

1 STATE OF ILLINOIS  
2 HEALTH FACILITIES and SERVICES REVIEW BOARD  
3 525 WEST JEFFERSON, 2ND FLOOR  
4 SPRINGFIELD, ILLINOIS 62761

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6 HEALTH FACILITIES and SERVICES REVIEW BOARD  
7 LONG TERM CARE ADVISORY SUBCOMMITTEE  
8 BED BUY/SELL WORKGROUP DISCUSSION

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TELECONFERENCE

JULY 29, 2014

1                   TRANSCRIPT OF PROCEEDINGS

2   PRESENT:

3   Mr. Michael Waxman, Subcommittee Chair

4   Mr. William Bell, Subcommittee Vice Chair

5   Mr. William Casper, Subcommittee Member

6   Ms. Cecilia Credille, Subcommittee Member

7   Mr. Paul Corpstein, Subcommittee Member

8   Mr. John Florina, Proxy

9   Mr. Timothy Phillippe, Subcommittee Member

10  Mr. Greg Will, Subcommittee Member

11  Ms. Courtney Avery, HFSRB Staff

12  Mr. Frank Urso, HFSRB Staff

13  Mr. Nelson Agbodo, HFSRB Staff

14  Ms. Claire Burman, HRSRB Staff

15  Mr. Mike Constantino, IDPH Staff

16  Mr. Tom Roate, IDPH Staff

17  Mr. Bill Dart, IDPH Staff

18  Ms. Ann Guild

19  Mr. Charles Foley

20  Mr. John Kniery

21  Mr. Dale Galassie

22

23

24

1 MS. AVERY: It's 2:31. Let's start a  
2 roll call. And remember the court reporter is  
3 remote and we have to say our name -- which I'll  
4 start, Courtney Avery -- before speaking. So if we  
5 can just take a quick attendance, that would be  
6 great.

7 Courtney Avery, Planning Board Staff --  
8 ooh, I have relapsed there -- Health Facilities and  
9 Services Review Board Staff.

10 MR. WAXMAN: Mike Waxman, chair of the  
11 committee -- chair of the subcommittee.

12 MR. CASPER: Bill Casper, committee  
13 member.

14 MS. CREDILLE: Cece Credille, committee  
15 member for IHCA.

16 MR. BELL: Bill Bell, co-chair.

17 MR. CONSTANTINO: Mike Constantino,  
18 IDPH staff.

19 MR. CORPSTEIN: Paul Corpstein,  
20 Licensure, committee member.

21 MS. GUILD: Ann Guild.

22 MR. URSO: Frank Urso is on the call.

23 MR. AGBODO: Nelson Agbodo, HFSRB  
24 staff.

1 MS. BURMAN: Claire Burman, HFSRB

2 staff.

3 MS. AVERY: Okay. Is there anyone

4 else?

5 MR. FLORINA: Yes, there is. This is

6 John Florina, visitor, but I am filling in for

7 Terry Sullivan as proxy if that is recognized.

8 MR. WAXMAN: I'm fine. I'm willing to

9 recognize that.

10 MR. URSO: Yeah, John, you're okay

11 because this is really a workgroup that is

12 comprised of some individuals that were chosen by

13 the subcommittee, so you can be serving as a proxy.

14 MR. FLORINA: Okay, thanks, Frank.

15 Just wanted to be clear.

16 MS. AVERY: Okay. Anyone else?

17 MS. CREDILLE: I'm sorry, for Ann, Ann,

18 can you clarify your role or title? I think you've

19 been at meetings, but I don't recall.

20 MS. GUILD: I have. Well, currently I

21 guess I'm public.

22 MS. AVERY: Hi. Who just joined us?

23 MR. PHILLIPPE: Hi. This is Tim

24 Phillippe.

1 MS. AVERY: Hi, Tim.

2 MR. PHILLIPPE: How are you today?

3 MS. AVERY: Good. How are you?

4 MR. PHILLIPPE: Good.

5 MS. AVERY: Anyone else?

6 (No response)

7 MS. AVERY: Court reporter, what is  
8 your name?

9 COURT REPORTER: Dorothy Hart.

10 MS. AVERY: Who just joined us?

11 MR. DART: Hi, Courtney. Bill Dart.

12 MS. AVERY: Okay, Ms. Hart, would you  
13 mind going over who we have on record so far?

14 (Whereupon the court reporter read  
15 the list of participants.)

16 MS. AVERY: Was there anyone that's on  
17 the line whose name was not called?

18 MR. URSO: This is Frank Urso. I have  
19 13 people. Is that what the court reporter has?

20 COURT REPORTER: Yes.

21 MS. AVERY: Okay, Claire or Cece.

22 MS. CREDILLE: This is Cece Credille  
23 and I was asked to head up a subcommittee of our  
24 subcommittee as a follow-up to our meeting in June

1 regarding specifics of buy/sell because we did not  
2 get through all of the items on a document that  
3 Claire had put together. So actually, it was Tim  
4 Phillippe and Bill Casper and myself that were  
5 designated to do this and open to everybody else  
6 who obviously is on the call and the assistance of  
7 the staff.

8 So I need approval of the agenda. And  
9 our agenda is to talk about the long-term care  
10 buy/sell discussion. That is the agenda.

11 MR. PHILLIPPE: So moved. This is Tim.

12 MR. WAXMAN: This is Mike. I'll second  
13 it.

14 MS. CREDILLE: So I would just like to  
15 start from what I have from my notes from our  
16 meeting of 6/24 is that we were moving forward to  
17 the Board with a recommendation of buy/sell. What  
18 we had agreed to at the last meeting is we were  
19 going to table the discussion of moratoriums. We  
20 agreed to a statewide buy/sell. We were going to  
21 table a pilot discussion at the time because we had  
22 trouble wrapping our arms around that piece. And  
23 then we actually started with requirements of the  
24 seller.

1                   And does anybody recall or is everybody  
2   comfortable that we got through the seller  
3   requirements and that we were going to move on to  
4   buyer requirements? So we only got through seller  
5   requirements.

6                   MS. BURMAN: Cece, this is Claire  
7   Burman. Actually, according to the transcript, we  
8   were going to combine buyer and seller to get to  
9   the workgroup.

10                  MS. CREDILLE: Okay.

11                  MS. BURMAN: We didn't have either one  
12   resolved.

13                  MS. CREDILLE: Okay. So from your  
14   document then on page 2, the first item for seller  
15   requirements is beds can be sold only from an  
16   existing nursing facility with an excess of  
17   long-term care beds as recognized by the annual bed  
18   inventory.

19                  MS. AVERY: Can I interrupt real quick?  
20   Who just joined us?

21                  MR. WILL: This is Greg Will with SEIU  
22   Healthcare. Sorry for being late.

23                  MS. AVERY: Okay. Sorry. Thank you.

24                  MS. CREDILLE: So is there any

1 discussion related to the first point?

2 MR. FLORINA: Cece, John Florina with a  
3 comment.

4 MR. CREDILLE: Yes.

5 MR. FLORINA: Throughout the document  
6 we refer to skilled nursing facilities. What if a  
7 facility is say an intermediate care or we're  
8 talking about the transfer of intermediate care  
9 beds? Does that make a difference in how we look  
10 at this?

11 MS. BURMAN: This is Claire Burman.  
12 The board only deals with skilled beds.

13 MR. CONSTANTINO: Claire, we consider  
14 skilled and intermediate one and the same for our  
15 purposes, for CON purposes.

16 MR. FLORINA: I just wanted to make  
17 sure the terminology was clear.

18 MR. BELL: This is Bill Bell. We may  
19 want to use the federal term of nursing facility  
20 beds. That would cover both intermediate and  
21 skilled.

22 MS. BURMAN: Yeah, that's a good idea.

23 MS. CREDILLE: Okay. Is there any  
24 discussion related to that with that clarification?

1 MR. CASPER: Yeah, I -- this is Bill  
2 Casper. I guess I question -- I mean I -- this is  
3 -- I'm not sure exactly the way this document  
4 originated, but I don't -- I don't know if there's  
5 a rationale for that. I think, you know, there's  
6 some language about not -- not -- an owner not  
7 being able to sell an occupied bed, but I could  
8 imagine some circumstances where an owner might be  
9 wanting to decompress and make private rooms from  
10 semi-private rooms and that might -- they might  
11 currently be occupied, but over a period of time  
12 could not -- be not admitted to and freed up for  
13 sale. So I guess I'm questioning where -- why that  
14 -- why that is there and, you know, why -- I guess  
15 -- I guess kind of my -- to step back a bit, I  
16 think if the intent of a buy/sell program is to  
17 somewhat open the system to a more open market  
18 mentality, by being too overly prescriptive we're  
19 not going to foster a lot of things that may be  
20 beneficial to the system overall.

21 MS. CREDILLE: I would concur -- this  
22 is Cece. I would concur with that on being over  
23 prescriptive -- not being overprescriptive, that  
24 is.

1 MR. CORPSTEIN: So you're thinking that  
2 you want to be able to sell the beds --

3 COURT REPORTER: I'm sorry. Who is  
4 speaking?

5 MR. CORPSTEIN: I'm sorry. This is  
6 Paul Corpstein. So I'm trying to understand. So  
7 you want it to be for the facilities to be able to  
8 sell a bed that is occupied for whatever reason;  
9 thereby, the resident would be transferred?

10 MR. CASPER: Well, there are procedures  
11 for how to close beds, so, you know, if I were --  
12 say I had 40 double occupancy rooms and I wanted to  
13 create a service and a program based on single  
14 occupancy rooms, I mean over time I would bring the  
15 -- I mean it wouldn't be reflected in any  
16 statistical report that was submitted to the state,  
17 but over time I could stop admitting, I could free  
18 up 20 beds and -- and before proceeding with  
19 renovation to single occupancy rooms, I would sell  
20 off 20 of those beds. So I mean the way -- your  
21 terminology is a little bit biased I think in terms  
22 of occupied beds. Yes, they're occupied today. I  
23 have a plan to reduce my number of beds by 20.

24 I mean right now we've got a renovation

1 project going on in 12 beds of a 48-bed floor going  
2 through the building and renovating the building.  
3 Well, you know, seven months ago those beds were  
4 occupied. Right now they're empty being renovated.  
5 So an occupied bed today doesn't have to be an  
6 occupied bed tomorrow.

7 MR. WAXMAN: This is Mike Waxman. I  
8 suspect the language was written so that someone  
9 would not try in a desperate move to sell an  
10 occupied bed and throw in the resident as a bonus,  
11 you know.

12 I hear what you're saying, Bill, and it  
13 makes an awful lot of sense. I think we're trying  
14 to find language that would preclude somebody from  
15 having a sale and say buy the bed and I'll throw in  
16 a resident. I think that's all we're trying to do  
17 is eliminate the possibility of somebody being  
18 asked to move from point A to point B because the  
19 bed is being sold.

20 So if there is some language that would  
21 satisfy what you're trying to do, I think we're  
22 open for it. Because I think we all agree with you  
23 that people would -- you know, as time goes on and  
24 we know that one of the things we have to do is

1 offer unique programs and there's a certain segment  
2 of the market that wants private rooms, so I think  
3 it all makes sense. We just have to figure out how  
4 to say it.

5 MR. FLORINA: Mike, this is John  
6 Florina, if I could make a comment. If we go back  
7 to one of the primary reasons for doing this for  
8 the redistribution of beds to meet the need, if the  
9 bed's already occupied, the need's being met. So  
10 if we move people out, we now have created excess  
11 beds.

12 MR. PHILLIPPE: This is Tim Phillippe.  
13 I don't have any -- I agree actually with Bill's  
14 comments. I don't know that -- it should be  
15 worded, I agree, so that people not -- we don't --  
16 you cannot sell the bed and make the person leave  
17 the facility. Clearly, when it's transferred, it  
18 needs to be an empty bed. However, if somebody  
19 wants to downsize gradually for private rooms and  
20 somebody builds across the county and adds rooms, I  
21 don't know that anybody gets hurt by that. As a  
22 matter of fact, more people are probably in nicer,  
23 new rooms.

24 MR. WAXMAN: This is Mike Waxman. I

1 think we all agree. I think the problem is, how do  
2 we say it?

3 MR. PHILLIPPE: Let's see. Let me  
4 suggest something.

5 COURT REPORTER: I'm sorry. Who's  
6 speaking?

7 MR. PHILLIPPE: When people decertify a  
8 bed -- people do -- I've heard they've been  
9 decertifying some beds for Medicaid in the state.

10 MR. WAXMAN: Tim, say who you are so  
11 the court reporter knows.

12 MR. PHILLIPPE: Okay. I'm sorry. This  
13 is Tim Phillippe. We already have a process in the  
14 State of Illinois where people decertify beds for  
15 Medicaid. But they cannot do it if somebody is  
16 currently in it. They can't make people move out  
17 of the bed. So couldn't we use a rationale similar  
18 to that?

19 MR. WAXMAN: This is Mike Waxman. So  
20 all you're saying is that the seller can only sell  
21 unoccupied beds.

22 MR. PHILLIPPE: Right.

23 MR. WAXMAN: Bill, is that all we need  
24 to say?

1 MR. CASPER: Well, I suppose at the  
2 time of -- if they're occupied at the time of the  
3 sale you can, yes. I mean because I think this --  
4 this document references historical data. I think  
5 that's probably the concern. In other words, if  
6 your occupancy report shows you're 92 percent  
7 occupied for the past year and you want to sell,  
8 you know, 20 percent of your beds, this would  
9 preclude you from doing that, even though on the  
10 day the sale takes place -- I mean nursing home  
11 census, if you don't fill a bed when someone passes  
12 away, it's empty. Right?

13 MR. WAXMAN: Right.

14 MR. CASPER: Or moves out I should --  
15 however they move out. So I mean I think that's --  
16 I think my issue was -- I think there was an  
17 implication that it was tied into what a historical  
18 occupancy was rather than current occupancy.

19 MR. PHILLIPPE: This is Tim Phillippe  
20 again. The next point actually mentions that when  
21 it goes to the 90 percent occupancy standard.  
22 Right? That's what you're referring to. So the  
23 question is, going back to Bill's original point,  
24 is there any reason why this is important? Do we

1 need -- is there any reason why we should not allow  
2 beds to transfer from a facility that wants to  
3 reduce its size and census? I guess I can't think  
4 of a practical reason to care personally.

5 MR. WAXMAN: Are we going to bump up  
6 against the issue of access to Medicaid beds?  
7 Would that be an issue of someone selling licensed  
8 Medicaid beds?

9 MR. PHILLIPPE: This is Tim. I would  
10 think that's an issue of how far we let the beds  
11 move. If we go statewide, this is an important  
12 issue, because beds may move from a Medicaid region  
13 in the south with lower payment to the Chicago  
14 area, northern part of the state. If beds are only  
15 moving -- I think originally we were talking about  
16 maybe the same area, a county or 30 miles or some  
17 kind of local, then it wouldn't make much  
18 difference if the same people had access to beds in  
19 the same area, I think.

20 MR. WAXMAN: Again, I agree with your  
21 analysis.

22 COURT REPORTER: I'm sorry. I don't  
23 know who's speaking.

24 MR. WAXMAN: This is Mike Waxman.

1 MS. CREDILLE: But the premise of  
2 buy/sell is that you would sell beds in an  
3 overbedded area to an underbedded area.

4 COURT REPORTER: I'm sorry. Who was  
5 speaking?

6 MS. CREDILLE: This is Cece. This is  
7 Cece Credille. So I actually forwarded to Claire,  
8 to Courtney, to Tim, and to Bill Casper actually  
9 the calculated bed need in the state from  
10 7/15/2014. So for a minute I'd just like to refer  
11 to that. There are currently, if I can count  
12 right, 1140 beds underserved or available in the  
13 State of Illinois.

14 So where we would be overbedded, folks  
15 in the overbedded market could in theory put their  
16 beds up for sale, and we would have to determine  
17 how many or how we want to do that process, and  
18 then in the underbedded market those beds could be  
19 moved to those underbedded markets. If you looked  
20 at the whole state and not just by county --  
21 because if you look by county here, it's pretty  
22 limited in contiguous counties and in health  
23 service areas. If you open this up to statewide,  
24 then you would be looking at equalizing and better

1 access across the state, which is the whole point  
2 of this, and the ability to provide upgraded  
3 facilities, allow for private room changes, as we  
4 all talked about.

5 MR. WAXMAN: This is Mike Waxman.

6 Mike Constantino, is health service  
7 area 6 in southern Cook County?

8 MR. CONSTANTINO: 6 is city of Chicago.  
9 7 is Cook County and Du Page County.

10 MR. WAXMAN: Thank you.

11 MS. CREDILLE: So as an example, in  
12 Chicago in planning area -- this is Cece --  
13 planning area 6A it's overbedded by 1,480 beds and  
14 then planning area 6B is underbedded by 86. So it  
15 would still -- it would demonstrate that Chicago is  
16 overbedded. But if you went to some counties  
17 downstate, actually Menard County has a need for  
18 68, Boone County has a need for 56, and there -- I  
19 mean and so forth. There are different areas.  
20 There's planning area 7A, which is I think you said  
21 Du Page, Cook. There's a need for 446 in 7A but an  
22 excess of 559 in 7B. So, in theory, you would be  
23 selling beds where there were excess beds and  
24 moving them to underbedded.

1                   And so then, you know, I think it's  
2 back to Bill Casper's point. It's an occupied bed  
3 at the time of the transaction.

4                   Anybody?

5                   MR. PHILLIPPE: This is Tim again. I  
6 would -- I understand the -- the way I understand  
7 the issue is if we do it statewide -- the movement  
8 of beds will not just be determined by the bed  
9 needs you show in your report, even though the  
10 report is very useful to look at. Because what it  
11 may show is there are locations say where there is  
12 no bed need, a county right now there's no official  
13 bed need. That doesn't mean there aren't quality  
14 providers there who have newer buildings who could  
15 actually add on and grow. Because some of the  
16 issue has to do with the age and attractiveness of  
17 a location, along with the reputation probably. So  
18 I wouldn't just assume that the beds are going to  
19 move from where we have too many to where we have  
20 too few according to the bed need formula.

21                   However, if you -- if we are really  
22 looking statewide -- and that would be the least --  
23 that would actually be the model that would reduce  
24 the sale price, because there's more competition if

1 you open it up statewide. Then if we do that, I do  
2 think there is a concern in some locations where  
3 there is already a shortage of access for Medicaid  
4 that we could just make that worse. I think that's  
5 a concern that some people have and it makes sense.

6 MS. GUILD: This is Ann. I believe at  
7 your last meeting you all agreed that this would be  
8 statewide.

9 And to the extent that the problem is  
10 losing Medicaid-certified beds in a planning area,  
11 you could control for that by saying, you know, if  
12 you're selling beds, you have to maintain the same  
13 percentage of Medicaid-certified beds or, you know,  
14 come up with some other metric so that people  
15 didn't just sell their Medicaid-certified beds.

16 MR. BELL: This is Bill Bell. Isn't  
17 there also a planning board review of this? I mean  
18 they would be able to say yea or nay based upon  
19 certain factors?

20 MR. CONSTANTINO: Bill, I don't know if  
21 that's been established yet.

22 MS. AVERY: Can you repeat it, Bill? I  
23 didn't hear everything you asked.

24 MR. BELL: This is Bill Bell and I'm

1 just wondering, isn't there also a planning board  
2 process here where this just doesn't happen just  
3 because a seller and a buyer want to do it, but  
4 there would actually be a planning function here  
5 that would look at this and say that, well, wait a  
6 minute, what about the Medicaid beds, or that there  
7 would be a review that would go on beyond just the  
8 buyer and the seller?

9 MS. AVERY: And Mike is -- Mike -- this  
10 Courtney, sorry -- Mike Constantino is correct.  
11 That has not been established yet, but there will  
12 be some kind of mechanism for that determination  
13 built into the rules.

14 MR. WAXMAN: This is Mike Waxman.  
15 Courtney, is that a statement or a question?

16 MS. AVERY: I was responding to Bill's  
17 question that at this point, no, it's not something  
18 that we do, because this is all new.

19 MR. WAXMAN: Okay.

20 MS. AVERY: But I'm pretty sure there  
21 will be a process and determination and looking at  
22 the beds and the payment sources and everything so  
23 we won't have that situation where there's a lack  
24 of beds in one area and overbedded with those

1 payment sources from another.

2 MS. CREDILLE: Well, if I can -- in  
3 Ohio they only allow the sale of beds or transfer  
4 or sale -- I guess it's the sale of beds -- this is  
5 Cece again -- from overbedded to underbedded. They  
6 don't just allow people to put beds wherever they  
7 want. And so it has equalized access over time.  
8 And with the bed need formula, you know, over time,  
9 because of changes, that will continue to  
10 fluctuate.

11 MR. WAXMAN: This is Mike Waxman. I  
12 think Tim just raised a very good point in that  
13 there are several facilities or potentially  
14 facilities that have an incredible reputation and  
15 unique programs that could use the extra beds and  
16 there are demands for those beds from the  
17 community. So this would be another way for them  
18 to get the beds, you know, as an alternative to the  
19 20 -- 10 percent, 20 bed rule.

20 MR. FOLEY: May I interrupt? This is  
21 Charles Foley. I just want you to know I'm here,  
22 along with John Kniery.

23 MR. WAXMAN: Chuck, you can always  
24 interrupt.

1 MR. FOLEY: My apologies. I just  
2 wanted you to know I was here, Mr. Chairman.

3 MR. WAXMAN: We're glad to have you.

4 MR. FOLEY: Thank you, sir.

5 MS. AVERY: This is Courtney again.  
6 And I've got the planning function, the mechanism  
7 we would really have to look at as the next step.  
8 But I'm pretty sure that the board would like some  
9 kind of mechanism where we would see the planning  
10 and the approval of the transfer of beds.

11 MR. CASPER: Courtney, this is Bill  
12 Casper. I think you're absolutely correct. I mean  
13 part of what I think ultimately the subcommittee is  
14 going to have to come up with is some set of  
15 parameters for review by the review board.

16 MR. WAXMAN: This is Mike Waxman. I  
17 think -- I totally agree with Bill and I think the  
18 discussions of the last few minutes have really  
19 raised the need for that, that before we can even  
20 talk about buying and selling I think we do have to  
21 establish some rules as to who reviews and what  
22 they're going to be reviewing for buying and  
23 selling. I think that's real clear now and I think  
24 the discussion has made that clear.

1 MR. FLORINA: Mike, John Florina. I  
2 don't think you can separate the two, but before  
3 you can get into how to enforce it and review it  
4 you have to figure out what is it we want to do.

5 I believe on page 1 of this document  
6 for discussion it dealt with the FSRB -- HFSRB  
7 parameters which dealt with complying with all CON  
8 rules. So clearly, there may have to be additional  
9 rules for reviewing this particular area. I just  
10 assumed that was a given based upon the document.

11 UNIDENTIFIED SPEAKER: Correct.

12 MR. WAXMAN: And, John, again this is  
13 Mike, I wasn't trying to suggest we do -- we  
14 separate the two. I'm saying that we have to be  
15 aware of the rules as we -- or, the role of the  
16 mother board and their need as we try to establish  
17 who the buyer -- what the buyers and sellers can  
18 do. But, no, I agree with you, it can't be  
19 separated. But it's clear that how they review and  
20 what they review is very, very important.

21 MR. FLORINA: My point is that whatever  
22 it is that this group recommends as far as this  
23 program would have to be under the scrutiny somehow  
24 of the CON process.

1 MR. WAXMAN: Correct.

2 MR. FLORINA: In order to decide what  
3 that scrutiny would be, we first need to know what  
4 we're requiring to be able to do that. I'm just  
5 saying don't put the cart before the horse.

6 MS. CREDILLE: John, this is Cece. I  
7 agree with you. We'll never get off the dime  
8 otherwise. I think we did -- we did agree as a  
9 group that because of the study that was done we --  
10 we agreed that there needed to be some kind of CON  
11 review process with the buy/sell and we were not  
12 going to go with the recommended free market. And  
13 so then, what does it look like?

14 MR. PHILLIPPE: This is Tim Phillippe.  
15 Just to move us forward, I'm fine either way we do  
16 this. Okay? I mean I -- I'm serious. Because  
17 really let's think about what we're doing. Okay?

18 We're not allowing these beds to be  
19 used to build a new facility. This is for  
20 expansion. I believe that's what -- everyone  
21 agreed to that already. Okay? That means it's  
22 much less important than it would be if you could  
23 buy beds from various sources and build a new  
24 building, which they allow in some states. So then

1 if a building wants to expand, it can already use  
2 the 10 percent, 20 bed rule. So all we're really  
3 talking about is something expanding a current  
4 facility beyond the current process. So it's not a  
5 major deal. I don't think it's a huge deal. So it  
6 would be nice --

7 MS. CREDILLE: I didn't understand --  
8 this is Cece. I didn't understand that we weren't  
9 going to allow for new facilities. So, for  
10 example, if somebody wanted to sell beds from any  
11 area of the state that was overbedded to Menard  
12 County where there are 68 available beds, someone  
13 could build a 68-bed facility, or someone could go  
14 to Kendall County and if they purchase 94 beds,  
15 they could build a facility in Kendall County for  
16 -- I'm back to the calculated bed need, and they  
17 could build a facility of 94 beds in Kendall  
18 County.

19 MR. PHILLIPPE: All the discussions  
20 that we've had in the past that I remember involved  
21 expansion of a current facility. They did not  
22 involve a new one. And the other -- and also, the  
23 practical issue is if there's a bed need of 68 beds  
24 in the county, why would they just not go through

1 today's process? If we don't have a moratorium --  
2 without a moratorium -- you have to do that in the  
3 states with a moratorium, but without a moratorium  
4 it doesn't make any difference. This is Tim  
5 Phillippe, by the way.

6 MS. CREDILLE: Well, that's because we  
7 got stuck and agreed to table moratorium. Because  
8 if there is a moratorium on beds, then you would  
9 have to look at just the current bed need and you  
10 could only move beds, buy/sell based on the current  
11 bed need. But the moratorium means that we  
12 couldn't create any more beds than what's sitting  
13 in the bed need.

14 MR. PHILLIPPE: So just -- this is Tim  
15 Phillippe asking a question about this. Say you  
16 had the moratorium and you took what you said, so  
17 if we are -- if it's -- I want to build a new  
18 building in a county that already -- that does not  
19 have a bed need, then I would not be allowed to or  
20 I'd have to buy beds that are already currently in  
21 that county to build in that county?

22 MS. CREDILLE: Well, in the current CON  
23 process, if there wasn't a bed need, you likely  
24 wouldn't get a CON. Likely I say. It's up for

1 board review. But in the current process you  
2 wouldn't need --

3 (Whereupon the call was  
4 disconnected.)

5 MS. AVERY: Well, I guess we're just  
6 going to have to go back. Cece and Tim, do you  
7 feel comfortable going ahead?

8 MR. PHILLIPPE: Yeah.

9 MS. CREDILLE: I said I was not aware  
10 -- this is Cece -- that we were referring only to  
11 -- that we had all agreed to only building  
12 additions.

13 MR. PHILLIPPE: Okay. This is Tim. I  
14 understand. I heard that. So I mean I just  
15 thought it had been -- I heard a lot of discussion  
16 and consensus about it in the past and so I thought  
17 that had been already talked about. It will make a  
18 bigger difference.

19 You know, I understand what we're  
20 trying to do is very difficult because all the  
21 pieces are interconnected, but it would seem to me  
22 -- it's hard for us to do this, but we need to make  
23 the decision on the big pieces first, the big  
24 issues like if we're going to recommend a

1 moratorium or not and other things. That would  
2 allow -- it would make it easier to decide the  
3 smaller issues.

4 MS. CREDILLE: Correct. But what we --  
5 so at the last meeting it was troublesome because  
6 we tabled the big ones. We tabled moratorium. We  
7 tabled pilot. And then we've moved right into a  
8 document on buyer and seller requirements.

9 MR. PHILLIPPE: I will -- this is -- I  
10 guess probably -- who's left on our committee? Is  
11 it just you and I?

12 MS. CREDILLE: No, Bill Casper's back  
13 on I think.

14 MR. CASPER: Yeah, I'm here.

15 MR. PHILLIPPE: Oh, good, good. Okay.  
16 Here's what I would recommend, I would recommend --  
17 unless other people know better and are wiser than  
18 me who have experience in these kind of matters, I  
19 would suggest that we need to go back to the  
20 committee and not -- suggest we make the decisions  
21 on the bigger issues first. Because all this -- it  
22 all changes things, really. Like the first -- the  
23 issues like moratorium, pilot, are we going to do  
24 it statewide or nearby area, those are big issues,

1 and then everything else will flow from that.

2 MS. CREDILLE: I agree that you have to  
3 go macro first to go to micro. And we did the  
4 reverse. We're trying to do the reverse.

5 MR. PHILLIPPE: This is Tim. I  
6 understand because they were hard and so we thought  
7 we'd put them off.

8 MR. WAXMAN: Hi, this is Mike Waxman.

9 MR. PHILLIPPE: Oh, good.

10 MS. CREDILLE: Mike, the conversation  
11 that we're having is the fact that we tabled the  
12 macro issues is limiting us on making micro --  
13 decisions on the minutiae here because the  
14 decisions on the minutiae are driven by the bigger  
15 issues. You know, if we agree to a moratorium as a  
16 group, which is what IHCA again supports, then that  
17 moves us in a direction on the document that I sent  
18 with available beds, then that's what we're dealing  
19 with, and we look at this total pool of beds we  
20 have right now and we're not going to go over that,  
21 and we look at access. But that's a whole  
22 different conversation if we don't have a  
23 moratorium.

24 And then it begs the question of the

1 pilot, which we also tabled, and if we're looking  
2 at statewide, which I would support and IHCA  
3 supports the statewide, because then you'll -- we  
4 will have a period of time to look at whether or  
5 not this works.

6 And quite honestly, when you look at  
7 bed need in the state, we'd have a heck of a time  
8 trying to say we could only do it with contiguous  
9 counties or based on bed need -- current bed need  
10 in the state. It's pretty limiting to impact  
11 access and to be innovative in the state.

12 MR. WAXMAN: This is Mike Waxman.  
13 Claire, do you remember from the transcript where  
14 -- whether or not there is a majority of people in  
15 favor of a moratorium or a majority of people not  
16 in favor of a moratorium or --

17 MS. BURMAN: It wasn't --

18 MR. WAXMAN: -- no conclusion?

19 MS. BURMAN: It didn't go either way.  
20 There were mixed feelings. And I -- I think when  
21 we first brought it up, and this is a couple of  
22 years ago now, no one wanted to talk about  
23 moratorium. I don't know if you remember that. It  
24 just wouldn't take off the ground. But now two

1 years later there are some who seem to think it's  
2 really part of the success of a buy/sell program,  
3 as evidenced by Ohio's experience.

4 MR. WAXMAN: Again this is Mike. Is  
5 there consensus among the subcommittee on the  
6 concept of a moratorium?

7 MS. BURMAN: No. No, we did not reach  
8 a consensus on it and it did not come to a vote  
9 either. So it's something that just remained  
10 unresolved and that's why it was tabled.

11 MR. FOLEY: Claire, this is Charles  
12 Foley. I believe, and correct me if I'm wrong, at  
13 the last meeting it was stated that we almost now  
14 have a moratorium in existence since there are a  
15 limited number of planning areas that currently  
16 show a need for beds. So, therefore, there was no  
17 need for an official moratorium.

18 MS. BURMAN: Well, that's I think --  
19 yeah, there're words stated to that effect, but a  
20 moratorium is still different than what we have in  
21 place right now.

22 MR. FOLEY: I understand that also.

23 MS. BURMAN: Okay.

24 MR. FOLEY: But I thought that reasons

1 -- I thought that was one of the reasons that's why  
2 we did not want to go for an all-out moratorium. I  
3 don't -- I don't think we need a moratorium to make  
4 this program successful if we're still going to  
5 have it.

6 I do agree with Cece in that if we do  
7 have it that it needs to be on a statewide basis,  
8 however. I think that's correct.

9 You know, whether or not we use this  
10 for the purpose of a new facility I'm not truly  
11 sold on that just yet. Yes, for existing providers  
12 I thought the -- the intent of all this was to help  
13 out the existing providers and give them the  
14 opportunity, obviously, to modernize and not to  
15 worry about competition in the area of a new  
16 facility just yet.

17 MS. CREDILLE: But if -- again, if you  
18 go back to the premise that is used in Ohio, you  
19 wouldn't worry about a facility next door in an  
20 overbedded area. The facility next door would  
21 happen in an underbedded area. And at the end of  
22 the day, if there is a new facility in an area,  
23 then that -- in an underbedded area, then that  
24 meets the need of that population group and creates

1 access. And if we put parameters in place on a new  
2 facility, for example -- I'm making this up -- 25  
3 percent -- you have to certify 25 percent Medicaid  
4 beds, then you solve the issue of making sure that  
5 there is public aid facilities -- beds in a new  
6 facility if we would go that route.

7 MR. FLORINA: Cece, this is John  
8 Florina, if I could make a comment. At the last  
9 meeting I recall discussing this and my notes say  
10 that the moratorium was not necessary and that we'd  
11 proceed to discuss it without that in place. As  
12 Chuck pointed out, we have a de facto moratorium  
13 anyway, because if there's no bed need in an area,  
14 you usually can't get approved. So to proceed with  
15 a moratorium changes a lot of what we have to  
16 discuss.

17 I'm trying to work from the assumption  
18 -- and I've been reassured a number of times  
19 through these committee meetings -- that the bed  
20 need methodology that's being used is correct on a  
21 statewide basis. So do we not accept that or do we  
22 start from a different point, you know, by not  
23 accepting the fact that the methodology is supposed  
24 to be based on a statewide calculation of need by

1 planning area? I'm just not sure if you want to do  
2 a wholesale change of everything regarding this  
3 planning process or do it step-by-step based upon  
4 where we're at and where we want to get to.

5 MS. CREDILLE: Well, I would -- at this  
6 moment, I wouldn't -- I would leave the planning --  
7 I'm not suggesting changing planning areas or  
8 anything and you would leave the bed need formula  
9 as is. And that's the basis of the decisions and  
10 discussion and review by the CON board with  
11 buy/sell based on bed need. And the moratorium  
12 would prevent new beds. Because we discussed at  
13 the last meeting that Illinois, if you even look at  
14 beds per thousand, has one of the highest number of  
15 beds per thousand of states.

16 MR. WAXMAN: This is Mike Waxman.  
17 Courtney or Frank, has the mother board ever  
18 discussed to your knowledge the concept of  
19 moratorium?

20 MS. AVERY: No. They're still waiting  
21 on recommendations from the subcommittee.

22 MR. WAXMAN: Okay.

23 MR. FOLEY: Obviously, I'm a  
24 consultant, so everybody knows what my business is.

1 I'm sorry. This is Charles Foley. But thinking --  
2 I thought this whole thing -- we were supposed to  
3 be helping out existing providers. There are a lot  
4 of areas in this state where there is not a bed  
5 need where existing providers want to modernize and  
6 they feel that they can't because there's not a  
7 need for beds. And I thought that's what this  
8 program was going to do, hopefully.

9 To go out with a moratorium I think is  
10 further going to increase our problems. I don't  
11 think we're doing any justice at all to the  
12 residents of this state. In this state right now  
13 we have several, several facilities that are in  
14 excess of 50 years old, 60 years old. And, you  
15 know, we've got to help out these people to either,  
16 number one, replace their facility or, number two,  
17 upgrade.

18 To have a moratorium is basically  
19 telling the industry you have to buy beds in order  
20 to do so. But what if they don't want to buy beds?  
21 You know, if they're sitting there with a 90  
22 percent plus occupancy rate and they want to add  
23 beds, let's help them to add beds, you know,  
24 period. I don't think -- you know, we've got all

1 these old facilities. We need to help out our  
2 residents to make sure that they're placed in  
3 today's state-of-the-art facilities.

4 And to have this moratorium and to wait  
5 on people to buy and sell beds, which is a process  
6 that's going to take forever when you're trying to  
7 get five, six, seven facilities together so one  
8 person could buy up any additional beds, nothing is  
9 ever going to get done in this state.

10 MS. CREDILLE: But that's not what  
11 happened in Ohio over time.

12 MR. FOLEY: Go back and read some of  
13 those records over again. I mean I do know that  
14 they still have the process over there. And I'm  
15 not saying that it can't work. I'm not saying that  
16 at all. I'm just saying all we're doing is just  
17 slowing down our process.

18 Ohio is different from Illinois.  
19 You've got two different -- entirely different  
20 states, you know. And to compare us with Ohio, to  
21 compare us with Missouri, to compare us with other  
22 states -- I think we need to compare us with  
23 Illinois, what does Illinois want, and just leave  
24 it at that.

1 MR. PHILLIPPE: This is Tim Phillippe.  
2 The one thing, as we were talking, about if -- if  
3 we had a moratorium and if beds could only move  
4 from locations with excess capacity, which is most  
5 everywhere, to those few places that have openings,  
6 okay, my question is, how does that meet our need  
7 for innovation that's in part of the -- I thought  
8 that's actually one of our goals is to promote  
9 innovation.

10 MR. FOLEY: That's correct, Tim. Thank  
11 you.

12 MR. PHILLIPPE: So if we're doing it --  
13 the only way I could see we're doing it then, based  
14 on the rule of not moving them outside of -- they  
15 would have to go into a place with a need, then the  
16 only advantage -- I assume you would be limited to  
17 buying beds within the county and keeping them in  
18 the county so it doesn't change that county's, or  
19 whatever area we choose, it doesn't change the bed  
20 capacity in that specific area. But otherwise,  
21 what we're doing is actually worse than today in a  
22 way because the places that have bed need today,  
23 they can build without buying the beds. So I'm not  
24 sure why we would care. I got lost in here because

1 if you're going to have to move to a place that has  
2 the need, you can build today in a place that has  
3 the need without buying the beds. Can't we?

4 MR. FOLEY: That's correct.  
5 This is Charles Foley.

6 MR. PHILLIPPE: I mean that's my  
7 understanding. And the problem people have is they  
8 want to build today where there is no need.

9 MR. WAXMAN: This is Mike Waxman.  
10 Where there is no documented bed need but there is  
11 a demand. That's different.

12 MS. CREDILLE: Correct. And there's  
13 the 90 percent rule and --

14 MR. WAXMAN: I agree that -- I think  
15 it's critically important for the consumers or  
16 users that, you know, nursing homes that are  
17 creative and inventive and excellent quality care  
18 be in a position to add beds because they have a  
19 demand for them, regardless of whether or not  
20 there's a bed need in that area or not. I mean I  
21 think that's part of what our concern is is that  
22 there are certain beds -- certain nursing homes in  
23 geographical locations whose reputation is such  
24 that they have a waiting list and I think consumers

1 should be able to get into those homes by allowing  
2 those particular nursing homes or homes that want  
3 to change their specialty to participate in the  
4 higher community coming out of hospitals. I think  
5 that's really important to what we have to do, as  
6 Chuck says, for the State of Illinois residents.

7 MR. FOLEY: Michael, this is Charles  
8 Foley. You know, you're absolutely correct. I  
9 mean there are -- you need to look at it from both  
10 sides. There aren't a lot of facilities out there  
11 operating in excess of 90 percent that are located  
12 in areas where there's not a bed need. So,  
13 therefore, they feel their hands are tied and they  
14 cannot add beds even though they have a waiting  
15 list, but there's not a bed need, so therefore,  
16 they aren't free to even file their application. I  
17 have been advocating for a long time to have, you  
18 know, what is called a high occupancy, you know,  
19 variance, which would help out, you know, those  
20 facilities.

21 But then at the same time, even with  
22 that, we still have a lot of facilities that are  
23 underutilized. They're still good facilities, you  
24 know. And forget about the star system. But

1 they're still good facilities, but they may not be  
2 at 90 percent for a lot of other reasons, you know,  
3 such as they're converting a lot of beds, you know,  
4 to private, there's isolation issues, gender  
5 issues, you know, et cetera, which would put them  
6 in a hindrance, so to speak, that they cannot add  
7 beds because they're under 90 percent. So here  
8 comes a whole new issue of another problem here and  
9 that is the 90 percent occupancy, you know, issue.  
10 And I don't think we want to get into that right  
11 now.

12 But there's just so much here that --  
13 what is our purpose? What is our goal? Which I  
14 think is to help out existing providers. And I  
15 think we should expand on that.

16 MS. CREDILLE: Well -- this is Cece --  
17 it's not to help our existing providers alone.  
18 It's to look at access across the state and  
19 services available where it's underserved. So it's  
20 not just to help out the providers.

21 MR. PHILLIPPE: This is Tim Phillippe.  
22 When you talk about helping where the people are  
23 underserved, I assume -- are we talking about where  
24 there's a bed need?

1 MS. CREDILLE: Correct.

2 MR. PHILLIPPE: If there's a bed need  
3 today, they don't need -- nobody needs this  
4 process. They can go through the normal CON  
5 process.

6 MR. FOLEY: That's correct.

7 MR. PHILLIPPE: Why would they not do  
8 that?

9 MR. FOLEY: Right.

10 MR. PHILIPPE: Why would they need this  
11 to help them? How would this help them? It would  
12 only raise the cost of construction because you're  
13 going to have -- you'd have to buy the beds also.

14 MS. CREDILLE: Because you could have  
15 an expedited process. And we already struggle in  
16 the -- I mean it goes back to -- I think it all  
17 goes back to whether or not we agree we need a  
18 moratorium or not. And if you -- if you were  
19 buying and selling and looking at going from  
20 underserved to overserved -- or, overserved to  
21 underserved, rather, and you had an expedited CON  
22 process with buying and selling of beds.

23 MR. PHILLIPPE: This is Tim just  
24 responding about the advantages of expedited. If I

1 was going to build a hundred bed facility and I pay  
2 10,000 a bed, I would much prefer to take a little  
3 longer and go through the CON process than pay all  
4 that money out.

5 MR. KNIERY: This is John Kniery and I  
6 hate to throw a wrench into anything, but the CON  
7 has not been taking -- the process has not been  
8 long lately.

9 MR. PHILLIPPE: No, in my experience it  
10 has not.

11 MS. AVERY: Well, that was -- this is  
12 Courtney. That was going to be my question.

13 Cece, what is -- without taking up a  
14 whole lot of time, how would that look different  
15 from now if the review period was expedited due to  
16 bed buy and sell? I don't think there would be  
17 much of a difference.

18 And, John and Tim, you're absolutely  
19 correct. It has not been lengthy as it has been in  
20 the past.

21 MS. CREDILLE: Yeah, I can't -- I can't  
22 speak to how it's working currently on receiving  
23 CONs. But it's pretty limited in giving some areas  
24 where folks are again looking to build. And,

1 again, the buy/sell provides an option for  
2 providers who may not have -- who have little to no  
3 options. And there are an awful lot of those in  
4 the state.

5 MR. FOLEY: Why don't we -- this is  
6 Charles Foley again. Why don't we not then create  
7 a process, if you want then, that even in those  
8 areas where there is an identified bed need, even  
9 in those areas where there is an identified bed  
10 need somebody wants to build a new facility, why  
11 don't we let them at least go through the process  
12 of contacting all the existing facilities that  
13 have, let's say, for instance, posted that they  
14 have beds available to see if you want to sell  
15 those beds first?

16 But I'm like Tim, why go through that  
17 kind of process when there's a bed need, why pay  
18 for those beds when there's a bed need? So that's  
19 really I guess not a good idea.

20 Cece, I understand what you're trying  
21 to do and say, and I'm trying to think of something  
22 to help you in that respect. But I think, you  
23 know, I have faith in our bed need, you know, to  
24 some respect. But I think all that our bed need

1 shows us right now is that it is a forward-  
2 thinking, you know, methodology. It is a planning  
3 tool. And that's all it's supposed to be. It's  
4 not supposed to be accurate in any way, shape, or  
5 form. It's just a -- it's just a planning tool is  
6 all it is. And if there was excess beds and  
7 somebody wants to add beds, okay, there's excess  
8 areas, let them have the process of buying some  
9 empty beds then across the state if that's what  
10 this committee wants to do.

11 MR. PHILLIPPE: This is Tim. Let me  
12 just ask a practical question, because that's the  
13 best way I try to understand the implication. With  
14 the way we're discussing, I'm assuming that we  
15 would be recommending that beds could be moved  
16 around within a certain area, they could be bought  
17 and sold as long as they weren't moved very far, so  
18 they could stay within a county or smaller area I  
19 guess if it's up in a large metropolitan area. So  
20 if we did that, say I go -- somebody goes  
21 downstate, a town that has or county that has maybe  
22 five or six nursing homes and they're all those  
23 50-year-old ones that Charles was talking about,  
24 and they buy up excess beds from the different

1 providers there and then build a new building in  
2 town that's innovative. Would the -- the rules  
3 we're talking about, would they allow that?

4 MR. FOLEY: Yes. But I'll put myself  
5 in the seat -- I'm sorry. This is Charles Foley.  
6 I'll put myself in the seat of a provider. If  
7 you're going to buy beds from me and then turn  
8 around in the same area and build a new facility,  
9 why would I sell you my beds?

10 MR. PHILLIPPE: It's going to be pretty  
11 tough to sell them unless the people are far enough  
12 away they don't think it competes with them.

13 MR. FOLEY: You're absolutely correct.  
14 I mean I do understand we have large counties, but  
15 when you get down south that's not the case, except  
16 for -- well, no, even down south that's not the  
17 case by planning area. So I think it would be  
18 really difficult to do, Tim; wouldn't you?

19 MR. PHILLIPPE: Right. And so that  
20 would mean it's not going to -- what I'm trying to  
21 do is speak to the point that Cece had about only  
22 allowing transfers from places that are overbed --  
23 underbed -- or, overbedded to the places that had a  
24 need. If we do that, that pretty much stops any

1 new construction.

2 MR. FOLEY: Yeah. And if there's --  
3 I'm sorry. This is Charles Foley again. If  
4 there's -- I don't know -- in one way I'm for this  
5 process and in another way I'm against it.

6 But if we pick a county -- say let's  
7 pick one, St. Clair County for an example. St.  
8 Clair County currently has excess beds and I go  
9 down in a southern county area and buy say a  
10 hundred beds. Okay? If all the facilities in that  
11 area are now operating under 90 percent and then  
12 here comes Tim Phillippe with an application to  
13 build a new 120 bed facility, that's going to  
14 further hurt all of those facilities. And I think  
15 all of the providers down there will be up in arms  
16 about it and will request a public hearing and  
17 oppose such a project. Maybe. I don't know.  
18 Maybe the thing to do instead is to buy a couple  
19 facilities, close them down and build -- or one,  
20 close them down and build replacement facilities  
21 which was already there.

22 MS. CREDILLE: Well, I'm not -- you  
23 know, I thought from -- this is Cece again -- from  
24 the beginning we were trying to improve access and

1 we were looking to go from overbedded to  
2 underbedded. If we -- if that concept is not how  
3 we want to base the premise of buy/sell, then  
4 that's what we recommend. I'm not married to that,  
5 but that's the process that they utilize in Ohio.

6 Claire, can you comment on other states  
7 whether or not they have -- the ones that have  
8 buy/sell if they use a methodology like Ohio from  
9 overserved to underserved on buy/sell or is it open  
10 period within the state?

11 MS. BURMAN: Some use a formula; some  
12 don't. I mean each state's program for this is  
13 different from one another. There are no two that  
14 are very similar.

15 MS. CREDILLE: But we wouldn't have to  
16 do -- I was focusing more on the access issues we  
17 have.

18 MR. CASPER: So this is Bill Casper. I  
19 think there's -- I'm just kind of listening, but I  
20 think that -- and there's a couple of points I  
21 think that are clear.

22 One is, it seems to me, that on the  
23 point of the fact that in an underbedded area right  
24 now -- without a moratorium in an underbedded area,

1 there's really no impediment to someone creating --  
2 applying for a CON and building new beds. So  
3 clearly, there is some demographic or economic  
4 reason -- either there is a flaw in the bed need  
5 formula and there really isn't any need in those  
6 areas or in high Medicaid areas and based on the  
7 Medicaid rate in this state the owner is willing to  
8 invest the money to build a new building down  
9 there. So I think that looking to a buy/sell  
10 program as the mechanism to equalize bed supply  
11 across planning areas doesn't change the underlying  
12 economics or demographics that have created those  
13 underbedded areas currently, unless some other  
14 types of incentives are built into the process, or  
15 disincentives.

16 But I think the -- Ohio imposed a  
17 moratorium. That then creates a limited market  
18 and, therefore, accelerates the demand for a  
19 buy/sell program. Because a buy/sell program  
20 doesn't -- I think the point's been made here  
21 already. If you can apply for a certificate of  
22 need and a build new nursing home in an area with  
23 bed need, why would you add the cost of buying beds  
24 to that?

1                   So I think -- I think the policy goal  
2   of equalizing bed across -- beds across areas,  
3   almost by necessity, if that's your policy goal,  
4   you have to somehow limit the ability to create a  
5   new license.

6                   MR. FLORINA: This is Florina again. I  
7   think that ability is already there by following  
8   the bed need methodology and the purview of the  
9   board to either approve or deny it based upon the  
10  application in lieu of what the bed need is.

11                  MS. GUILD: This is Ann. I'm thinking  
12  we may also be oversimplifying the term access.  
13  Because as I listen to this, it's not just about  
14  access to beds in a county in southern Illinois  
15  that has a bed need already. It's about providing  
16  access in an area where perhaps there isn't a big  
17  enough bed need to do anything meaningful, to  
18  create access for services that people want, that  
19  potential residents want, and at the same time not  
20  harming access for those that need Medicaid-  
21  certified beds. It's not just about the bed. It's  
22  what are you going to do with that bed.

23                  MS. CREDILLE: So if I can sort -- we  
24  were attempting to go through a document that

1 we've, you know, completely veered off on the  
2 buy/sell. What is it that we want to take back to  
3 the main committee which is -- most of the staff  
4 are going to be attending the meeting on -- I think  
5 it's August 17th or 19th, whenever our next meeting  
6 is, what do we want to take back here?

7 MR. PHILLIPPE: This is Tim. Just for  
8 -- with all of our past discussion, if we go back  
9 to the seller requirements, I would recommend we  
10 keep number 1 and 2. So, you can only sell excess  
11 beds and with the occupancy standard. That way it  
12 simplifies some of the complexities we get into.  
13 So we're less likely to move beds from areas of low  
14 income that need the beds into some other high-rent  
15 area that can afford private pay. So with all the  
16 discussion we've had, I just recommend we simplify  
17 and accept those first two.

18 MR. WAXMAN: This is Mike Waxman. I  
19 think in answer to your question, Cece, I think we  
20 have to go back to the whole board -- whole  
21 subcommittee and explain that in an attempt to  
22 simplify our process by putting some topics on  
23 hold, that in fact does not work, and that we may  
24 have to address some of the issues we tabled in

1 order to come back to this process. I think,  
2 therefore, we may have to engage the whole  
3 subcommittee then on a discussion of some of the  
4 issues that we tabled to move forward at all. I  
5 think that's where you're at. I may be wrong.

6 MR. PHILLIPPE: This is Tim Phillippe.  
7 I agree. I said that earlier, too. I agree.

8 MR. WAXMAN: Oh, I'm sorry.

9 MR. PHILLIPPE: No, no. I agree. I  
10 think it's even more clear after this long  
11 discussion we've had.

12 MR. WAXMAN: Is Mike Constantino still  
13 on the phone?

14 MR. CONSTANTINO: I sure am.

15 MR. WAXMAN: Mike, can you determine  
16 how many CONS have been approved, if any, in areas  
17 where the numbers say they're overbedded?

18 MR. CONSTANTINO: Yeah.

19 MR. WAXMAN: I think that would be an  
20 interesting number to look at. Because we kind of  
21 assume that if it's an overbedded it's  
22 automatically the CON is going to get denied. But  
23 I need -- at least for my own personal need, I'd  
24 like to know if that's true or not true. Because I

1 thought that the overbed issue was just one piece  
2 of the criteria as to whether or not a CON was  
3 going to get approved.

4 MS. AVERY: I'll -- I can respond to  
5 that. We have approved -- the board has, rather,  
6 approved applications that are in the area where  
7 there is underutilization and no bed need. There  
8 was one -- I think it was Neighbors -- I can't  
9 remember the name of it -- that demonstrated the  
10 perfect factors. They had a waiting list. There  
11 were no other beds in the area. They needed to  
12 expand and they had an agency -- an aging facility.

13 MR. WAXMAN: Okay.

14 MS. AVERY: The board also takes into  
15 consideration the documented issues that the  
16 applicant addresses or provides that says that  
17 there's a need even though your inventory does not  
18 reflect a bed need.

19 MR. WAXMAN: Okay. And I think that's  
20 very, very important information.

21 MS. AVERY: And that facility was  
22 Neighbors now that I remember. That facility did  
23 come in for technical assistance with the staff and  
24 discussed all of those issues, and our response was

1 we cannot guarantee you that it will be approved,  
2 of course, but you can document your story and  
3 present that to the board. And they came in for  
4 technical assistance on those issues.

5 MR. WAXMAN: And I think that's the way  
6 we address another underlying issue of what we're  
7 trying to accomplish, which is to allow those homes  
8 that have unique programs and a waiting list to get  
9 more beds or build a newer facility.

10 Tim, isn't that kind of where you're  
11 at, too?

12 MR. PHILLIPPE: Yes.

13 MR. WAXMAN: Okay. So I think --  
14 again, this is Mike. I think it would be  
15 interesting if Mr. Constantino can bring to the  
16 meeting then in the last twelve months, you know,  
17 how many CONs were -- how many applications were  
18 presented in overbedded areas and what percentage  
19 of those were approved. I think that's kind of a  
20 key -- in my mind I think that's kind of a key  
21 piece of information.

22 MR. URSO: Mike, this is Frank Urso.  
23 You're just talking about long-term care facilities  
24 now; right?

1                   MR. WAXMAN: Yeah. Nursing -- what did  
2 we decide we're going to use? Nursing homes?  
3 Nursing beds? Those applications.

4                   MR. PHILLIPPE: Cece, this is Tim  
5 Phillippe.

6                   MS. CREDILLE: Yes.

7                   MR. PHILLIPPE: In terms of using our  
8 time best to make a recommendation, like you asked,  
9 at the next meeting, should we then kind of list  
10 these macro issues, take back our -- really, do  
11 what Mike said and go back to the full subcommittee  
12 saying that we believe we need to decide these  
13 first? And that was -- the ones I listed were the  
14 geographic region where the transfer was allowed to  
15 take place, whether it was statewide or all the way  
16 down to a very small region, a moratorium or not,  
17 and whether or not there would be a pilot period  
18 first. Those are at least three. Are there other  
19 -- does that make sense that we would identify the  
20 macros that are left?

21                   MS. CREDILLE: Yeah. Those were the  
22 three that we tabled and then we tried to leap  
23 right into the minutiae to be able to recommend  
24 stuff to the board, so that's how we landed here.

1 And I agree. I'm okay -- I'm okay going back.

2 Can I just -- I would like to revisit,  
3 though, because it does -- it will make an impact  
4 -- and I know I'm going back to minutiae, but we  
5 have to think about this. And Tim suggesting on  
6 the seller requirements that he agreed to 1 and 2,  
7 although I realize we're not getting into more of  
8 the minutiae, where you can only sell beds in  
9 excess of the 90 percent standard. But the  
10 standard in Illinois is 78 percent occupancy. So  
11 because folks have taken really beds offline, and  
12 that goes back to our issue that we come back to  
13 all the time, having 90 percent as one of the  
14 parameters would limit a number of folks in the  
15 state from being able to buy/sell. So it's 90  
16 percent of your licensed beds, not 90 percent of  
17 what you're really operating, and the buy/sell  
18 addresses the issue of beds you're not operating.  
19 That's really what it does.

20 MR. PHILLIPPE: I'm sorry. Are you  
21 talking about seller or buyer?

22 MS. CREDILLE: I'm talking about -- I'm  
23 on seller.

24 MR. CASPER: This is Bill Casper.

1 Cece, I would -- you know, I think I agree with you  
2 on that, because one of -- one of the underlying  
3 issues which I think from my experience is a little  
4 bit unique to this state is the fact that you don't  
5 need to give up a license if you're not operating a  
6 bed for some period of time. I don't know if it's  
7 unique, but it's uncommon. That if you're not  
8 currently operating beds that -- you know, I think  
9 at the hospitals now if a bed is not in operation  
10 for a certain period of time, it has to be taken  
11 off the license. So what that does is that sort of  
12 gives you a realistic understanding of what the bed  
13 supply really is. And I think one of the -- one of  
14 the factors in some of these quote-unquote  
15 overbedded areas or regions is that there are a lot  
16 of beds that are not occupied but are in the bed  
17 count as licensed beds.

18 MR. FLORINA: Cece, this is Florina  
19 again. Maybe I'm misunderstanding number 2. If  
20 you can clarify it a little bit. It appears to me  
21 by using the 90 percent occupancy standard that  
22 actually gives a facility that has beds not being  
23 used and not being counted in the inventory  
24 available to sell because they would have more beds

1 in total to count towards that 90 percent.

2 MR. PHILLIPPE: Yeah. This is Tim.

3 That's just what I thought, too. I didn't think  
4 the operating issue made a difference because it's  
5 90 percent of licensed capacity.

6 MR. CASPER: Yes. Then you might  
7 actually be identifying those beds that are sitting  
8 out there that we can't get a handle on as being  
9 uncounted to get them out of -- out of the way.  
10 They'll sell the beds that are already there  
11 they're not using.

12 MR. PHILLIPPE: Right.

13 MS. CREDILLE: Perhaps I read it the  
14 opposite way. So if that's the case, that makes it  
15 better. So if you -- I'm making this up. If you  
16 have a 200 bed facility but you created 50 private  
17 rooms, so you've taken yourself down to 150, then  
18 you would sell what? The 90 percent of -- you  
19 could sell down to 90 percent of 150 or 90 -- or  
20 what?

21 MR. PHILLIPPE: No. I think it would  
22 be -- this is Tim Phillippe. I'm sorry. I think  
23 if we started counting the setup beds versus  
24 licensed, it'll get too messy to try to prove what

1 is accurate. We -- to be clear we would have to  
2 use licensed beds. So that would be looking at 200  
3 beds. So whatever they're averaging -- if they're  
4 set up for 150 and they average 140, they would be  
5 140 of 200, they would have quite a few beds to  
6 sell.

7 MR. CASPER: Right. Tim, this is Bill.  
8 Now I understand. I think that's correct. So,  
9 yeah, that actually that -- that does create the  
10 incentive -- the ability to bring some of those  
11 beds out. So I think I was reading that the wrong  
12 way.

13 MS. CREDILLE: And so, Bill -- Bill  
14 Casper, would you support then that you could --

15 MR. CASPER: I think --

16 MS. CREDILLE: -- could and should be  
17 able to sell 50 of those beds?

18 MR. CASPER: Yes.

19 MS. CREDILLE: I do, too.

20 MR. CASPER: Yeah. So I would support  
21 that.

22 MS. AVERY: Is that to establish a new  
23 facility or just to sell?

24 MS. CREDILLE: Well, we seem to be in

1 disagreement as a group on that.

2 MR. PHILLIPPE: I think that's a macro  
3 decision that we should take back to the  
4 subcommittee because it has a much bigger impact.

5 MR. CASPER: Yeah. This is Bill Casper  
6 again. My -- I mean my personal position would be  
7 that I would tend to be agnostic on that issue as  
8 to if the business plan was to buy 50 beds from one  
9 person and 40 beds from another person and 30 beds  
10 from third person and build a new building with it,  
11 if either the bed need formula where they wanted to  
12 build or the other criteria that enabled them to  
13 build allowed them to build a new building, they  
14 should do that, and if they were using each one of  
15 those purchases to add beds to three existing  
16 facilities in the area, they should be allowed to  
17 do that also. That would be my -- I don't know  
18 that -- I don't know if there would be -- what the  
19 policy -- I mean, obviously, there's a higher cost  
20 to build a new building per bed than maybe to add  
21 beds. Not necessarily so. But I'm not sure what  
22 the policy or goal of restricting people's -- an  
23 operator from building versus adding would be.

24 MS. CREDILLE: Well, and in providing a

1 new state-of-the-art facility to the consumer where  
2 you're talking about access, whether it be access  
3 because they're underbedded or to Ann's point of  
4 access because the consumer is looking for  
5 state-of-the-art or private rooms or clinical  
6 capacity that would go along with it, then  
7 everybody wins in the state.

8 MR. PHILLIPPE: This is Tim. I'm not  
9 sure everybody wins. Let me talk about the Indiana  
10 experience because it happened like that, even  
11 though -- because they really had no CON for a  
12 while.

13 What would happen is in an existing  
14 area someone would come in and build that nice new  
15 building. All they would take is short-stay  
16 Medicare and a little bit of private pay. All the  
17 other buildings actually end up having less  
18 resources to provide care to the other 80 percent  
19 that are left in their building.

20 So a lot of the -- and this impact  
21 increases in Illinois because the difference  
22 between Medicare short-stay funds and even a little  
23 bit of private pay and Medicaid is very large.  
24 We're much worse than Indiana. And even -- and

1 Ohio has much less of an issue because the Medicaid  
2 rate is too high. So the question is, you know, is  
3 that good public policy to let somebody come in and  
4 provide one -- a nice state-of-the-art that makes a  
5 lot of money, because they don't have to really  
6 staff it better or run it better, but it looks  
7 nicer, and they take all the revenue that make  
8 every -- all the other care in the county is harmed  
9 by it.

10 MR. FOLEY: Then I -- this is Charles  
11 Foley. Then I guess based on that what you're  
12 saying, I think Cece even said earlier that we then  
13 require these facilities to provide at least a  
14 minimum number, whatever the committee comes up  
15 with, of Medicaid beds and make sure that they take  
16 their fair share also.

17 MR. PHILLIPPE: This is Tim again. I  
18 agree with that. However, I've heard this stated  
19 before over the last years by new buildings, but  
20 saying you will certify the bed doesn't mean  
21 they're averaging a Medicare -- Medicaid census.

22 I have tax credit independent living  
23 buildings where I have rules that I have -- if I  
24 say I'm going to have 60 percent of people below a

1 certain income, I have to certify that every year.  
2 So I come in, I get the funding to build low-income  
3 units and get the deal, but then I have to prove I  
4 actually provided services to those low-income  
5 people. I don't think today there's any  
6 enforcement mechanism after the approval.

7 MR. FOLEY: Well, I think you just gave  
8 the answer, though, Tim. I think the answer is  
9 what you just said, and that is, you know, one of  
10 the recommendations this committee could make would  
11 be to require that new facility to certify that  
12 they do in fact have -- which would be a part of  
13 the -- of their other cost report would show that  
14 also.

15 The big question is, okay, what if they  
16 don't? What if they only got -- if we say the  
17 minimum is 25 percent and you only did 23 percent,  
18 so what does that mean? You know, I don't know.  
19 And that's the issue that this committee is going  
20 to have to come up with.

21 MR. PHILLIPPE: And that would be an  
22 issue for the staff because it's a -- do they want  
23 to add that enforcement work?

24 MR. FOLEY: That is absolutely correct.

1 That's a lot more work, you know, than they  
2 probably can handle right now based on their  
3 workload. But I think that's a very important  
4 issue.

5 MR. PHILLIPPE: This is Tim. Could I  
6 ask one of the staff actually to answer? Because  
7 you have been in the meetings and I know I've been  
8 in meetings where people proposed that they're  
9 meeting a need in a county for Medicaid, but what's  
10 -- and all I have is ad hoc information, just what  
11 I generally know about things. But am I correct  
12 there's no real enforcement mechanism right now?  
13 Is that correct?

14 MR. CONSTANTINO: That's correct.

15 MR. FOLEY: I think the staff left.

16 MR. CONSTANTINO: No, no. That's  
17 correct.

18 MR. PHILLIPPE: They gave up on us.

19 MR. CONSTANTINO: No, no. That's  
20 correct.

21 MR. GALASSIE: This is Dale. I've  
22 primarily been listening. I apologize I was late.

23 I was -- you know, my memory is going  
24 back seven or eight years now, but I do remember

1 long-term care having to account through IDPH. So  
2 I guess I'm leaning toward, yes, there is  
3 enforcement.

4 MR. PHILLIPPE: I don't think the  
5 providers feel that.

6 MR. URSO: Tim, this is Frank Urso.  
7 Are you saying in terms of enforcement is there any  
8 monitoring or surveillance once the board issues a  
9 permit or exemption? Is that what you mean by  
10 enforcement?

11 MR. PHILLIPPE: Yes. For example, if a  
12 new facility is, even without a bed need, is  
13 pitched based on the idea of access to Medicaid and  
14 they build a nice new building, the question is, do  
15 they have Medicaid people in the building two years  
16 later? That's exactly right.

17 MR. URSO: This is Frank Urso. I think  
18 I would answer that it depends. Normally there are  
19 post-permit requirements that mean they have to  
20 move that project along with due diligence and they  
21 have to submit specific reports and they have a  
22 certain completion date and the board watches that  
23 completion date to make sure they complete on time  
24 and that they also complete within the approved

1 permit amount. So those are the basic general  
2 monitoring parameters.

3 But let's say that in an application a  
4 nursing home suggested very strongly that they  
5 would take on a certain population, the board can  
6 very well put a condition on that permit.

7 Okay? And that condition could be -- if you're  
8 telling the board that you're going to have, you  
9 know, 25 percent Medicaid patients, the board could  
10 put a condition on that permit and that condition  
11 would be monitored, as well as those other factors,  
12 to determine if they in fact complied with what  
13 they said they were going to do either orally or in  
14 their written documentation to the board.

15 So in terms of enforcement, those are  
16 the ways in which that can be done.

17 MR. WAXMAN: This is Mike Waxman. You  
18 know, I was listening to you, Frank, and the 25  
19 percent, is that 25 percent of licensed beds or 25  
20 percent of current occupancy? Which is a major  
21 difference in the State of Illinois.

22 MR. URSO: Well, I think it depends on  
23 how it's defined by the applicant, okay, and how  
24 the board actually determines how they want this

1 applicant to go forward. It could be -- it could  
2 be 25 percent of licensed beds. It could be 25  
3 patients. It could -- you know, it depends on what  
4 the agreement is and what the applicant said  
5 they're willing to do and agree to.

6 MR. KNIERY: Frank, this is John  
7 Kniery. If I can take it a step further, I think  
8 that your staff has gone back -- I remember one  
9 particular client --

10 MS. AVERY: Yes.

11 MR. KNIERY: -- or provider in  
12 Springfield who claimed that they would do a number  
13 of Medicaid beds and they were -- they weren't  
14 ramped up yet, but the state did follow up and the  
15 state did require that they, you know, meet that  
16 obligation. So there is some. I don't know how  
17 formal it is, but there is -- there is some  
18 follow-up.

19 MS. AVERY: John, this is Courtney. It  
20 is very much followed up with compliance. And that  
21 applicant came back and said what was prohibiting  
22 them from establishing those beds as Medicaid-  
23 certified and was still working towards doing so.

24 MR. KNIERY: Right, right.

1 MS. CREDILLE: Can I --

2 MR. PHILLIPPE: That's helpful to note.

3 This is Tim. Because I -- probably I'm aware of  
4 the one that's the most glaring example, the one  
5 you're talking about, because I happened to be in  
6 the board meeting when it was approved and then I  
7 know a lot about Springfield and the providers  
8 there. And so that -- and providers have talked  
9 about it, you know, informally. And so there is --  
10 so if we have an enforcement, that helps a lot.  
11 Because in Illinois it's not a matter of just  
12 having certified beds. People have to be accepted  
13 into those beds on Medicaid.

14 MS. CREDILLE: How did -- can I ask out  
15 of curiosity, just knowing how some folks operate,  
16 how -- how do you -- who's the enforcement arm?  
17 Who goes in and at what time period? I'm just kind  
18 of curious.

19 MR. URSO: Well, you know, the board  
20 has subpoena powers. They can subpoena records.  
21 Okay? They could -- and Bill Bell is hopefully  
22 still on the line. He, when he worked for IDPH,  
23 has allowed his surveyors to go in and conduct  
24 surveys based upon a board recommendation if he had

1 the -- you know, if he had the staff and the time  
2 to do that. So I mean there's a number of  
3 different mechanisms in which the board could  
4 monitor if conditions and permit factors are being  
5 complied with.

6 MR. PHILLIPPE: This is Tim. Thank  
7 you. I appreciate that. That helps me understand  
8 what the options are. That's good.

9 MS. CREDILLE: Those are good options.  
10 Those are very good options.

11 MR. URSO: I mean it's not like the  
12 board does this every day, okay, in terms of  
13 issuing subpoenas. But the board does have the  
14 authority to do that.

15 MR. GALASSIE: This is Dale. The state  
16 does have agreements with some county health  
17 departments who then serve as the arm of the state  
18 for facilities in that county for regulation and  
19 compliance.

20 MR. PHILLIPPE: That's good. This is  
21 Tim. You know, it's not -- it's not an issue for  
22 me personally or probably for our association.  
23 However, just in terms of public policy, I am  
24 always concerned about access for lower income

1 residents, which is more than half of the people in  
2 nursing buildings today in the State of Illinois.  
3 And there are places that already have access  
4 problems. So I think it's just wise to consider  
5 that.

6 MS. CREDILLE: Okay. So are we -- I  
7 think this has all been good discussion. I have  
8 actually four items. It's geography, moratorium,  
9 pilot, and then building versus adding beds only  
10 are our four.

11 Does someone have another large topic  
12 area that we need to take back to the large  
13 committee?

14 MR. FLORINA: Cece, this is Florina.  
15 Claire did a good job putting together a document  
16 for discussion, and if I can just add to what you  
17 said, it's item number 1 -- or, a. for  
18 implementation, it's item number b. under distance,  
19 under item d. 4. it deals with establishing a new  
20 SNF, and then item g. is moratorium. So they're on  
21 our work document here already.

22 MS. CREDILLE: Right. But they've just  
23 bubbled to the top as the key issues before we can  
24 really go into any detail.

1 MR. PHILLIPPE: Cece, this is Tim. I  
2 couldn't hear the first couple very well. But the  
3 one thing that came up that I hadn't thought about  
4 until you pointed it out today well was where  
5 they're allowed to move to, could you move beds  
6 within an overbedded area or are you allowed to  
7 move beds into an overbedded area.

8 MS. CREDILLE: Okay.

9 MS. GUILD: I suggest at the next  
10 meeting starting with moratorium because in fact  
11 the big committee already talked about -- I thought  
12 at least that they decided on, you know, whether  
13 you could add new beds or whether you could create  
14 a new building and they also recommended statewide.  
15 But I think the moratorium question might change  
16 that whole perspective. So I would start there  
17 because it is the biggest issue I think on the  
18 table.

19 MR. WAXMAN: Well, I don't think --  
20 again, this is Mike Waxman. You know, I think when  
21 we had our discussions at the last meeting -- until  
22 we got into details of this conference call, I  
23 don't think we realized at the board meeting or  
24 subcommittee meeting just how impacted -- or,

1 impactful those issues were to the other issues. I  
2 mean I think today's discussions made that very  
3 clear to us. So I think we have to go back and  
4 explain that to the whole committee that we did an  
5 excellent job today. And I'd like to thank the  
6 subcommittee for doing that. But it did point out  
7 that the issues we tabled can't be tabled. They  
8 have to be addressed.

9 MR. URSO: This is Frank Urso. Can I  
10 say one thing?

11 MR. WAXMAN: Sure. If I wouldn't stop  
12 Chuck Foley, I wouldn't stop you.

13 MR. URSO: Thank you.

14 Cece, you mentioned about occupancy,  
15 you know, in terms of, you know, the state looks at  
16 90 percent but that the real occupancy is in the  
17 seventies. Should that be a topic that perhaps the  
18 subcommittee should look at and think of ways in  
19 which that can be dealt with?

20 MS. CREDILLE: I can't talk about it  
21 anymore. We've been doing it for three years. But  
22 certainly, Frank.

23 MR. URSO: Maybe the timing is right.  
24 Who knows?

1 MS. CREDILLE: I can't. I just can't.

2 MR. WAXMAN: Welcome to the State of  
3 Illinois, Frank.

4 Well, I don't know about the rest of  
5 you, but my cell phone is on its last leg, so -- my  
6 battery is almost dying, so --

7 MS. CREDILLE: I think we're good.  
8 We've got what we need to address at least from  
9 this at the next meeting. I do know that we missed  
10 -- we didn't talk about CON applications, but at  
11 the last meeting we got sidetracked on this. But  
12 we know what needs to come from this. So I thank  
13 everybody for your time. I appreciate it.

14 MS. AVERY: Before everyone hangs up  
15 can we have a last roll call please? So I have  
16 Mr. Waxman, Mr. Casper, Ms. Credille, Mr. Bell,  
17 Mr. Constantino, Mr. Corpstein, Ms. Guild, Mr.  
18 Urso. I don't know if -- Nelson, did you rejoin?

19 MR. AGBODO: Yes, I'm here.

20 MS. AVERY: Okay. Claire, Ms. Burman  
21 is on, Florina is on, Phillippe is on, Mr. Dart,  
22 Mr. Will, and now Dale Galassie.

23 MR. FOLEY: Foley and Kniery.

24 MS. AVERY: And Mr. Foley and John

1 Kniery.

2 MR. CONSTANTINO: George Roate.

3 MS. AVERY: Hi, George.

4 MR. ROATE: Hello.

5 MR. WAXMAN: Wow, it became a major  
6 party.

7 MS. CREDILLE: So we'll all know what  
8 we're talking about when we talk again in three  
9 weeks.

10 MR. WAXMAN: Right.

11 MS. AVERY: Did I miss anyone?

12 (No response)

13 MS. AVERY: Great. Thank you.

14 (The meeting concluded at 4:13 p.m.)  
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