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SERVICES REVIEW BOARD

STATE OF ILLINOIS

HEALTH FACILITIES AND SERVICES REVIEW BOARD

**LONG-TERM CARE ADVISORY SUBCOMMITTEE
APPLICATION WORKGROUP MEETING**

**CONFERENCE CALL
DECEMBER 5, 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
(217) 782-3516

LONG-TERM CARE ADVISORY SUBCOMMITTEE
APPLICATION WORKGROUP MEETING

CONFERENCE CALL

DECEMBER 5, 2012

AGENDA

1 CALL TO ORDER: Wednesday, December 5, 2012

2 1. Attendance

3 2. Approval of Agenda

4 3. Proposed Application Changes Discussion

5 4. Other Business

6 5. Next Meeting

7 6. Adjournment

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LONG-TERM CARE ADVISORY SUBCOMMITTEE

APPLICATION WORKGROUP MEETING

CONFERENCE CALL

Meeting of the Health Facilities and Services
Review Board, Long-Term Care Advisory Subcommittee,
Application Workgroup, was held on the 5th day of
December, 2012, between the hours of 2:02 p.m. and
3:50 p.m. of that day, with the reporter at the
offices of the Health Facilities and Services Review
Board, 525 West Jefferson Street, 2nd Floor,
Springfield, Illinois 62761.

1 MEMBERS PRESENT:

2

3 Michael Scavotto

4 Cecilia Credille

5 Eli Pick

6 ALSO PRESENT:

7 Mike Constantino

8 George Roate

9 Courtney Avery

10 Alexis Kendrick

11 Juan Morado

12

13

14

15 REPORTED BY:

16

17 Court Reporter:

18 Rhonda Rhodes Bentley, CSR/CCR/RPR

19 Illinois CSR #084-002706

Missouri CCR #1313

20 Midwest Litigation Services

15 South Old State Capitol Plaza

21 Springfield, Illinois 62701

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1 (Starting time of the call: 2:02 p.m.)

2 MR. SCAVOTTO: This is Michael Scavotto,
3 S-c-a-v-o-t-t-o.

4 MR. CONSTANTINO: Thanks, Mike.

5 MS. KENDRICK: Alexis Kendrick, A-l-e-x-i-s
6 K-e-n-d-r-i-c-k, Board staff.

7 MR. ROATE: George Roate, IDPH staff or
8 Board staff. Last name is spelled R-o-a-t-e.

9 MR. CONSTANTINO: Mike Constantino,
10 C-o-n-s-t-a-n-t-i-n-o. Anybody else on the line?

11 MS. CREDILLE: Cece Credille, C-r-e-d as in
12 David -- i-l-l-e, a representative for Illinois Health
13 Care Corporation.

14 MR. CONSTANTINO: Anybody else?

15 MR. SCAVOTTO: This is Mike Scavotto. I
16 suspect Eli will be joining us momentarily. I haven't
17 heard to the contrary.

18 MS. KENDRICKS: Is Mike Waxman on?

19 MS. CREDILLE: No, he is not.

20 MR. CONSTANTINO: Should we wait a couple
21 minutes for Eli or Eli? I'm sorry.

22 MR. SCAVOTTO: I would say yes.

23 MR. CONSTANTINO: Okay.

24 MR. SCAVOTTO: If he's not on by 2:05,

1 let's just -- we can still go ahead with the two
2 committee members, Cece and myself.

3 MR. CONSTANTINO: All right. We're going
4 to need to -- When we start discussion of the
5 application, we're -- you're going to need to give
6 your name and then speak, if you would, please, for
7 the court reporter.

8 MR. SCAVOTTO: Mike Scavotto. I will shoot
9 Eli an email, see if I can jog him into this
10 conference call.

11 Okay. This is Mike Scavotto. Cece, do you
12 have any objections proceeding without Eli?

13 MS. CREDILLE: No, I don't.

14 MR. SCAVOTTO: Okay. All right. Let me go
15 through the agenda. We've taken care of the
16 attendance. Need to approve the agenda.

17 Mike Constantino, is there -- do we need to
18 approve this agenda? There's only two of us here.

19 MR. CONSTANTINO: No. No. I say we
20 approved it.

21 MR. SCAVOTTO: Okay. So do I. Now, we're
22 going to move on to proposed application changes.

23 Okay. George, let me start with you, if I
24 can, because I know you were on the last call. There

1 was quite a discussion on Alternatives, 1125.330, and
2 the note I have in my papers is that the staff was
3 going to sit down and review those alternatives and
4 give us some input on what they -- how they thought
5 they should be addressed moving forward. Has the
6 staff had a chance to do anything like that?

7 MR. ROATE: I have reviewed the
8 alternatives and the use of alternatives in the past,
9 and while the fact that they're not -- they're not --
10 I guess I should say there's no negative findings on
11 the state agency report for any -- it's a
12 non-reviewable section of the application, the
13 discussion of alternatives is a -- is a viable -- I
14 guess is a viable section of the application based on
15 the fact that just to show the applicant that or for
16 the applicant to explain that, yes, they considered
17 other alternatives.

18 Now, a minimum -- should there be a minimum
19 of two, three, four alternatives? No because
20 depending on some projects, and some projects may have
21 no alternatives. So I guess, if anything, based on my
22 review, instead of tasking the applicant out to
23 complete a minimum of three or four alternatives, just
24 to examine or just to discuss briefly what

1 alternatives were looked at, if any, and if there were
 2 no alternatives, just a brief explanation as to why
 3 this alternative was chosen and why it was seen as the
 4 only viable alternative.

5 MR. SCAVOTTO: Any reaction to that, Cece?

6 MS. CREDILLE: Yes. I mean it -- I'm
 7 sorry. What was the question? I mean we had a long
 8 discussion at the meeting yesterday that there was
 9 concern on behalf of the committee that this was a
 10 section that I don't want to say doesn't hold merit,
 11 that's not -- that's not the right choice of words,
 12 but if it's -- it's not a section that makes or breaks
 13 an application, then there are people on the committee
 14 that are representative by alternative care. There
 15 was a concern about how the application could be more
 16 inclusive of alternative care options available.

17 Is that -- Is that fair, Mike? I mean
 18 that's -- Scavotto?

19 MR. SCAVOTTO: That was the discussion that
 20 we had yesterday.

21 MS. CREDILLE: Right.

22 MR. SCAVOTTO: I really -- I don't know how
 23 we're going to satisfy their desires when there's such
 24 -- such a difficulty in how they're reimbursed. We've

1 -- I don't see the -- I don't see HCVS being a really
2 viable discussion as an alternative, you know, when it
3 remains largely a private-pay phenomenon. They get
4 better reimbursement. They get more generalized
5 reimbursement. I think it opens it up to them.

6 So I'm perplexed with that one, but I --
7 and the notes that I had from the last meeting were
8 that Courtney and her staff were going to examine the
9 utility of the Alternative section. So what I'm
10 getting from George is that you're leaning towards
11 keeping the alternatives. I mean -- and the
12 discussion we had in the first meeting was -- that led
13 to the conclusion this is pretty soft section, and
14 we're not -- we're not getting a lot of useful
15 information out of this, and that that seemed to be
16 the reaction of the staff as well.

17 I don't want to put words in the staff's
18 mouth, but that's -- that's the general impression
19 that I got.

20 MR. ROATE: No. George Roate here.

21 No, by all means I agree that it is, and
22 we're calling the term "soft" being a soft section;
23 however, once again the discussion -- the discussion
24 of a viable alternative or any other viable

1 alternatives that were considered made. So I -- I
 2 personally think it would be a useful tool and, like I
 3 said, not really one to -- not that they would have to
 4 address a certain minimum number, just the fact that
 5 if there was another alternative that they had in --
 6 if they were considering any other alternative in the
 7 sense that I say explaining for them to offer the
 8 Board or Board members an idea of what their options
 9 were initially and embarking on this project, what
 10 other options they were considering, and, you know,
 11 once again faced against the option chosen. So
 12 even --

13 MR. SCAVOTTO: Let's move this along a
 14 little bit and get off the dime. What I would like to
 15 see from the -- from the -- from you, George,
 16 reflecting the opinion of the staff and Courtney is
 17 some sample language that would improve upon this
 18 section. Give us a starting point to wrap this thing
 19 up and see if we want to see what we want to do with
 20 it. I know it's in the rule, and -- but if we -- if
 21 it's not really useful now, we think we can make it
 22 useful, what would that language look like?

23 MR. ROATE: Okay.

24 MR. SCAVOTTO: Fair enough?

1 MR. ROATE: Yes, sir.

2 MR. SCAVOTTO: Now, the other item on the
 3 follow-up we had was on 1125.330, and that is -- and
 4 that involved Frank, and unless Frank has joined the
 5 discussion, today, we're SOL on that one. Just for
 6 everybody's benefit, there was a question whether or
 7 not we were talking about patient origin versus
 8 patient referral, and my reading of the rule indicated
 9 that we were talking about patient origin, and what's
 10 in the application is patient referral. That's really
 11 -- That's two vastly different things. We needed to
 12 get that -- We needed to get that clarified. Let's
 13 just leave that one as it is, and let's charge on.

14 All right. Picking up where we left off at
 15 1125.540 on my page 14 of the application. I got some
 16 -- When I'm looking at this section, I have some -- I
 17 have some questions on how this thing is organized. I
 18 could be wrong. So I want to ask this question. I
 19 understand that going through here, almost everything
 20 is in the rule. The one -- one item does not appear
 21 to be in the rule, and that's that first bullet under
 22 item 3, but everything else is , is directly in the
 23 rule or sufficiently plagiarized from the rule, to be
 24 -- to make it a rule. So we're talking about the

1 service demand for establishing general long-term care
 2 service.

3 It looks today like there's -- there's two
 4 things that have to be done. Number one, we go
 5 through this referral documentation business all over
 6 again, and, number two, which is at 5, point No. 5,
 7 you -- we have to document the demand in an area of
 8 rapid population growth. And that's -- and that's a
 9 point of confusion for me because if I look at (a) --
 10 if I look at 5(a) through 5(g), I'm not sure that
 11 we're looking at the criteria for rapid population
 12 growth, or are we looking at the criteria for
 13 establishing general long-term care? What is the
 14 intention between 5(a) through 5(g)? Is that strictly
 15 for rapid population growth, or is that supposed to be
 16 for the establishment of general long-term care.

17 MR. CONSTANTINO: Mike, this is Mike
 18 Constantino.

19 The way we've interpreted this -- this rule
 20 if we -- essentially it's an option. We're saying to
 21 you, if you could -- you do not have the referral
 22 sources, you can rely upon that rapid population
 23 growth within that service area. You just need to
 24 justify it -- justify that to us.

1 To the best of my knowledge I have not seen
 2 a long-term care application use that argument, rapid
 3 population growth anywhere, but it is in the rule.
 4 It's a carryover from the hospital rules. It was used
 5 in the Centegra application that was recently approved
 6 by the Board. And it has been included in large
 7 modernization projects, the hospitals relying upon the
 8 -- upon the argument there's rapid population growth
 9 within their market area or service area.

10 MR. SCAVOTTO: Okay. To me that's very
 11 helpful. So it's the method is 1 through 4 or 5?

12 MR. CONSTANTINO: Yeah, that's how we've
 13 always interpreted that, yes.

14 MR. SCAVOTTO: Okay. I'm not sure I would
 15 -- well, obviously I didn't pick that up.

16 MR. CONSTANTINO: No. No. It's confusing.
 17 I understand that. No. It is.

18 MS. CREDILLE: Mike, this is Cece for Mike
 19 Constantino.

20 So is it clear when people fill out
 21 applications, that they leave -- for example, on the
 22 skilled nursing site, I'm talking about, that they
 23 leave 5 blank essentially because they assume that 1
 24 through 4 is going to apply to them? Is that what

1 happens in reality.

2 MR. CONSTANTINO: Oh, yes. Yeah. I have
3 never seen a long-term care application use rapid
4 population growth in the application. We just do not
5 see it. And when we get something like that, we look
6 at the data we have when we do our inventory
7 projections, and we're not seeing any type of rapid
8 population growth in the State of Illinois. So it's
9 very seldom used and never in a long-term care
10 application. I have never seen it in a long-term care
11 application.

12 MR. SCAVOTTO: Well, this is Mike Scavotto.

13 So let's keep this narrative going in the
14 direction that it's headed. What do we need 5 for?
15 It's in the rule. We know that.

16 MR. CONSTANTINO: Yes, it is in the rule,
17 right. That's why we are there.

18 MR. SCAVOTTO: That we should target for
19 elimination.

20 MR. CONSTANTINO: Well, that's -- that is
21 up to you guys, you know.

22 MR. SCAVOTTO: I'm asking is it going to
23 ruin the staff's day if we target this for
24 elimination?

1 MR. CONSTANTINO: No, it's not going to
2 ruin our day.

3 (LAUGHTER.)

4 MR. SCAVOTTO: So if there's no -- there's
5 no marriage to this provision from the staff's
6 standpoint then?

7 MR. CONSTANTINO: No. When we -- When we
8 put -- Well, back up a minute. What we tried to do,
9 we tried to meet a deadline on these long-term care
10 rules, and essentially we just copied what we had in
11 place and put them in to a new section, 1125, and said
12 we met the requirements of the statute. That's
13 essentially what we tried to do with the rules until
14 we had the committee in place, and you guys can spend
15 a lot of time going back through the rules and
16 determining what is best for the skilled care nursing.

17 MR. SCAVOTTO: Okay.

18 MR. CONSTANTINO: Now, that's why it was
19 done. So this rule's been in place for years, Mike,
20 that rapid population growth.

21 MR. SCAVOTTO: But it's not used?

22 MR. CONSTANTINO: No, I don't see it at all
23 in long-term care. I do see it some in hospitals.

24 MR. SCAVOTTO: Okay. So if we eliminate 5

1 -- I know I'm covering a lot of ground. If we
 2 eliminate 5, the service demand for establishing a
 3 skilled nursing facility can only be met by
 4 documenting the number of referrals, which is what
 5 seems to be said from items 1 through 4? There's no
 6 rule for demographics in establishing general
 7 long-term care service demand.

8 MR. CONSTANTINO: Well, we think our bed --
 9 bed need calculation does that. Now, I mean that's a
 10 whole another discussion.

11 MR. SCAVOTTO: But it's logical that we
 12 work through this. So this is good.

13 MR. CONSTANTINO: We believe that meets the
 14 demographic criteria you're looking -- would be
 15 looking for. That's why we as part of the
 16 requirements for need for long-term care facility, the
 17 first criteria we look at is whether or not there is a
 18 need for beds in the planning area, and that's
 19 determined by the formula in our projections.

20 MR. SCAVOTTO: Okay.

21 MR. ROATE: George Roate here. My
 22 apologies for the interruption. Somebody just
 23 recently signed on.

24 MS. AVERY: Hi, this is Courtney.

1 MR. SCAVOTTO: Oh, hi, Courtney. Okay.

2 MR. MORADO: And Juan is on as well. I
3 didn't get a chance to chime in. I'm sorry.

4 MS. AVERY: Sorry I'm late.

5 MR. SCAVOTTO: Okay. Eli, you out there?

6 MR. ROATE: No.

7 MR. CONSTANTINO: No.

8 MR. SCAVOTTO: No, no answer. Okay. So I
9 can see the logic of your position on the bed need
10 calculation serving -- serving the requirement under 1
11 to 4 under 540, but let me ask you another question.

12 1 through 4 requires referral information to be
13 submitted to the staff. Are you having difficulty
14 getting that, and our understanding is that you are?

15 MR. CONSTANTINO: Yes, we -- for long-term
16 care we are. We're having difficulty with it. We
17 have to have some way to determine whether or not
18 there's demand for the service. In the past before
19 the -- before the rules were changed, we relied upon
20 our bed need formula to determine whether or not there
21 was demand for the service.

22 MR. SCAVOTTO: Does the requirement that
23 you get referrals help you or hinder you? Are you
24 neutral on it?

1 MR. CONSTANTINO: Well, we're having a very
 2 difficult time getting referrals for long-term care,
 3 Mike. It's -- When we get a long-term care
 4 application, we see -- you know, we'll see something
 5 from a hospital that says we will -- we refer X number
 6 to the long-term care community in our market area
 7 every year, and we plan -- we will utilize the
 8 proposed facility, something like that is what we've
 9 been receiving.

10 MR. SCAVOTTO: That's like a letter of
 11 support.

12 MR. CONSTANTINO: Yes, essentially. That's
 13 a -- pretty much the extent what we've been getting
 14 from the hospitals. We are having a lot of trouble,
 15 we discussed it internally, and we haven't come up
 16 with anything better yet.

17 MR. SCAVOTTO: If the bed need calculation
 18 is serving the purpose, I mean I understand we're
 19 going to hit the bed need calculation later, but if
 20 the bed need calculation is serving the purpose,
 21 you're having difficulty getting the referral data,
 22 why don't we go for it and say we suggest a rule
 23 change or we don't need this referral data. I've done
 24 a lot of CONs in my career. I don't want to say how

1 long that is, but I can't -- I can't think of one time
2 where I had to establish demand on the basis of
3 someone else's estimate of referrals.

4 MR. CONSTANTINO: You know, the ones you've
5 done, did you have trouble getting referrals?

6 MR. SCAVOTTO: Yeah. They weren't going to
7 tell you. It was competitive.

8 MR. CONSTANTINO: Yeah.

9 MR. SCAVOTTO: They didn't want to tell
10 you. And those states that I did them in, I'm not --
11 you know, I don't think the requirement for referrals
12 was the -- was worded the same way as it is here.
13 More like -- more like letters of support. You had to
14 document your primary service area, and you had to
15 have -- you had to have some way of determining that.
16 You had a way of attracting admissions to your
17 facility. That seemed to do it. But getting --
18 getting referring facilities including physicians to
19 say, I'm going to give you 30 a month or 30 a year,
20 whatever the case might be, was not something that
21 I've ever seen before.

22 MS. CREDILLE: I'm speaking -- This is
23 Cece.

24 I'm speaking now from the Manor Care side,

1 and my knowledge of the operations in our other states
2 and the people that work on our CON applications, and
3 they are not familiar with this process in other
4 states. This is unique to Illinois in trying to
5 obtain referral letters with specifics of numbers of
6 referral.

7 As I said in our last conference call, it's
8 becoming increasingly difficult with the
9 reorganization that's happening and the changes in the
10 marketplace, where physicians are not operating
11 independently, they're employed by health care
12 systems, you have physicians then who are reticent to
13 provide referral information because now they are
14 employed by a hospital, the hospitals are reticent to
15 provide referral information for a multitude of
16 reasons in terms of patient choice, and I think that
17 -- I think whoever sent it said it, if it was Mike
18 Scavotto or Mike Constantino, that really you get
19 letters of support is what you get more than actual
20 referrals. And that's really what you could get out
21 there in the marketplace.

22 MR. SCAVOTTO: I would agree. Yeah.

23 MR. CONSTANTINO: Yeah. Well, this is a
24 personal opinion, and I'll throw this out here. I

1 would have liked to have seen us have a market
2 feasibility study. I know I threw that out here a few
3 weeks ago at one of the meetings, and I thought that
4 might address some of the things we --

5 MR. SCAVOTTO: It might. We're not
6 finished with that by any means.

7 MR. CONSTANTINO: Yeah. What's -- For
8 example, what's the -- what's the other -- what's --
9 what other competition is in the market area. We
10 don't ask any questions about regarding that. And I
11 thought that would be a good replacement for
12 alternatives. I'll be truthful with you, and it's in
13 the statute, I know alternatives is in the statute, we
14 have to ask the questions, but it doesn't provide us
15 with very much.

16 MR. SCAVOTTO: Okay.

17 MR. CONSTANTINO: You guys have looked.
18 You and Cece know that.

19 MR. SCAVOTTO: I'm looking for --

20 MR. CONSTANTINO: Yeah.

21 MR. SCAVOTTO: I don't think any members of
22 the -- of this subgroup have any illusions here. You
23 have to follow the rules, but if the rules aren't
24 working, let's see what we can do to change them.

1 MR. CONSTANTINO: Unfortunately that's in
2 the statute. We have to ask that question, and --

3 MR. SCAVOTTO: I know. I think we get
4 that.

5 MR. CONSTANTINO: And Alexis and Courtney
6 will have to get that changed for us.

7 MR. SCAVOTTO: Okay. Courtney, we're
8 headed your way with this.

9 MS. AVERY: We'll be waiting.

10 MR. SCAVOTTO: I can hardly wait. All
11 right. That's good discussion though. It's very good
12 discussion.

13 Okay. Cece, any further comments on this
14 before we move on.

15 MS. CREDILLE: No. We're on the same
16 place, Mike.

17 MR. SCAVOTTO: Okay. Good enough. Okay.
18 1125.550, and Service Demand, Expansion of Long-Term
19 Care.

20 MR. CONSTANTINO: That's just related to --

21 MR. SCAVOTTO: Is that in reference to No.
22 2 and 3? No, that's 540. Where is 550? Yeah,
23 reference No. 2 and 3 to 540 section (d) and (e),
24 don't seem to match the corresponding paragraphs in

1 540. Does that trigger any memories from you, Cece?

2 MS. CREDILLE: Well, I mean I'm looking at
 3 No. 3, I mean it ties to the discussion of the fact
 4 that this is based on hospital's application and the
 5 population growth, and we don't use it at all. So
 6 that's -- it's logic follow from our prior discussion,
 7 3 would be eliminated again with rule change, and then
 8 No. 2, this falls to projected referrals again, it's
 9 more of the same.

10 MR. CONSTANTINO: Yeah. Because the --
 11 This is Mike Constantino -- because the capital
 12 expansion threshold is so high now, and because the --
 13 you have the lesser of ten percent or 20-bed rule in
 14 place, we don't see many expansion projects anymore.
 15 In fact, unless someone is doing a very large
 16 modernization and want to add beds, this was the only
 17 time this would come into play. So our capital
 18 expenditure threshold is close to seven million
 19 dollars now for long-term care, and with -- with that
 20 bed rule in place, a ten percent rule, we just do not
 21 see many modernization projects at all. Almost all
 22 the applications we get are for new facilities.

23 MR. SCAVOTTO: Okay. So a rule change
 24 cleaning this up sounds like it would be a welcome

1 addition.

2 MR. CONSTANTINO: In my opinion I think it
3 would, yes.

4 MS. CREDILLE: Mike, this is Cece,
5 Constantino.

6 Are you suggesting then that this could be
7 eliminated period then?

8 MR. CONSTANTINO: No, we do -- like I said,
9 we do get maybe one or two -- one a year, someone
10 doing a large modernization and wants to add a few
11 beds. I can think of one right off the top of my
12 head. It was just approved at the last meeting.
13 Kniery and Foley did it. Oh, boy. I can't -- Now, I
14 can't think of the name of the facility. It's --

15 MS. AVERY: When?

16 MR. CONSTANTINO: It was at the October
17 meeting, Foley and Kniery submitted an application.
18 It was for 119-bed facility, a large modernization,
19 and they wanted to add ten beds.

20 MS. AVERY: Yeah.

21 MR. CONSTANTINO: Of course, they had --
22 they were over the 90 percent utilization. So it
23 wasn't an issue. I mean as far as adding the ten
24 beds. And that's what we tried to address in

1 Historical Service Demand, (a) and (b) there in 1.

2 MR. ROATE: Mike, this is George Roate.

3 I think you just described Manor Court of
4 Freeport, Mike.

5 MR. CONSTANTINO: Oh, is that what it was?

6 MR. ROATE: I'm double checking, but I
7 think that was it.

8 MR. SCAVOTTO: Mike Scavotto here.

9 So, Mike, was this -- was this project
10 approved.

11 MR. CONSTANTINO: Oh, yes. Yeah. Yep.

12 MR. SCAVOTTO: Okay. So help me out here.
13 It was for a ten-bed expansion.

14 MR. CONSTANTINO: No, it was for a large
15 modernization, Mike. They wanted --

16 MR. SCAVOTTO: Modernization. So the 1020
17 rule didn't apply.

18 MR. CONSTANTINO: Yeah, it was over the
19 threshold hold. So they had to come in, and they
20 added ten beds when they did that.

21 MR. SCAVOTTO: Okay.

22 MR. CONSTANTINO: Yeah.

23 MR. SCAVOTTO: Okay. It was over the
24 threshold on the dollars?

1 MR. CONSTANTINO: Right. Yeah.

2 MR. SCAVOTTO: Okay. So where I'm going
3 with this is pretty straightforward. You say you're
4 not getting that many -- like one or two in a year.
5 So we eliminate this rule. How do we handle those
6 applications that you do get?

7 MR. CONSTANTINO: Well, I don't think we
8 can eliminate this expansion rule because we do get
9 that one or two during the year. What we can do
10 though is eliminate like Cece suggested 2 and 3 --
11 items 2 and 3 in the rule. Change the rule, so they
12 would just address since you were asking -- asking a
13 question, are you at 90 percent; if so, you can add
14 the number of beds to reduce your high utilization.

15 MR. SCAVOTTO: So we'd be using Historical
16 Service Demand --

17 MR. CONSTANTINO: Right.

18 MR. SCAVOTTO: -- 1 and 2 -- just use item
19 1.

20 MR. CONSTANTINO: Yeah. Yeah. Yeah. It
21 -- I believe that is a pretty simple way to do it, and
22 it allows the Board to make a decision based upon high
23 occupancy of the existing facility.

24 MR. SCAVOTTO: Okay. All right. Cece, did

1 you have anything else under 550?

2 MS. CREDILLE: No, I think we've covered it
3 all.

4 MR. SCAVOTTO: All right. 560. Variances
5 to Computed Bed Need. What do we have there? Cece,
6 the only comment I have here is from you. Eliminate
7 all bed need variances with the exception of the CCRC
8 variance and tighten that one so that providers cannot
9 start out as CCRC and then end up as general
10 providers. There is no reason to treat religious
11 organizations or fraternal organizations as special.
12 Other states don't. So why should Illinois?
13 Religious organizations cannot get a CON for a new
14 SNF, and a whole slew of states that you named here,
15 just because it's a religious organization. And you
16 named Maryland, West Virginia, Michigan, Iowa,
17 Virginia, South Carolina, Delaware and Washington,
18 North Carolina, Ohio or New Jersey just for the
19 record.

20 MS. CREDILLE: Yes.

21 MR. SCAVOTTO: Cece, you want to pick up
22 your thought process from there.

23 MS. CREDILLE: Well, I know that this was
24 brought up at the meeting yesterday related to CCRC.

1 So I'll need a little help on that, but if there's
 2 currently -- you know, again, given just exactly what
 3 Mike Scavotto has read here, I don't know why -- other
 4 than it's a rule, why there was a variance for
 5 religious organizations. I don't know why that --
 6 why --

7 MR. CONSTANTINO: That -- That's in place
 8 -- been in place for years. I couldn't tell you the
 9 exact date, but it's been in there for quite some
 10 time. .

11 MS. AVERY: Just for clarification, I don't
 12 think it was written for religious organizations. For
 13 instance, Clare Water Tower and a couple of others
 14 came in under the -- CCRC -- I'm sorry -- CCRC
 15 variance.

16 MS. CREDILLE: I don't know -- my mind, it
 17 seems there are two, CCRC and the religious, so I may
 18 be wrong on this. Am I wrong on that?

19 MR. CONSTANTINO: Well, we call it the
 20 defined population variance. Essentially a religious
 21 organization would be a defined population.

22 MR. SCAVOTTO: Okay.

23 MR. CONSTANTINO: We have two variances,
 24 the CCRC, and what we determine -- we call defined

1 population. Say, for example, the Elks Club wants to
 2 build a nursing home and only provide service to Elks
 3 members. We would consider that to be a defined
 4 population.

5 MS. CREDILLE: And is there only -- This is
 6 Cece again. Is there any -- any real follow-up to see
 7 that that occurs once a facility is open? I mean I
 8 just wonder if this regulation has passed its
 9 usefulness in health care environment.

10 MR. CONSTANTINO: The variances were only
 11 supposed to be used when there was no need in the
 12 planning area. It was -- It was an attempt by the
 13 Board to allow organizations or -- or some type of
 14 entity to put a nursing home in an area where there is
 15 no calculated bed need, and they did this through
 16 these variances -- these two variances, the CCRC
 17 variance and the defined-population variance. That's
 18 how it was originally designed.

19 MR. SCAVOTTO: So this is Mike Scavotto.

20 So, Mike, is it -- and, Courtney, I guess
 21 I'll ask you this question as well, is -- so is that
 22 another way of saying that there's a political
 23 accommodation or a deal that we have to recognize
 24 that's been made here? Sounds like it.

1 MS. AVERY: I don't think I'll put it in
 2 that context. I think we probably would get some
 3 pushback, and Cece is correct, they -- I've always
 4 been reluctant as a Board member to see those come
 5 back and remove the variance because there is no need,
 6 then all of a sudden we're opening it up because those
 7 existing CCRC's are operating way below the threshold.
 8 So then it's -- they feel like they need to have other
 9 patients in those beds to -- in order to get funding
 10 for them or have them operating.

11 MR. SCAVOTTO: So way below the threshold
 12 in terms of occupancy?

13 MS. AVERY: Correct. Because seniors
 14 aren't being hospitalized like they used to.

15 MS. CREDILLE: This is Cece again.

16 As a practical matter, CCRCs in the State
 17 of Illinois don't -- at least in today's world don't
 18 service only their population with SNF.

19 MS. AVERY: Well, when they first came for
 20 the CON, they should have, and yes, they do come back
 21 for it, and no, we don't really monitor it that
 22 closely.

23 MS. CREDILLE: And then there's the other
 24 situation this was the -- you'll have to correct me,

1 the September Board meeting or August, whichever day
2 it was, there was an application denied, and I think
3 the community was not a CCRC, but it was a retirement
4 community, and they were looking for a SNF, and I
5 don't recall who it was. And so I'm wondering if
6 they'd have been a CCRC, perhaps they would have
7 gotten approval, but because they weren't a CCRC or a
8 retirement community, they were denied? I don't know.
9 I'm asking if that could happen, and if that is what
10 happened really with the project.

11 MS. AVERY: I would have to know which
12 project it is. Mike, do you recall?

13 MR. CONSTANTINO: I don't recall that one.
14 I have to -- I'll have to look back.

15 MS. CREDILLE: One in Naperville, but I do
16 not know the community.

17 MS. KENDRICK: This is Alexis. Is that the
18 one where the mayor came in --

19 MS. CREDILLE: Yes. Yeah.

20 MS. KENDRICK: I thought they were removing
21 the CCRC.

22 MS. AVERY: I'm trying to find my agenda
23 now to look at it.

24 MS. CREDILLE: I'm just asking the

1 question, so if -- if you weren't licensed as a CCRC,
2 you wouldn't -- you couldn't get a variance, and you
3 in fact couldn't get the beds, but if you're licensed
4 as a CCRC in today's world still, you could get a 120-
5 bed, 60 beds, 50 beds, whatever.

6 MR. SCAVOTTO: I think that's right.

7 MS. CREDILLE: Yeah.

8 MS. KENDRICK: Commitment's to the specific
9 population. I mean that's the understanding I have
10 behind it.

11 MR. CONSTANTINO: Yeah. What's happened,
12 you know, we would approve a nursing home, and then --
13 as a skilled care facility and then they would develop
14 that area around them, some of the developers would
15 put in assisted living, and then they would put
16 independent living, and then all of a sudden they're
17 calling it a continuum care retirement community, a
18 CCRC, and the board's approved that for a nursing
19 home. We never even looked at it as a CCRC.

20 MR. SCAVOTTO: It might have been separate
21 ownerships or same owner.

22 MR. CONSTANTINO: Well, what we've come to
23 find out when we started collecting information, a
24 number of long-term care facilities are CCRCs, which

1 exceeds the number the Board has approved. When we do
 2 our survey, we ask that question, are you a continuum
 3 care retirement community, and we get a number of yes
 4 responses, positive responses to that question.

5 And, like I said, what's happened they'll
 6 come in for a long-term care facility, and then over
 7 the years, they've developed the assisted living
 8 around that long-term care facility and independent
 9 living, they do not have a CCRC variance. They
 10 haven't been to the Board under that variance.

11 MR. SCAVOTTO: This is Mike Scavotto.

12 This is very interesting. So is it -- is
 13 it possible for an organization to morph into a CCRC,
 14 do it legitimately, without the approval of the
 15 planning Board.

16 MR. CONSTANTINO: Yeah, the Board only
 17 would approve -- have to approve the skilled care
 18 facility only.

19 MR. SCAVOTTO: Okay.

20 MR. CONSTANTINO: We have no jurisdiction
 21 over independent living or assisted living.

22 MR. SCAVOTTO: Right. Okay. So they
 23 could?

24 MR. CONSTANTINO: Oh, sure. Definitely,

1 and that's what happened that we -- we are seeing more
2 of these facilities that are calling themselves
3 CCRCs which the Board has not approved as such.

4 MR. SCAVOTTO: But there's no way if they
5 can do this -- if they can add independent and
6 assisted without the approval of the Board --

7 MR. CONSTANTINO: Yeah.

8 MR. SCAVOTTO: -- there's no way that the
9 Board could possibly expect to keep up with what's
10 going on in the business.

11 MR. CONSTANTINO: We -- We -- The Board has
12 to approve the skilled care portion, Mike.

13 MR. SCAVOTTO: Agreed. I understand that.

14 MR. CONSTANTINO: Okay.

15 MR. SCAVOTTO: But they approved skilled,
16 but now you're sitting there saying, my list says
17 we've -- we've got -- we've got a hundred skilled and
18 we've got 80 of them that are CCRCs, and all of a
19 sudden it turns out that maybe you've got 150 that are
20 CCRCs because they added assisted and independent
21 without your knowledge, and this is really because you
22 don't regulate that, that's no way you could possibly
23 know --

24 MR. CONSTANTINO: That's correct.

1 MR. SCAVOTTO: -- another 70 that's been
2 added?

3 MR. CONSTANTINO: And they're not bound by
4 any agreement that they can only serve the residents
5 of the community. That's what the Board approves.
6 When the Board approves a CCRC, the Board's telling
7 them you can only serve the residents of that
8 community.

9 MR. SCAVOTTO: With the skilled?

10 MS. CREDILLE: But there's no -- This is
11 Cece again. But there's really no mechanism to
12 enforce that because that is not really how CCRCs in
13 today's world operate.

14 MR. CONSTANTINO: That -- That's all --
15 That's all correct. We do not -- We have no mechanism
16 to enforce it. That's true. Other than their -- if
17 we would find out or somebody would complain, and we
18 do an investigation, then they -- and they are serving
19 the residents of the entire planning area, then they
20 would be subject to fines.

21 MS. CREDILLE: Can I ask --

22 (SPEAKING ALL AT ONCE.)

23 MR. SCAVOTTO: Start over again, whoever
24 just spoke.

1 MS. AVERY: This is Courtney. I'm saying
2 we have had that happen, and the long-term care
3 industry has complained about a CCRC opening up
4 outside of their community.

5 MR. PICK: Hi, this is Eli. Sorry I'm
6 late.

7 MR. SCAVOTTO: Look at the windows and the
8 blackboard.

9 MS. CREDILLE: This is Cece again. Can I
10 ask -- this is a naive question. Since the beds are
11 to meet the service of the CCRCs community only, are
12 they included in the beds in the planning area?

13 MR. CONSTANTINO: Oh, yes, they're included
14 in the need calculation, and in the -- and in our bed
15 inventory. Yep.

16 MR. SCAVOTTO: Let me interrupt. Eli,
17 we're at 1125.560.

18 MR. PICK: Yes. Sorry again, guys, I'm
19 late.

20 MR. SCAVOTTO: That's okay. Not a problem.
21 Glad you joined us. Okay. So --

22 MR. CONSTANTINO: Let me just say one other
23 thing.

24 MR. SCAVOTTO: If I'm a CCRC in the sense

1 that I've got assisted and independent already, I want
2 to add skilled, your process makes some sense to me if
3 we -- you agree that we can add beds to serve our own
4 members. On the other hand, what doesn't make sense
5 is on a skilled, I can add independent and I can add
6 assisted, I could become a CCRC, and that's -- that's
7 -- to me that sounds like the reason why your records
8 aren't tying, and there's no way you could keep up
9 with that activity because you don't -- there's no
10 reason for you to do it.

11 MR. CONSTANTINO: No, that's true.

12 MR. SCAVOTTO: Okay.

13 MR. CONSTANTINO: Those were correct
14 statements, yes.

15 MR. SCAVOTTO: Now, I've got a question.
16 I've got a policy question in logic, and, Courtney,
17 you're going to have me help me through it, at a
18 future time if you don't want to do it right now.

19 MS. AVERY: Okay.

20 MR. SCAVOTTO: What I thought I heard as an
21 explanation for the variance was that it was created
22 for times when there was no calculated bed need in the
23 planning area.

24 MR. CONSTANTINO: That's correct, Mike.

1 MR. SCAVOTTO: Okay. So we've got no
 2 calculated bed need in the planning area, and then
 3 we're giving these variances, doesn't that -- doesn't
 4 that call into question the logic of having a
 5 calculated bed need? If we're not going to use it,
 6 why have it?

7 MS. AVERY: I think it's the uniqueness of
 8 the CCRC at the -- in the community, and given those
 9 who can afford to live there to not have to in a sense
 10 leave home but just simply go upstairs or across the
 11 courtyard. So it's a matter of -- for lack of a
 12 better term -- privileged health care.

13 MS. CREDILLE: How does that apply to the
 14 religious then because we started with a defined
 15 population equals religious? This is Cece.

16 MS. AVERY: You're speaking of two
 17 different things. This is Courtney. I think there's
 18 two different things that you're describing, Cece, the
 19 defined population and the CCRC variance because the
 20 defined populations are assisted or the example that
 21 Mike gave -- first is meaning who can or someone who
 22 can afford to go and live at the Clare Water House
 23 Tower and pay for the condo, pay the assessments, have
 24 the comfort of having health care under all under one

1 roof of where you live. So it's two different
2 populations.

3 MS. CREDILLE: Right, but --

4 MS. AVERY: The defined populations aren't
5 supposed to let anyone outside of their group into
6 those beds.

7 MR. SCAVOTTO: But -- This is Mike. Now,
8 that defined population applies to fraternal and
9 religious and the general community at large if it's a
10 CCRC. The --

11 MS. AVERY: No, not -- defined isn't the
12 general population at large.

13 MR. SCAVOTTO: If it's a CCRC.

14 MS. AVERY: If it's CCRC, it's kind of like
15 a defined population, but I don't have to belong to a
16 certain group. I don't have to be a sister in that
17 order.

18 MR. SCAVOTTO: Okay. So we've got three
19 defined populations. One is a generalized CCRC, the
20 other one is religious, and the third one is fraternal
21 like the Elks. Is that correct?

22 MS. AVERY: It's really just two. It's a
23 CCRC, and then you can come in under the defined
24 population.

1 MS. CREDILLE: But defined population can
 2 be a freestanding SNF. Am I hearing -- This is Cece
 3 again -- a free-standing skilled facility, not a CCRC
 4 model. And if you are a fraternal or religious
 5 organization, and you come in and say I'm only going
 6 to admit whatever your religious affiliation or
 7 membership is, it can just be a SNF. Right?

8 MR. CONSTANTINO: That's the only
 9 jurisdiction we have is over the SNF, yes.

10 MS. CREDILLE: So it's two -- two ways then
 11 to have variances outside of the bed need calculation.

12 MR. CONSTANTINO: Well, those variances are
 13 only supposed to be used when there's no need in the
 14 planning area. That's why they were put in there.
 15 That's the only time they were ever supposed to be
 16 used.

17 MR. SCAVOTTO: What's happening now?

18 MR. CONSTANTINO: Well, we've seen come in,
 19 for example, Erickson, just -- and I know they went
 20 bankrupt, but Erickson came in and wanted to do a
 21 large continuing care retirement community up there in
 22 Naperville. In fact, that might be the one they
 23 wanted to do at the August meeting that Cece was
 24 talking about. And they came in, and it was a hundred

1 and -- it was a huge project, and they were going to
2 do independent, assisted, and skilled care. We
3 approved them for the CCRC. They brought the entire
4 project before the Board, but the Board could only
5 have jurisdiction over that long-term care portion.

6 So what they did, they provided us with a
7 total project cost, the hundreds of thousands of
8 dollars, and then they also provided us with just the
9 cost for the skilled care, and that's the only thing
10 we reviewed. It was listed in our inventory as a CCRC
11 because they were limited by Board action to the
12 residents of that community, and at the time it was
13 approved there was no bed need in that area. That's
14 the only time those variances are ever supposed to be
15 used.

16 We're saying we will allow you to do this
17 variance to the calculated bed need. That's why they
18 were put in there so these organizations where there
19 wasn't a need for beds, they could establish a
20 facility to serve these groups, or in some cases the
21 continuing care retirement community, it should be
22 just very limited use.

23 But, like I said, what's happened is we've
24 had individuals come before us, get approved for the

1 skilled care, and then eventually develop a CCRC
2 community around that skilled care unit, which serves
3 in this -- in that case would serve just the residents
4 of the entire planning area instead of the residents
5 of that continuing care community.

6 MR. SCAVOTTO: Wait a second. This is
7 Mike. Let's back up. You lost me on that last one,
8 and -- but before I follow up on that, I just want to
9 say that I'm finding this discussion to be very
10 informative, and I can appreciate why variances were
11 created. I can understand that you want to provide
12 for the convenience of a CCRC community to use a
13 self-contained SNF. I get that. I can see where
14 there's an exception, but, Mike, I'm not -- I'm not
15 following you on your last comment about -- I mean
16 very limited use intended, and if we seem to have
17 gotten away from that. Can you give me that example
18 again?

19 MR. CONSTANTINO: Okay. We've had
20 individuals come before the Board and be approved for
21 120-bed facility, skilled care facility. They didn't
22 tell us anything about they're going to develop in the
23 future, independent living or assisted living, because
24 they knew we had no jurisdiction over that. So over

1 the years they developed a community of independent
 2 living and assisted living in that nursing home.
 3 Okay. In our books, under -- In our books it's not
 4 classified as a CCRC, but when we went out and asked
 5 whether or not the facility was a continuing care
 6 retirement community, they told us it was because they
 7 had developed these other two -- these other two types
 8 of housing, the independent and assisting.

9 MR. SCAVOTTO: Well, okay. Let me proceed
 10 now.

11 MR. CONSTANTINO: They didn't need the --
 12 At the time they were approved, there was -- there was
 13 a bed need in the planning area. So they did not need
 14 to utilize that variance.

15 MR. SCAVOTTO: So my question to you is
 16 what's wrong with that.

17 MR. CONSTANTINO: There's nothing wrong
 18 with that. I'm not saying there is. I'm just saying
 19 that's what's happened, you know, that some folks have
 20 done it like that, developed a continuing care
 21 retirement community like that.

22 MR. SCAVOTTO: Okay. I don't -- I don't
 23 have a problem with them doing that.

24 MR. CONSTANTINO: No, we don't either, but

1 when we go out there, we've had people interested in
 2 how many continuing care retirement communities there
 3 are in the state. Well, when we look at our database
 4 and say well, gee, this doesn't reflect what's in our
 5 survey. We've got quite a bit more than what was
 6 approved by the Board, and that's what happened.
 7 That's the reason it happened.

8 MR. SCAVOTTO: Now, let's turn that around.
 9 Let's reverse the flow. I've -- I started out with
 10 assisted and independent, and I went to you, and I
 11 said, I now want to add 120-bed SNF, you say okay, and
 12 I come back in five years, and I say that 120 needs to
 13 be -- needs to be 220. Pick a number. Needs to be
 14 higher. I need a CON to do it, and I'm still going to
 15 serve my defined population because I've increased my
 16 independent and my assisted living. What's wrong with
 17 that scenario? Seems to me that that flows directly
 18 according to your rules.

19 MR. CONSTANTINO: You know, like I said,
 20 the only time that variance is ever supposed to be
 21 used is when there wasn't a calculated bed need into
 22 -- in the planning area. In the example you gave,
 23 where they -- they have the independent and assisted,
 24 and they want to establish a skilled care facility,

1 they would have to tell us where the -- where the
 2 residents were going to come from, and if there was a
 3 calculated need in the planning area, they did not
 4 need to use that variance. There was -- They wouldn't
 5 because it's limited to only areas in which there is
 6 not a calculated bed need. That's how it was
 7 designed. It was the variance to that bed need.

8 MR. SCAVOTTO: Let me -- This is Mike. Is
 9 there -- Is there a need on -- I'm -- You're not
 10 coming out and exactly saying this, Mike, but I'm
 11 sensing that this is where you're going. I don't mean
 12 to put words in your mouth. So if I do, stop me, and
 13 no offense will be taken, but are you suggesting that
 14 the use of this variance has gone beyond its intended
 15 purpose, it's original intended purpose, and we need
 16 to get back to that?

17 MR. CONSTANTINO: Yes, in some -- there was
 18 some -- there was some facilities approved when the
 19 variance did not apply.

20 MR. SCAVOTTO: Okay.

21 MS. CREDILLE: This is Cece. In the
 22 example that Mike Scavotto just gave, could somebody
 23 have come back in the back door, become a CCRC, and
 24 then -- let's just say -- I'll even lower the number,

1 they started originally with a 50-bed SNF, you've got
 2 -- they got approved by the Board under the normal SNF
 3 approval process, now, over the years they've become a
 4 CCRC, and then they come back and want to add another
 5 hundred beds, now they're a CCRC, and so the second
 6 time around in theory they could get a variance
 7 because there's no bed need but they've added AL, IL,
 8 or whatever they've done, and they say they have need
 9 and now they are a CCRC and they could get a variance.

10 MR. CONSTANTINO: Yeah, that could happen,
 11 yes.

12 MR. SCAVOTTO: What's the problem with that
 13 as long they're serving their defined population?

14 MS. CREDILLE: That's if they serve -- if
 15 they serve their defined population.

16 MR. SCAVOTTO: Well, I agree with that. I
 17 don't know if that's a big if or a small if.

18 MR. PICK: This is Eli. It depends on the
 19 market area. There are some environments where they
 20 got a variance and they're only supposed to be serving
 21 the defined population, and because of their lack of
 22 utilization, they're accommodating outside of this
 23 defined population, and no one is aware of it.

24 MS. CREDILLE: Yeah, Eli, we chatted about

1 this in the beginning, about that that -- it is
2 happening in the industry.

3 MR. SCAVOTTO: Yep, we agree.

4 MR. PICK: Well, what I'm hearing Mike talk
5 about is this disconnect between the planning board
6 being able to just keep track of what -- what programs
7 are being available separate from variances. So if
8 there are, let's say, 20 CCRCs in the State of
9 Illinois, but there are actually 35 CCRCs, the
10 planning board has no way to know that they exist.

11 MR. SCAVOTTO: That's true. But then
12 depending on how they were created.

13 MR. CONSTANTINO: That's true.

14 MR. SCAVOTTO: The SNF came first and then
15 it added IL and AL, yeah, you're right.

16 MR. CONSTANTINO: That's correct.

17 MR. PICK: So one of the things we may want
18 to incorporate is some reporting mechanism that
19 doesn't limit, you know, the operator from doing what
20 they're already doing, but they're just reporting that
21 they are a CCRC by virtue of the menu of services that
22 they offer, and that the planning board only wants
23 that information in order to maintain an accurate list
24 of what services are available.

1 MR. CONSTANTINO: Yes, we collect that
2 during our survey process, and like I had -- like I've
3 stated it, the CCRCs approved by the Board, and what's
4 being reported to us now, there's quite a bit of
5 difference.

6 MR. SCAVOTTO: Yeah.

7 MR. PICK: I would -- You know, I remember
8 -- I had a good friend of mine, who was an
9 administrator of a nursing home in Downers Grove,
10 which was sponsored by the Baptist Church, and then
11 they developed AL and IL around the nursing home
12 because they had a 40-acre campus, and, frankly, the
13 reason he did it because the nursing home couldn't get
14 over 15 percent occupied, and by developing the other
15 services in the continuum, they filled up the nursing
16 home as well as the residential. You know, we'll go
17 back into the early 90s is when he did it.

18 MR. SCAVOTTO: Makes sense to me.

19 MR. PICK: Sure.

20 MR. CONSTANTINO: Yeah.

21 MR. SCAVOTTO: So it's -- This is Mike. It
22 seems that we've got a couple of issues that we've got
23 to resolve on this. We're not going to resolve it on
24 this call.

1 Has the -- Has the intended limited use
2 been extended or expanded inappropriately? I'm not
3 sure that that's the case. I'm sure -- I'm sure that
4 there's some people out there that are abusing the
5 system, and I know there are. I'm not naive on that.
6 Do we deal with this with better reporting? Do we try
7 to tighten that variance up? I just -- There's no way
8 that the staff can keep up with what the -- with the
9 developments in the example that we've been kicking
10 around. Start with an SNF and add IL and AL, your
11 numbers are never going to jive. I'm wondering if
12 there's any -- if there's any reason to really be
13 concerned about that. Part of me says yes, and part
14 of me says no. So I would -- I would rely on Eli and
15 Cece to straighten me out on this one, is this a big
16 deal or not?

17 MS. CREDILLE: My question is from the
18 original comments that I made -- It's Cece again -- is
19 that you could make an exception for a CCRC if we
20 wanted to tighten up reporting and et cetera, but my
21 question remains why you need variance on fraternal
22 and religious organizations as well when a number of
23 other states -- and I don't know if this is
24 all-inclusive -- do not make exceptions for that.

1 MR. SCAVOTTO: Your point is keep the CCRC
2 designation but drop religious and fraternal?

3 MS. CREDILLE: Potentially, and you could
4 tighten up the requirements on the CCRC or the -- I
5 don't know how you do it in a state with no money but
6 -- the enforcement end of it. You're supposed to be
7 servicing that specific population, and I don't know
8 if there's money to do that because it sounds like it
9 is an issue only if someone raises it. Does somebody
10 go out -- I'm not sure what penalties occur or what
11 happens. Courtney gave an example that has occurred,
12 but I still have the question, a fraternal or
13 religious variance in this day and age.

14 MR. PICK: Yes, Cece, this is Eli. You're
15 really going into a head wind, you know, trying to,
16 you know, remove a religious variance that's been on
17 the books for, you know, quite a number of years
18 already. So I -- I don't disagree with you, I don't
19 know that there's a justifiable need, but I think
20 politically to devote the energy and the political
21 effort to get it removed is probably going to be less
22 efficient than, you know, really looking closer at the
23 application about what qualifies as, you know, a
24 religious or fraternal organization in order to get

1 that variance.

2 MS. KENDRICK: Mike, this is Alexis. How
3 often does a defined population variance get used?

4 MR. CONSTANTINO: We haven't seen one since
5 Mercy when they developed their facility. I think
6 that was in 2010, Alexis.

7 MS. KENDRICK: Okay. I think in terms of
8 people having more often -- people removing their CCRC
9 variance happens more often than coming in for a
10 defined population variance.

11 MR. CONSTANTINO: We have a --

12 MR. SCAVOTTO: That makes sense, but Mike
13 -- and this is Mike Scavotto. Mike, what was Mercy's
14 defined population?

15 MR. CONSTANTINO: Well, they -- It was
16 Sisters of Mercy. I'm sorry, Mike. They were
17 Catholic institution. It was for the Sisters.

18 MR. SCAVOTTO: For the Sisters themselves?

19 MR. CONSTANTINO: Yeah, Sisters of Mercy.
20 I'm sorry, I said Mercy.

21 MR. SCAVOTTO: I mean I know they did some
22 -- There's no real debates with Mercy, and I guess
23 there was another one -- anyway up there in McHenry
24 County.

1 MR. CONSTANTINO: No, I should have said
2 Sisters of Mercy.

3 MR. SCAVOTTO: Okay. That makes sense.

4 MR. CONSTANTINO: Yeah, you know, we have a
5 -- down the street here in Springfield, we have a
6 convent. You know, it's always been a issue here at
7 Public Health whether or not they should be licensed
8 as nursing homes.

9 MR. PICK: Because they've aged to the
10 point where they're providing nursing home services in
11 the convent?

12 MR. CONSTANTINO: Yeah. Yep. Yep.

13 MR. SCAVOTTO: Yes, some of them now are
14 going after Medicaid reimbursements, and some of the
15 Sisters are in rough shape.

16 MR. CONSTANTINO: We don't have the -- I
17 don't know -- kahunas, I guess, to take on something
18 like that.

19 (LAUGHTER.)

20 MR. SCAVOTTO: Oh, yeah. All right.
21 Discretion is the better part of valor.

22 MR. PICK: Mike, this is Eli. I agree with
23 Alexis, what I've heard of more recent are, you know,
24 CCRCs who came in under the variance that are now

1 asking the Board to remove the restriction and allow
2 them to accept -- to be able to accept patients from
3 or residents from the planning area, and, you know, I
4 would think that would be a bigger problem.

5 MR. CONSTANTINO: Yes, we have seen quite a
6 few of those applications, yes.

7 MR. SCAVOTTO: And how are they usually
8 resolved?

9 MR. CONSTANTINO: The Board has approved
10 them for the most part. We require them to submit a
11 -- We require them to submit an application for a new
12 facility. So they're paying the additional -- they're
13 paying the fee -- the CON fee again. The Admiral in
14 Chicago, I think, was a recent one that the Board just
15 approved, and that fee came close to a hundred
16 thousand dollars. So I mean it's not something that
17 -- you just can't come in and ask the Board to do it,
18 and it's not --

19 MR. SCAVOTTO: I understand.

20 MR. CONSTANTINO: -- it's not costly. It
21 is costly.

22 MR. SCAVOTTO: Yeah, you have to pay your
23 dues.

24 MR. CONSTANTINO: Yeah.

1 MR. SCAVOTTO: Are we still requiring them
2 to establish a need?

3 MR. CONSTANTINO: Well, in that case, what
4 the Admiral, with Admiral, I don't believe there was a
5 need in the planning -- Well, I can't -- I shouldn't
6 say. I'm trying to think now back about that
7 application. The Board -- The Board did approve it,
8 and I can't recall if there was a need in the planning
9 area.

10 MR. SCAVOTTO: Can we get some data on
11 this, because I think this is -- this is really --
12 this is -- it's a material point. Can we get some
13 data on the expansions of SNFs created under variance,
14 and how many there have been over the last several
15 years, and how many had an actual need.

16 MR. CONSTANTINO: Sure. We can -- can do
17 that.

18 MR. SCAVOTTO: Okay.

19 MR. PICK: Mike, this is Eli. I'm aware of
20 a project in Naperville, where a retirement -- CCRC
21 just applied for, you know, expanding their beds to
22 serve the planning area, and that was based on the
23 need that -- the bed need in that planning area.

24 MR. CONSTANTINO: Yeah, I think isn't that

1 the Erickson facility that someone purchased, Eli?

2 MR. PICK: Yes, that's exactly right.

3 MR. CONSTANTINO: Yeah. They were approved
4 eventually.

5 MR. SCAVOTTO: And there is a bed need in
6 that service area. That's why it was approved.

7 MR. CONSTANTINO: Yes, that's correct.

8 Yes. I believe there was the same thing at the
9 Admiral too. I'm not real clear on that one.

10 MR. SCAVOTTO: Okay. Okay. I think it
11 would be helpful if we could move on and --

12 MR. PICK: Okay.

13 MR. SCAVOTTO: -- deal with another level
14 of ambiguity. Let's see if we can get some -- a
15 different look at this through the lens of having some
16 data and see how many have been created over the last
17 couple years, say three years, depends on -- Mike, if
18 you want to go back five, that's fine, but I think the
19 more pressing thing is how many were created without a
20 need. I'm very curious about that one.

21 MR. CONSTANTINO: Okay.

22 MR. SCAVOTTO: Let's go on to 570. Use
23 this on the follow-up on the next call. What is 570?
24 570 is Service Accessibility. Cece, this is -- this

1 is primarily you on this one, and the service doesn't
2 address major service restrictions, and, Eli, you
3 agreed with that. So did I.

4 MR. PICK: Looking at my notes.

5 MS. CREDILLE: How do you guys know what
6 was said here?

7 MR. SCAVOTTO: I'm reading it. So my
8 comments on this one is that on -- on 570, I thought
9 the first and last bullets under the first paragraph,
10 they start off is, the absence of the proposed
11 service, and the last one is the area population and
12 existing care system, they struck me as superfluous in
13 regard to the first one. I'm thinking that every
14 planning area in the state has nursing beds, and
15 therefore the proposed service, which is the skilled
16 beds, is already established. It's possible that the
17 first bullet includes a hospital reference, which
18 doesn't seem applicable to long-term care. How did I
19 get that idea? Oh, that's the second one. Okay. So
20 the question that I have is whether or not the first
21 bullet and the last bullet are superfluous.

22 MR. CONSTANTINO: You're correct on the
23 first one. There is nursing care services in all the
24 planning areas in the state, that's correct.

1 MR. SCAVOTTO: Okay.

2 MR. CONSTANTINO: The fourth bullet there,
3 this is something that was developed for the
4 hospital's review.

5 MR. SCAVOTTO: That's where I'm getting at,
6 yep. And I'm wondering if that -- if that applies to
7 long-term care.

8 MR. CONSTANTINO: That, I don't know.

9 MR. PICK: Mike, this is Eli. Could you
10 read what the fourth bullet says?

11 MR. SCAVOTTO: No, I'm going to have --
12 You're going to have to continue to guess.

13 MR. PICK: Okay.

14 MR. SCAVOTTO: Here it comes. What it says
15 is, the area population and existing health care
16 system exhibit -- The area population and existing
17 care system exhibit indicators of medical care
18 problems, such as average family income level below
19 the State average poverty level, or designation by the
20 Secretary of Health & Human Services as a Health
21 Professional Shortage Area, a Medically Underserved
22 Area, or Medically Underserved Population. To me that
23 says hospital, not long-term care.

24 MR. PICK: The only exception is there

1 are only certain area designations for like mental
2 health services and nursing homes.

3 MR. SCAVOTTO: Okay.

4 MR. PICK: So for specialized services in
5 long-term care, it's applicable. It's not applicable
6 for the general long-term care community, you know, a
7 long-term care licensed care community.

8 MR. SCAVOTTO: The second bullet we cover
9 Medicare, Medicaid, managed care and charity care.
10 And the third bullet we cover restrictive admission
11 policies of existing providers. So I --

12 MS. CREDILLE: That one applied really to,
13 for example, the religious or fraternal organizations.

14 MR. SCAVOTTO: It could. It could. Makes
15 sense.

16 MR. CONSTANTINO: That's correct.

17 MR. SCAVOTTO: So, Mike Constantino, how do
18 you -- how does the staff look at these four bullets
19 under Service Restrictions?

20 MR. CONSTANTINO: Well, essentially what we
21 say is there is service in the planning area. There
22 is -- For example, we rely upon the applicant to
23 identify access limitations and restrict admission
24 policies. I have never found anything regarding the

1 designation by the Secretary of Health & Human
 2 Services as it relates to long-term care. I don't --
 3 we've never come across anything like that, and what
 4 we do is we look at facilities within -- within a
 5 timeframe of 30 minutes, and if they're underutilized,
 6 we -- we say we're negative on the criteria because
 7 there is -- because it does not meet the requirements
 8 of the -- of the rule. In this case it would not meet
 9 the absence of the proposed service or access
 10 limitations because there's beds available for use.

11 MR. SCAVOTTO: So it's an occupancy thing
 12 then?

13 MR. CONSTANTINO: Yeah. That's how we --
 14 when we look at it, yes, and write the report, that's
 15 how we look at it, yeah, occupancy.

16 MS. CREDILLE: Well, we're going to get
 17 into occupancy in 580 again.

18 MR. SCAVOTTO: Right.

19 MR. PICK: Yep.

20 MR. SCAVOTTO: All right. So --

21 MR. CONSTANTINO: That's correct. Those
 22 two criteria pretty much parallel each other.

23 MR. SCAVOTTO: If we drop that fourth
 24 bullet, is anyone going to cry? I mean it's in the

1 rule, it comes right out of the rule. But again it's
 2 one of those things that we're going to have to clean
 3 up the application by a rule change. It doesn't sound
 4 like it affects the review of anything.

5 MR. PICK: I agree with you, Mike. This is
 6 Eli.

7 MR. CONSTANTINO: I don't have a problem
 8 with removing it, but my guess is the staff is
 9 probably going to have to discuss it. Discuss it with
 10 Claire and Legal. I can't -- I can't -- I've never
 11 been able to find anything -- able to find anything on
 12 a Department of Human Services website related to --
 13 to that regarding long-term care.

14 MR. SCAVOTTO: Okay.

15 MR. CONSTANTINO: Once again that was taken
 16 from -- from the hospital.

17 MR. SCAVOTTO: I've got the rules. I went
 18 through this and laid it all out against the rule. I
 19 agree. I mean a lot of this stuff comes right out of
 20 the rule. I'm just -- if it's not useful, let's show
 21 it the door. Was there -- Cece, did you have any --
 22 Let me back up a minute. This is Mike. Eli, I'm
 23 going to read this to you because you're driving.

24 MR. PICK: Okay.

1 MR. SCAVOTTO: This is required under the
 2 second item under Service Restrictions, and it's
 3 location and utilization of other planning area
 4 service providers. B, patient/resident location
 5 information by zip code. That's a favorite. C,
 6 independent travel time studies. D, certification of
 7 a waiting list. E, admission restrictions that exist
 8 in area providers. F, assessment of area population
 9 characteristics that document that access problems
 10 exist. G, most recently published IDPH Long-Term Care
 11 Facilities Inventory and Data. Those are all to be --
 12 are applicable to long-term care. Right. I think
 13 we've got a connection there.

14 Are we comfortable moving to 580 with the
 15 suggestion that the staff take a look at dropping that
 16 fourth bullet as being superfluous?

17 MR. PICK: Yes, I'm -- this is Eli. I'm
 18 okay with that.

19 MS. CREDILLE: Can I ask -- This is Cece --
 20 on No. 2, are there any issues with any of those
 21 items, for example, I don't understand the time-travel
 22 studies, I don't know if it ties to 580 and the 30
 23 minutes drive time, and then the certification of a
 24 waiting list, can or are providers providing waiting

1 list information these days, and is the waiting list
 2 for the future facility or a facility they already
 3 have, and then -- so if there's a waiting list and so
 4 then they have to come to their new facility, or --

5 MR. SCAVOTTO: Mike, can you respond?

6 MR. CONSTANTINO: Yeah, the independent
 7 travel time, right now our rules requires to use
 8 Mapquest, however, if someone wants to pay for an
 9 independent travel-time study, we will take that over
 10 the Mapquest. We have specific criteria for an
 11 independent travel-time study if they submit one.
 12 Generally I don't see it in long-term care. We do see
 13 it in the ESRD applications though. That's why it's
 14 in there. It's just another option to the Mapquest
 15 distance in time. We give that a higher priority.
 16 The independent travel time study, if somebody wants
 17 to pay the engineer to do it. Certification of a
 18 waiting list, I have never seen one. Maybe in any
 19 application we've received for the establishment of a
 20 new facility.

21 MS. CREDILLE: This has been with the
 22 documentation. This says the documentation is
 23 required at the start of No. 2. So I as an outsider
 24 who has never filled out a CON application myself --

1 MR. CONSTANTINO: Well, I think if you go
2 down to that second sentence, the applicant shall
3 provide the following documentation as applicable. I
4 think we give you some leeway there.

5 MR. SCAVOTTO: Yeah, but there's a
6 disconnect between required and then as applicable.
7 So maybe we can tighten that up.

8 MR. CONSTANTINO: Okay.

9 MR. SCAVOTTO: I can see -- I can see the
10 point. I think Cece's got a -- I read this the same
11 way.

12 MR. CONSTANTINO: Okay. We can do that.

13 MR. SCAVOTTO: And then what's applicable,
14 you've got to fill it out. You've got a choice.

15 MS. AVERY: Right. We'll figure it out.
16 Clean it up.

17 MR. SCAVOTTO: That's an easy one. Great.
18 All right.

19 Well, we're moving on to 580, which is
20 Unnecessary Duplication/Maldistribution.

21 MR. PICK: Okay.

22 MS. CREDILLE: This is -- Eli, this is one
23 of yours, this is a favorite section of yours.

24 MR. SCAVOTTO: Eli, you better still be

1 within range.

2 MR. PICK: Say that again.

3 MR. SCAVOTTO: Are you there, Eli?

4 MR. PICK: Yeah.

5 MS. AVERY: I didn't hear any beep so he's
6 still there.

7 MR. PICK: I'm still here.

8 MS. CREDILLE: This involves the 30 minutes
9 drive time discussion. This is your -- one of your
10 favorites.

11 MR. SCAVOTTO: I would just like to point
12 out to everybody, that the perverted English teacher
13 in me says if we have unnecessary duplication, it
14 implies that there is necessary duplication.

15 (LAUGHTER.)

16 MR. SCAVOTTO: So we might -- Mike, can we
17 just -- Courtney, will you look at a new title? I'm
18 just avoiding -- avoiding duplication/maldistribution.
19 I think that sets aside the intent of the regulation.

20 MS. AVERY: Look at a new title for it?

21 MR. SCAVOTTO: Yes, rather than unnecessary
22 duplication, you want to avoid duplication and
23 maldistribution.

24 MS. AVERY: Okay. Take that into

1 consideration also.

2 MR. SCAVOTTO: I believe there's no
3 political capital attached to that question.

4 MS. AVERY: We'll play with it and see
5 what's the best way to communicate it.

6 MR. SCAVOTTO: Okay. So Eli, let's see,
7 oh, yeah, Eli, I'm going to read your comments on this
8 one.

9 MR. PICK: Okay.

10 MR. SCAVOTTO: I would like to hear the
11 intent from Claire and Mike Constantino on both the
12 items mentioned regarding 30 minutes. One of the
13 questions is whether or not the bed inventory should
14 distinguish between types of accommodations since the
15 legislation specifies that the intent is to move
16 toward consumer preference, which is private. Then
17 perhaps the question of segregating the types of beds
18 makes sense and if preferential treatment should be
19 given to projects that reduce high density beds and
20 offer lower density. Sounds preferable.

21 MR. PICK: Sounds preferable.

22 MR. SCAVOTTO: Although the rest of us
23 didn't react that way.

24 MR. PICK: All confused.

1 MR. SCAVOTTO: No, you want to expound on
2 that because I think it's a good place to start.

3 MR. PICK: Yeah, I think the two parts is,
4 number one, the 30-minute drive time I think was --
5 is, you know, at least my interpretation of the intent
6 was to, you know, make sure that we've got things
7 placed in the -- the proximity. So ease of the access
8 to consumers, and so, you know, I know one of the
9 examples that we had discussed in many of the prior
10 meetings with the reform of the rule was if there's a
11 project that's on the border of two planning areas,
12 and one planning area has a need and the other one
13 doesn't, that the 30-minutes drive time is now applied
14 so that it's more -- is that the consumer who lives or
15 consumers who live near the border of the planning
16 area don't have to drive further to get to the beds
17 that are available because that planning area has no
18 bed need, but if they had driven a short distance
19 across a planning area border, they could have gotten
20 to a new project that would service their needs in a
21 more convenient manner. So that was -- That's part
22 one.

23 The part two is that giving preference to
24 projects that reduce the density, again in response to

1 consumer preferences, should be the orientation of the
 2 Board in its approval process and to give
 3 consideration when a bed need calculation is made. So
 4 even if an area doesn't have a bed need per se, but a
 5 new project that has a higher -- offers a --
 6 significantly more private rooms and, you know,
 7 individualized spaces and programs, that that should
 8 be taken into consideration when reviewing a project
 9 even when a planning area may not have a need, and
 10 that the existing facilities that are older and have,
 11 you know, three and four bed wards, are what's
 12 available, then those beds should somehow be taken
 13 into consideration based on consumer preference. Does
 14 that help explain it.

15 MR. SCAVOTTO: Uh-huh. Yes. Cece, did you
 16 have any observations on this?

17 MS. CREDILLE: No, Eli said it correct. I
 18 mean the three and four-bed wards, that is an issue.
 19 And I -- 30 minutes drive time, as we've said before,
 20 in Chicago, is interesting.

21 MR. SCAVOTTO: So yeah, it's -- it's
 22 irrelevant. Can --

23 MS. CREDILLE: Correct.

24 MR. SCAVOTTO: But it can be relevant in a

1 rural area.

2 MR. PICK: It doesn't necessarily have to
3 be a rural area. It could be a smaller metropolitan
4 area like a Peoria or a Moline. Chicago is definitely
5 not relevant.

6 MR. SCAVOTTO: No. That's right. We're on
7 the same page there.

8 MR. PICK: Yeah.

9 MS. CREDILLE: Yeah, we all are.

10 MR. SCAVOTTO: So, Mike Constantino, tell
11 us how this section is used in practice.

12 MR. CONSTANTINO: Okay. This came out of a
13 court ruling years ago. A judge -- We were taken to
14 court. Somebody was complaining about our calculated
15 bed need methodology, and the judge told us that we
16 needed to look at facilities within 30 minutes. Even
17 if there is a calculated bed need, we had to look at
18 facilities within 30 minutes. So this is how that
19 developed, and it's gotten to this point. It's not
20 something that was originally in the -- in the rules.
21 We were required to do it by a court order. And it's
22 been in there for years now. It's both in the
23 long-term care and the hospitals. So we're -- we have
24 to look at all facilities within 30 minutes and their

1 utilization.

2 MR. SCAVOTTO: So when we're looking at the
3 utilization, what are we doing, we're looking at
4 population, we're looking at occupancy, bed need, bed
5 needs per thousand. How are we doing that?

6 MR. CONSTANTINO: We identify all the
7 facilities within 30 minutes or the applicant does,
8 and we look at the utmost current utilization we have,
9 okay, and if their existing facilities that do not
10 meet our target occupancy of 90 percent, we would be
11 negative on this criteria; in other words, we tell the
12 Board that there are beds available. It doesn't make
13 a distinction between three and four-bed wards, does
14 none of that. But there are beds available, again we
15 get into that issue with over-bedded, the State being
16 over-bedded, and that's how we address this criteria.

17 MR. PICK: Mike, this is Eli. I think the
18 over-bedders are dead beds?

19 MR. CONSTANTINO: Yes.

20 MR. PICK: Are definitely irrelevant issue
21 for exactly this.

22 MR. CONSTANTINO: Yeah.

23 MR. SCAVOTTO: The 90 percent occupancy
24 level is another thing I find interesting. Mike, are

1 you seeing fewer and fewer facilities able to meet
2 that 90 percent requirement?

3 MR. CONSTANTINO: Yeah, I think I'm wanting
4 to say the average utilization's been running around
5 76 to 78 percent.

6 MR. SCAVOTTO: Okay.

7 MR. PICK: Yep.

8 MS. CREDILLE: So how do you hold to this
9 occupancy now given that the State occupancy has
10 fallen to that?

11 MR. CONSTANTINO: Well, until the rule is
12 changed and/or until you guys say we're going to use a
13 different target, I have to use that 90 percent. I
14 can't -- we can't deviate from the rule or that
15 standard unless we change the rule.

16 MR. SCAVOTTO: Yeah.

17 MR. PICK: This is Eli. It doesn't mean
18 that there are no buildings that are over 90 percent.
19 It just means that, you know, for every 90 percent
20 building, there's a 50 percent building.

21 MR. CONSTANTINO: That's correct, yes.

22 MR. SCAVOTTO: Well, now, I'm looking at my
23 notes on this. And what's listed in 580 is I think
24 verbatim out of the rule. The one exception is that

1 or is item 2, the applicant shall document that the
 2 project will not result in maldistribution of
 3 services. There were three examples provided in the
 4 JCAR rule that were not put in the application. I'm
 5 not suggesting that they should be. What I am
 6 suggesting is that there's nothing in this -- if this
 7 reflects what's written in the rule, there's nothing
 8 that talks about 90 percent. So we might have some
 9 flexibility in dealing with that. Let me look.

10 MR. CONSTANTINO: Yeah, we consider the
 11 appendix. The 90 percent would be in the planning --
 12 planning rules for long-term care. That's where that
 13 number is coming from.

14 MR. SCAVOTTO: So where is the appendix?

15 MR. CONSTANTINO: Well, you're probably
 16 going to need to look at, Mike, the planning --
 17 general long-term care planning policies.

18 MR. SCAVOTTO: Okay. And is the 90 percent
 19 prescribed by rule?

20 MR. CONSTANTINO: Oh, yes. Yeah. The 90
 21 percent is prescribed by rule, yeah.

22 MS. CREDILLE: Given the State's average is
 23 currently 78 percent, is 90 percent occupancy
 24 something we can address without everyone losing hair

1 or whatever?

2 MR. CONSTANTINO: Yes, you sure can take it
3 up as an item for discussion and change. Yeah, that's
4 what I thought this committee was.

5 MS. AVERY: Exactly. That's why we're
6 doing this.

7 MR. SCAVOTTO: I agree.

8 MS. CREDILLE: Some are more palatable than
9 others.

10 MR. CONSTANTINO: Well, we might not like
11 it, but this is your -- this is your committee.

12 MR. SCAVOTTO: Right.

13 MR. PICK: Mike, I think you haven't heard
14 any of us preaching heresy yet. I think we are
15 advocating some different rules.

16 MR. CONSTANTINO: Yeah. No, I -- that's
17 fine with me. It's --

18 MS. AVERY: Well, again that's what the
19 task force intended as a result of feedback from the
20 long-term care subcommittee when they were meeting to
21 restructure the Board.

22 MR. SCAVOTTO: Well, good. I think we're
23 good. All right. Now, I'm confused a little bit on
24 this one. So what's the -- what is our sentiment on

1 the 30 minutes? I mean it's -- it doesn't make a
2 whole lot of sense, but obviously we're up against the
3 court order. Is that -- Is it possible to take a look
4 at that? Is that available? Do you have that
5 available?

6 MR. CONSTANTINO: I want to say it was in
7 the 1980s when that came about. I'll see whether we
8 have that documentation somewhere, and I'll send it to
9 you.

10 MS. AVERY: Don probably has it, Mike.

11 MR. CONSTANTINO: Who does?

12 MS. AVERY: He probably does.

13 MR. CONSTANTINO: Don Williams?

14 MS. AVERY: Yes, he has all of that. Don.

15 MR. CONSTANTINO: Okay.

16 (LAUGHTER.)

17 MS. CREDILLE: Can I ask, since a lot of
18 this application was generated by the hospital, what
19 is the occupancy standards for hospitals in the
20 current CON process?

21 MR. CONSTANTINO: Well, depends on the bed,
22 what bed category you're looking at. Generally,
23 Med/Surg is 85 percent, ICU is 60 percent. AMI,
24 rehab, they're all 85 percent. ICU is the one that's

1 the lowest at 60 percent. But they've been in rule
 2 for years too.

3 MR. SCAVOTTO: Today I would suspect that
 4 the critical care units have much higher occupancy
 5 levels and the general population is lower.

6 MR. CONSTANTINO: Yeah, I want to say maybe
 7 the Med/Surg average maybe around 50 percent.

8 MR. SCAVOTTO: Yeah, and the critical care
 9 sections are going to be higher.

10 MR. CONSTANTINO: Yes, that's --

11 MR. SCAVOTTO: Let me ask you this
 12 question. The same on 580, this is item 3, the
 13 applicant shall document that within 24 months after
 14 project completion, the proposed project, A, will not
 15 lower the utilization of other area providers below
 16 the occupancy standards specified in Section 210(c),
 17 and, B, will not lower to a further extent the
 18 utilization of other area facilities that are
 19 currently operating below the occupancy standards.
 20 How good a representation is that?

21 MR. CONSTANTINO: Well, we ask the
 22 applicant to attest to that, and that's a -- they
 23 provide a signed statement saying they're attesting to
 24 that. That's the extent of it, what we request. Do

1 we go back and verify? No.

2 MR. SCAVOTTO: I can't imagine an applicant
3 saying, I'm going to build -- I'm going to build a
4 facility, it's going to take your occupancy, but let
5 me build it anyway. I can't imagine an applicant
6 giving a negative answer to this.

7 MR. CONSTANTINO: We don't see any negative
8 answers, no. You're correct --

9 MR. SCAVOTTO: Okay. So --

10 MR. CONSTANTINO: -- Mike.

11 MR. SCAVOTTO: So this is required in the
12 rule?

13 MR. CONSTANTINO: Yep.

14 MR. SCAVOTTO: Does it add value to your
15 process?

16 MR. CONSTANTINO: Are you asking me do I
17 believe it?

18 MR. SCAVOTTO: Yes, do you believe that it
19 adds value to your process. I mean I know you don't
20 believe it.

21 MR. CONSTANTINO: No. No, it's -- it's --
22 Again this was something that was taken out of the
23 hospital rules. What we tried to do with all the
24 rules was make them uniform, and that's why you see a

1 lot of this overlap with the hospital rules.

2 MR. SCAVOTTO: Okay. One of the things
3 we're trying to do is make this specific for long-term
4 care.

5 MR. CONSTANTINO: Right. That's --

6 MR. SCAVOTTO: I appreciate the fact that
7 we're creating some problems in that respect.

8 MR. CONSTANTINO: Mike, can we take a short
9 break, the court reporter demands it.

10 (LAUGHTER.)

11 MR. SCAVOTTO: Well, we can take a short
12 break. We were only going to go through one more,
13 590, so let's take a short break.

14 MR. CONSTANTINO: She says she'll be all
15 right then. Mike, she said she'd be all right. We
16 can continue.

17 MR. SCAVOTTO: Okay. Okay.

18 MR. CONSTANTINO: She doesn't want to spend
19 much more time here, I don't think.

20 (LAUGHTER.)

21 MR. SCAVOTTO: I'm not into four-hour
22 conference calls. Okay.

23 MR. PICK: If you get paid by the hour,
24 it'd be a different story.

1 MR. SCAVOTTO: So 590, staffing ability.
 2 What do we have on this one? Cece, I've got an
 3 obligation from you that the section needs to be
 4 eliminated, no application has ever been denied
 5 because of it. My question was why is -- is this
 6 needed? This strikes me as a re-regulation as the
 7 quality of staffing is already checked by IDPH and the
 8 licensure surveys. It makes sense to provide staffing
 9 patterns just to demonstrate that the applicant knows
 10 what it is doing and knows how to tie staffing to a
 11 business plan. I'm suggesting make item (e) the only
 12 item in No. 2. Eli, I have a narrative description on
 13 how the proposed staffing plan will be achieved.

14 MR. PICK: Okay.

15 MR. SCAVOTTO: Eli, your comments were you
 16 agree on the quality portion, but I do think we need
 17 something regarding staff requirements, and the
 18 particular service area may have a more acute shortage
 19 of nurses. How the applicant will fill the positions
 20 are outlined in the staffing plan.

21 Okay. I will note here under item 2, there
 22 are (a), (b), (c), (d) and (e) bullets. The (d)
 23 bullet is requires signed contracts with the required
 24 staff. If I've done my homework correctly, that is

1 not required by the rule. That's just an observation.

2 MS. CREDILLE: This is Cece. I don't know.

3 Do you require, the 2(b), letters of interest from
4 potential employees?

5 MR. CONSTANTINO: No. We don't.

6 MS. CREDILLE: And applications filed for
7 each position? I mean the CON is so far out from when
8 the building -- when you're going to break ground, I
9 don't even know how you could get any of this.

10 MR. CONSTANTINO: I don't have a problem
11 with a narrative explanation of how you're going to --
12 post staffing will be achieved. I don't have a
13 problem with that. Just making that the one
14 requirement for that staffing availability. I -- like
15 I say, I don't know how the other staff would feel
16 about it, but I don't have a problem with that, a
17 narrative explanation that Cece suggested.

18 MR. SCAVOTTO: All right.

19 MR. CONSTANTINO: Well, it shouldn't be.

20 MS. CREDILLE: That would read much better.
21 I don't know how you can get quality here at all.

22 MR. SCAVOTTO: Quality in the sense of
23 quality information?

24 MS. CREDILLE: Quality information or real

1 information.

2 MR. SCAVOTTO: Well, that's what I'm
3 saying, yeah, I'm with you there. Yeah. You okay
4 with that, Eli?

5 MR. PICK: Yes, absolutely.

6 MR. SCAVOTTO: Courtney, anything sacred
7 about what we're attacking here?

8 MS. AVERY: No, not at all.

9 MR. SCAVOTTO: Okay. All right. So we're
10 going to say drop everything except (e).

11 MS. CREDILLE: I thought it was drop
12 everything in No. 2.

13 MR. SCAVOTTO: Yeah, drop everything in No.
14 2 except item (e). No. 1 is for each category of
15 service, document that relevant clinical and
16 professional staffing needs for the proposed project
17 were considered and that licensure and JCAHO staffing
18 requirements can be met. I mean you could work that
19 -- You could work that into (e).

20 MS. CREDILLE: Yeah, I mean you just need
21 one. I think No. 1 could serve for (e) then.

22 MR. SCAVOTTO: Put 1 into (e)?

23 MS. CREDILLE: Yeah, either one. You only
24 need one thing here.

1 MR. SCAVOTTO: Right. We end up with one
 2 requirement that makes sense. All right. So, staff,
 3 let me ask you this question. What difference does it
 4 make to you if I can staff the facility?

5 MR. CONSTANTINO: I rely upon licensure.
 6 We rely upon licensure to make sure it's staffed
 7 appropriately.

8 MR. SCAVOTTO: It's not going to cost the
 9 State anything.

10 MR. CONSTANTINO: No, you're correct, Mike.

11 MR. SCAVOTTO: It seems to me what you're
 12 -- you know, your exposure on this one is
 13 questionable. I don't -- I don't see what risk you
 14 have. If I'm building a facility and I can't staff
 15 it, I'm the one that stands for the loss, and I'm the
 16 one that gets the wrath at IDPH.

17 MR. CONSTANTINO: Yeah, you can't operate
 18 unless you meet IDPH's requirements.

19 MR. SCAVOTTO: Yeah.

20 MR. PICK: This is Eli. I guess the
 21 question is if the application is approved and the
 22 site is developed, and it never gets certified to
 23 open, does that have any implications to the program
 24 or to the State, cost implications?

1 MR. SCAVOTTO: If it's never opened?

2 MR. PICK: Yeah, because if, for example,
3 they aren't able to get staff.

4 MR. SCAVOTTO: Okay. So if it's not open,
5 the State never pays any Medicaid reimbursement to it.

6 MR. PICK: So there's no funding after the
7 site's developed because --

8 MR. SCAVOTTO: Maybe the communities gave
9 some TIF support or something, that's a possibility.
10 Unlikely I think for a project of that scope, but
11 yeah, unless -- unless the State's got dollars going
12 into the reimbursement, I don't see where -- I don't
13 see where the planning board or any other agency's got
14 a loss on the facility. We do as investors.

15 MR. PICK: No. No. I understand. What's
16 flashing through my mind is cost reports. That --
17 You're absolutely right, if there's no care delivered,
18 there's never an ongoing reimbursement, but you do
19 file a year end cost report, which does have some
20 reimbursement implications.

21 MR. SCAVOTTO: Yeah, you never open, you
22 don't exist, you don't file a cost report.

23 MR. PICK: Okay. It's not my area of
24 expertise.

1 MR. SCAVOTTO: I mean you're not even
2 there. If you don't even open, or if you open and you
3 have to go out of business, yeah, you got to -- you
4 have to file a terminated cost report, but then the --
5 then the sun sets set on that act, and you're done.

6 MR. PICK: Okay.

7 MR. CONSTANTINO: From a Board perspective,
8 all the documentation to complete the CON needs to be
9 on hand and approved by Alexis before licensure can
10 take place. So we would close the project out before
11 we would allow licensure to approve for occupancy.

12 MR. SCAVOTTO: Yeah, I think that's right.
13 Licensure won't go until we give them the green light.

14 MR. CONSTANTINO: Yeah.

15 MR. PICK: Yeah.

16 MR. SCAVOTTO: Okay. Unless there's an
17 objection, I'm going to suggest that we end the call,
18 and resume the next one at 1125.600, which is Bed
19 Capacity. I will draft up a summary and get it to
20 you, Courtney, for review before we get it
21 distributed, and we will meet again on the telephone
22 in the near future.

23 MS. AVERY: Do you want to set a date now?

24 MR. SCAVOTTO: Pardon me?

1 MS. AVERY: Do you want to come up with a
2 date now?

3 MR. SCAVOTTO: We can do that.

4 MS. AVERY: Cece and Eli?

5 MR. PICK: Yeah, that's fine.

6 MS. CREDILLE: I'm -- Yeah, I'm fine with
7 that. Are you looking still to do this in December,
8 Mike?

9 MR. SCAVOTTO: Let's see. Today's the 5th.
10 Can anyone do the 17th or the 18th?

11 MS. CREDILLE: No.

12 MR. CONSTANTINO: We couldn't hear that,
13 Cece.

14 MS. CREDILLE: My daughter is having
15 surgery on the 17th. We can do it the 19 or 20th.

16 MR. SCAVOTTO: I can do the 20th. Eli, can
17 you do the 20th, do you know?

18 MR. PICK: I'm looking right now. Yeah, I
19 can do the 20th in the morning.

20 MR. SCAVOTTO: In the morning. Cece, are
21 you okay?

22 MS. CREDILLE: Yep, I am.

23 MR. SCAVOTTO: Okay. Courtney, can we do
24 that?

1 MS. AVERY: At what time?

2 MR. SCAVOTTO: 10.

3 MS. AVERY: Yes. I'll --

4 MR. SCAVOTTO: 10 to 12.

5 MS. AVERY: Okay.

6 MR. PICK: Yes, that works.

7 MR. SCAVOTTO: Let's wrap it up. Thank
8 you, everybody.

9 MR. PICK: Thanks, everyone.

10 MR. SCAVOTTO: We'll try to wrap -- We'll
11 try to get through this and then start to wrap it up
12 in the next couple months.

13 MR. PICK: Okay. Sounds good.

14 MR. SCAVOTTO: 12/20 at 10 a.m.

15 MR. PICK: 10 a.m.

16 MR. SCAVOTTO: All right. See you on the
17 conference call.

18 MR. CONSTANTINO: Thanks, guys.

19 MR. SCAVOTTO: Adios.

20 (WHEREIN, the conference call was concluded
21 at 3:50 p.m.)

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CERTIFICATE OF REPORTER

STATE OF ILLINOIS)
)
COUNTY OF SANGAMON)

I, Rhonda Rhodes Bentley, CSR, RPR, a
Certified Shorthand Reporter, Registered Professional
Reporter, within and for the State of Illinois, do
hereby certify that the conference call aforementioned
was held on the time and in the place previously
described.



Certified Shorthand Reporter
CSR #084-002706

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