody else? Any other
10 business?

11 (Pause)

12 VICE-CHAIRMAN PICK: Then next meeting? So
13 we don't have a date yet for the next meeting?

14 MS. AVERY: No.

15 MR. PHILLIPPE: As long as you're on the next
16 meeting, could I propose it not be on a Monday?

17 VICE-CHAIRMAN PICK: Okay.

18 MR. PHILLIPPE: For those of us who live quite
19 a ways away, it means traveling on Sunday. It did save me
20 five hours -- maybe more than five -- in the cold doing a
21 Christmas program, though, after my five hours on Saturday,
22 standing for five hours. It wasn't really cold on
23 Saturday. I did think driving was better than standing.

24 MS. AVERY: Well, originally -- are we in

1 session this week, Matt, do you know?

2 MR. HARTMAN: Yes.

3 MS. AVERY: There was rumor that it was going
4 to be canceled and then it wasn't. So that's why we have
5 it on Monday.

6 (Discussion held off the record.)

7 MS. HANDLER: How does our next meeting fit in
8 to the consultant efforts, so that you can --

9 MS. AVERY: There will be workgroup meetings
10 probably in January, after the holiday.

11 VICE-CHAIRMAN PICK: Wait. That's
12 inconsistent with what I outlined, because if we wait until
13 January, then it will take 60 days for the workgroup --

14 MS. MITZEN: I'm agreeing with you.

15 MS. AVERY: So you want the workgroup to meet
16 in December?

17 VICE-CHAIRMAN PICK: Yes, that's Carolyn's
18 point. The workgroup should meet in December so it can
19 formulate its recommendations for elements the RFP would
20 include. That needs to go to the full Subcommittee for
21 review and then approval, I would suspect, and before Staff
22 actually releases an RFP. So, that would be in January.
23 So, I don't know that -- we could do that electronically.
24 We don't need to get physically together for just that one

1 item. So I think -- or conference call. And so we would
2 want to schedule something in January for this Subcommittee
3 to review the workgroup's recommendations for the RFP, and
4 then perhaps by the February meeting, we can actually
5 review the completed RFP and where it's going.

6 MS. AVERY: So if we meet in January via
7 conference call, we'll just have those two -- outside of
8 the normal agenda items, we'll have the CON application
9 update of their meeting Wednesday and then this?

10 VICE-CHAIRMAN PICK: You know what? The CON
11 application update, there's -- it's not being driven by
12 time. That can wait until the next regular meeting.

13 MS. AVERY: Okay.

14 VICE-CHAIRMAN PICK: The only thing that is
15 time sensitive is getting this RFP done. So, just the one
16 item, so we can have it done and get it out. So should
17 we -- as long as we are all here, should we pick a date in
18 January for the conference call, too?

19 (Discussion held off the record.)

20 VICE-CHAIRMAN PICK: Tuesday, the 8th of
21 January at 10:00 a.m.

22 MS. AVERY: Conference call, right?

23 VICE-CHAIRMAN PICK: Yep.

24 MS. HANDLER: You'll send a meeting notice, a

1 formal one?

2 MS. AVERY: Right.

3 VICE-CHAIRMAN PICK: Let's schedule it for 90
4 minutes -- I don't think we'll need it -- until 11:30.

5 MS. AVERY: So we'll still have the regular
6 approval of proxy, agenda approval, approval of the meeting
7 minutes here, and then that discussion, and maybe we'll
8 have more of a legislative update at that time, too.

9 VICE-CHAIRMAN PICK: And then for the regular
10 meeting, we'll schedule something for February? Any
11 particular Tuesday preference?

12 (Discussion held off the record.)

13 VICE-CHAIRMAN PICK: Okay. February 19th at
14 10:00 o'clock.

15 MS. AVERY: Do you want that to be an
16 in-person?

17 VICE-CHAIRMAN PICK: Yes. I assume it will
18 be here, right?

19 (Pause)

20 VICE-CHAIRMAN PICK: I think we've Concluded
21 our business today. Do we have a motion to adjourn?

22 MR. PHILLIPPE: So moved.

23 MR. RAIKES: Second.

24 VICE-CHAIRMAN PICK: All in favor?

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("Ayes" heard)

VICE-CHAIRMAN PICK: Opposed?

(No response)

VICE-CHAIRMAN PICK: Abstentions?

(No response)

VICE-CHAIRMAN PICK: Thank you. Motion

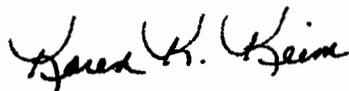
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END TIME: 1:19 P.M.

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CERTIFICATE OF REPORTER

I, KAREN K. KEIM, RPR, CRR, a Certified Court Reporter, 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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