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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD
LONG TERM CARE ADVISORY SUBCOMMITTEE
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

MEETING OF THE LONG-TERM CARE ADVISORY SUBCOMMITTEE

The meeting of the Subcommittee was held by
video conference on November 5, 2014, scheduled to
begin at 10:00 a.m.

1 MEMBERS PRESENT:

2 Chairman Michael Waxman

3 Vice Chairman William Bell

4 Alan Gaffner

5 Charles Foley

6 Tim Phillippe

7 Michael Scavotto

8 Cecilia Credille

9 Judy Amiano

10 Steve Lavenda

11 John Florina

12 Joe Ourth

13 Bill Casper

14 Kelly Cunningham

15 Neyna Johnson

16 Carolyn Handler

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1 ALSO PRESENT:

2 Frank Urso - HFSRB Counsel

3 Claire Burman - HFSRB Staff

4 Nelson Agbodo - HFSRB Staff

5 Ann Guild - HFSRB Staff

6 Courtney Avery - HFSRB Staff

7 George Roate - IDPH Staff

8 Michael Constantino - IDPH Staff

9 Jason Speaks - LeadingAge

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20 Court Reporter:

Jennifer L. Crowe, CSR

21 Illinois CSR #084-003786

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- 1 AGENDA
- 2 CALL TO ORDER
- 3 1. Roll Call
- 4 2. Approval of Agenda
- 5 3. Approval of August 19, 2014 Meeting
- 6 Transcript
- 7 4. LTC Subcommittee Membership Tenure
- 8 5. Proposed Amendments to LTC Advisory
- 9 Subcommittee By-laws
- 10 6. Update - Revisions to the LTC CON Rules
- 11 and Application
- 12 7. Update - "Buyer/Seller Requirements"
- 13 Workgroup
- 14 8. Other Business
- 15 9. Next Meeting
- 16 10. Adjournment

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1 (Start time 10:13 a.m.)

2 MR. CHAIRMAN: I would like to suggest that
3 we start, and since -- as Chairman I have that
4 right. So please, if we can come to order.

5 I am -- are you going to do roll call?

6 UNIDENTIFIED: Start there.

7 MR. CHAIRMAN: We will start in Springfield
8 with roll call, please.

9 MR. CONSTANTINO: Mike Constantino, Illinois
10 Department of Public Health.

11 MR. AGBODO: Nelson Agbodo, HFSRB staff.

12 MR. GAFFNER: Alan Gaffner, Alden Network.

13 MR. FOLEY: Charles Foley.

14 MR. PHILLIPPE: Tim Phillippe.

15 MS. CUNNINGHAM: Hi. Kelly Cunningham,
16 Healthcare and Family Services.

17 MR. SCAVOTTO: Mike Scavotto.

18 MR. BELL: Bill Bell.

19 MR. SPEAKS: Jason Speaks with LeadingAge.

20 I am not on the subcommittee, I'm just here kind of
21 observing.

22 MR. ROATE: And George Roate from Illinois
23 Department of Public Health.

24 MR. SPEAKS: That's it for here.

1 MR. CHAIRMAN: We have four voting members
2 in Springfield?

3 UNIDENTIFIED: I have five.

4 UNIDENTIFIED: I have got six.

5 MR. CHAIRMAN: We will start with you.

6 MR. FOLEY: I'm new.

7 UNIDENTIFIED: Six.

8 MR. CHAIRMAN: Six voting members in
9 Springfield?

10 UNIDENTIFIED: The guy in the blue shirt is
11 not included.

12 MR. CHAIRMAN: We will start here. Cece, is
13 that you down there, all the way down there?

14 MS. CREDILLE: Cece Credille, IHCA
15 representative.

16 MS. AMIANO: Judy Amiano with LSM or
17 LeadingAge I guess it is.

18 MS. GUILD: Ann Guild, HFSRB.

19 MS. HANDLER: Carolyn Handler, at large.

20 MR. URSO: Frank Urso, board staff.

21 MS. AVERY: Courtney Avery, board staff.

22 MR. CHAIRMAN: I am Mike Waxman. I'm Chair
23 of the committee.

24 MS. BURMAN: Claire Burman, board staff.

1 MR. LAVENDA: Steve Lavenda from Frost
2 Ruttenberg & Rothblatt.

3 MR. FLORINA: John Florina.

4 MR. FOLEY: F-L-O-R-I-N-A. I got you
5 covered, John.

6 MR. CHAIRMAN: All right. Chuck, you are
7 always there for us. We appreciate that.

8 We have several new members, some of which I
9 have not met yet. So I apologize for that. But
10 Steve, would you -- do you want to do like an hour
11 presentation?

12 MR. LAVENDA: An hour?

13 MR. CHAIRMAN: Five minutes.

14 MR. LAVENDA: Let's see, I'm a partner with
15 Frost, Ruttenberg & Rothblatt Health Care Group. I
16 have been with the firm for about 30 years. I have
17 been in the long-term care field close to 35 years.
18 My main responsibilities are with the cost reports,
19 Medicaid/Medicare reimbursements, and also I serve
20 on the Supportive Living Facilities Advisory Board,
21 and I was asked to be part of this committee a few
22 months ago. I gladly accepted.

23 MR. CHAIRMAN: Thank you, Steve.

24 John, you have been here, but you are now

1 officially a new member, so please.

2 MR. FLORINA: John Florina, licensed nursing
3 home administrator, nursing home administration. I
4 have been a visitor for the last approximately a
5 year and have now joined the ranks with the rest of
6 you. So thanks for inviting me.

7 MR. CHAIRMAN: John, had a year to decide
8 whether we were crazy enough for him to join, and
9 he decided to.

10 New members in Springfield. Chuck has been
11 here longer than I have, but he is now an official
12 member.

13 So Chuck, you have got 30 seconds.
14 Everybody knows who you are.

15 MR. FOLEY: I am Charles Foley. I'm from
16 Springfield. Health care consultant.

17 MR. CHAIRMAN: Thank you, Chuck. You know
18 I'm teasing. You can have another 30 seconds if
19 you need it.

20 MR. FOLEY: Well, actually I have got about
21 40 pages to read, if that's okay.

22 Go ahead, Alan, introduce yourself.

23 MR. CHAIRMAN: Alan, sorry, I don't know
24 you, but I know of you, so please.

1 MR. GAFFNER: Thank you. I look forward to
2 getting to meet you, Mr. Chairman.

3 Alan Gaffner. I have had over 34 years in
4 both acute care on the hospital side and long-term
5 care and have had the privilege of serving for
6 approximately ten years as Secretary of the
7 Illinois Health Care Association Board and also
8 served for two and a half years on the Health Care
9 Council of Illinois board.

10 This is my first meeting. I was extended
11 the opportunity to join. I know am serving with
12 the Alden Network. Over the years I have had
13 responsibilities in a lot of areas that span the
14 gamut from marketing, fundraising, legislative,
15 regulatory governmental affairs, and it is a
16 privilege to join this group, and I am grateful for
17 that opportunity.

18 MR. CHAIRMAN: Thanks to you, and, again, a
19 warm welcome to all of our new members. I think
20 the committee has changed since our beginning. I
21 think we have come into a more cohesive working
22 group with a more complete understanding of what
23 our direction is and what our obligations are, and
24 I welcome the new members to fall into that move

1 forward kind of opportunity. I feel like I just
2 won an election. I don't know why I'm doing this,
3 so forgive me. That's what you get for spending
4 three hours in a car doing five miles an hour.

5 So I need a motion to approve the agenda,
6 please.

7 MR. PHILLIPPE: So moved.

8 MR. CHAIRMAN: I have a motion. I need a
9 second?

10 MR. SCAVOTTO: Second.

11 MR. CHAIRMAN: I have second. All in favor.

12 (Ayes heard.)

13 MR. CHAIRMAN: Any opposed? Motion carries.

14 I need a motion to approve the transcript of
15 our last meeting which was August 19th.

16 Yes, sir?

17 MR. URSO: You need the person to say their
18 name.

19 (Discussion off the record.)

20 MR. CHAIRMAN: Okay. Well, we are fine. I
21 need a motion somewhere in the world to approve the
22 agenda, to approve the minutes. Now I scared
23 everybody. So somebody please move to accept
24 the --

1 MR. SCAVOTTO: I move we accept the meeting
2 transcript.

3 MR. FOLEY: Second.

4 MR. CHAIRMAN: Thank you. All in favor
5 (Ayes heard.)

6 MR. CHAIRMAN: Any opposed?
7 (No response.)

8 MR. CHAIRMAN: Motion carried. Thank you
9 all. I think everybody is aware that this meeting
10 will end at 1:30 instead of 2 due to whatever.

11 Next on the agenda is long-term care
12 subcommittee membership, and Frank, is that you, is
13 it Courtney?

14 MR. URSO: Claire, you sent out a document
15 that listed everyone's current terms.

16 MS. BURMAN: Yes, the last time that we --
17 yes, this is a listing of terms that were given to
18 the membership, and this is approximately from a
19 year ago. We needed to divide everybody into three
20 basic groups, one year, two year and three year.

21 Since that time we had one member who
22 resigned, Mr. Sullivan, and in our discussion of
23 this, this matter at the last Long-Term Care
24 Subcommittee meeting we were talking about perhaps

1 making the representation from different state
2 agencies more of a permanent membership. That is
3 something that we need to talk about and approve or
4 not today.

5 Then we have members who were never really
6 placed into any of the three groups. So this is
7 their opportunity to tell us what their preferences
8 are and see how we work that out.

9 So right now on the one-year list, which the
10 expiration of that term is October 2014, we have
11 Mr. Raikes, Mr. Scavotto, Ms. Johnson and Ms. Evans
12 who is not present right now.

13 I guess is Neyna present in Springfield?

14 MR. CONSTANTINO: Mike Constantino. No.

15 MS. BURMAN: Okay. We did not hear from
16 anyone in that group as to what they wish to do.

17 There was some discussion at the last meeting that
18 perhaps someone might want to stay on past this
19 one-year term, and it is open for discussion.

20 MR. SCAVOTTO: Could I speak? This is Mike
21 Scavotto. I am looking at this as my last meeting.

22 MS. BURMAN: Well --

23 MR. CHAIRMAN: We won't accept that.

24 MR. FOLEY: I will second that, Mike.

1 MR. SCAVOTTO: You will second that. Thank
2 you, Charles.

3 MR. FOLEY: No, that we don't accept.

4 MR. URSO: Let me, let me add onto what
5 Claire said. This is Frank Urso. According to the
6 by-laws that were approved, once the terms expire,
7 so for instance the one-year term and two-year
8 term, three-year terms, then the static three-year
9 terms begin.

10 So what I mean by that is anybody who is in
11 a one-year term now that expires, if they want to
12 remain, you know, on the committee or if new people
13 come forward, they become three-year terms.

14 So after the second term has expired, that
15 becomes a three-year term. So you have staggered
16 three-year terms once we end this initial
17 termination of terms.

18 So therefore, everybody's term after their
19 initial terms are completed, if I am not confusing
20 you, it becomes a three-year term.

21 So if Mr. Scavotto, for instance, decided to
22 stay on, he would then be in a three-year term.
23 Everybody else would be, once their term ends,
24 would be in a three-year term.

1 Does anybody have any questions about that?

2 MS. HANDLER: What about new people that
3 come on?

4 This is Carolyn Handler. My question is
5 what about the new individuals that came on since
6 the by-laws were revised?

7 So like Bill Bell, Bill Casper, do they come
8 into three-year terms automatically?

9 MR. URSO: Well, let me -- I will back into
10 answering that. What we are proposing with some
11 new by-law changes that are on the table is that
12 the members that represent state agencies would be
13 perpetual standing members. So that pulls four
14 members out of the 19, okay?

15 So you have IDPH, DHS, Healthcare and Family
16 Services and Aging. Those people would be on a
17 perpetual membership or those agencies I should
18 say, whomever represents those agencies.

19 So therefore you have 15 members left. So
20 essentially you have five members in each tier or
21 five members in each term, okay?

22 So with the new members that are coming on
23 board, a decision has to be made whose slot they
24 are filling, okay, or what slots are available.

1 So, for instance, Bill Bell and so on, there
2 would have to be a determination made where the
3 slots are open, that's where they would fit, and
4 there are five slots per term.

5 Does that answer your question, Carolyn?

6 MS. HANDLER: Yes, it does. Thank you.

7 MR. CHAIRMAN: Frank, just to clarify, when
8 it says one year, two year, three year, at what
9 point are we counting for year one, year two,
10 today's date?

11 MR. URSO: Well, technically it is the date
12 that is in the by-laws. So, in other words, the
13 first term expired October 1st, 2014.

14 MR. CHAIRMAN: Okay.

15 MR. URSO: The second term expires October
16 1st, 2015, and the third term expires October 1st,
17 2016. And once again, each of those termination
18 dates, that begins a three-year term for those
19 people that are in that, those five people or five
20 slots that are in that one-year term.

21 Do you need me to repeat anything there,
22 Mike?

23 MR. CHAIRMAN: So in effect, the people
24 whose one-year term expired last month --

1 MR. URSO: October 1st, correct.

2 MR. CHAIRMAN: So we need to know from these
3 one, two, three, four people -- we have heard from
4 Mike -- the other three people whether they want to
5 continue on in the new three-year term or whether
6 they are parting company with us forever.

7 MR. URSO: Correct. What you also have in
8 the one-year term is a vacancy. So one of these
9 people at the bottom of the list in terms of not
10 being in a term, one of them has to fit in a
11 one-year slot so to speak, so on, so forth.
12 Because when you take out the state agency people,
13 you have 15 slots left, and that's five slots
14 available in each term, if my math is correct.

15 Is it correct?

16 MR. CHAIRMAN: Okay.

17 MS. CREDILLE: This is Cece Credille. Can I
18 ask a separate question?

19 And I -- who are the representatives now,
20 the officials from IDPH, DHS, Department on Aging
21 and such, who are they?

22 MR. URSO: Well, you have Paul Corpsmen from
23 Illinois Department of Public Health, you have
24 Neyna Johnson from Aging, and you have Terri

1 Dederer from Healthcare and Family Services and who
2 is DHS?

3 MS. CUNNINGHAM: This is Kelly Cunningham in
4 Springfield. If I can -- yeah, just to correct
5 that, Frank, Terry is with DHS, and I am with HFS,
6 Kelly Cunningham.

7 MR. URSO: Okay. Thank you, Kelly, for
8 correcting that. So those are the four people who
9 are agency representatives.

10 MS. CREDILLE: This is Cece Credille again.
11 So Neyna Johnson is sitting up in a one-year term,
12 but you are proposing that she be a permanent
13 member under, as a Department of Aging rep?

14 MR. URSO: That's right. That's another
15 opening in a one-year slot, correct.

16 MR. CHAIRMAN: If she chooses.

17 MR. URSO: Well, the agency will always have
18 a slot, a perpetual slot.

19 MR. CHAIRMAN: But it may be somebody else.

20 MR. URSO: Correct, but she vacates the
21 one-year slot. So that opens up for the new
22 members, one new member to take that slot.

23 MR. CHAIRMAN: So do we need -- are we
24 looking for two volunteers to fill the one-year

1 terms and then agree to a three-year term after
2 that to solve this issue and move forward?

3 MR. FOLEY: Mr. Chairman, Charles Foley
4 here. I would like to ask Mr. Scavotto to kindly
5 reconsider.

6 MR. CHAIRMAN: I thought I did, but we
7 definitely would like to have Mike reconsider.

8 MR. FOLEY: Yes.

9 MR. SCAVOTTO: I will get back to you.

10 MR. CHAIRMAN: Yes, you reconsider?

11 MR. FOLEY: We have to vote now.

12 MR. SCAVOTTO: No, I made up my mind. I'm
13 out. I have been doing this from its inception,
14 and it is time to, time for other people to take
15 over and move on.

16 MR. FOLEY: Okay.

17 MR. BELL: I respect that.

18 MR. FOLEY: I respect that wholeheartedly.

19 MR. CHAIRMAN: So again, Frank, my question
20 is do we seek volunteers to fill, to take the names
21 off of the one-year term and then assume -- and
22 assure ourselves that they will move into a
23 three-year term effective today?

24 MR. FOLEY: I will volunteer to make Mr.

1 Scavotto's place.

2 MR. CHAIRMAN: Chuck, did you say that?

3 MR. FOLEY: Yes, sir, I did.

4 MR. CHAIRMAN: Okay. And you are willing to
5 accept the three-year term?

6 MR. FOLEY: Yes, sir, I am.

7 MR. CHAIRMAN: John, were you going to do
8 the same thing?

9 MR. FLORINA: I was going to make a comment.
10 I would like to work with some kind of specific
11 criteria. It appears we don't have any -- this is
12 Florina by the way -- that we don't have any
13 specifics as to how you fill an open spot when
14 there is an opening that occurs.

15 I'm not referring just to the initial one,
16 two and three-year terms that you have arranged,
17 I'm talking about somebody leaves in the middle of
18 their term, when you have a replacement do they
19 fill that spot, do they take a different term?

20 It is not clear, and here we are basically
21 just talking about it saying who wants to take
22 which slot. That's the point I was trying to make.

23 MR. CHAIRMAN: Well, in the past what we've
24 done is if someone leaves mid-term, they simply

1 step in -- whoever was newly appointed stepped into
2 that position.

3 This is actually the first time as a
4 committee we have designated terms with specific
5 end dates. It has not been done in the past. The
6 earliest by-laws did not establish end dates or
7 expiration or terms. So this is sort of a new
8 process, John, and anyone else that has the same
9 questions.

10 So in the future if someone was to leave in
11 the middle of their term, we would seek new
12 applications, that process, approval by a couple of
13 us and the mother board chair, and they would then
14 step into the position of the person who left.

15 MR. FLORINA: Is it appropriate that the
16 by-laws so state that so we know what we are
17 talking about?

18 MR. CHAIRMAN: Mr. By-law writer is looking
19 for that.

20 MR. URSO: John, we are going to talk about
21 by-laws today, and I think it would be really
22 appropriate if you had some thoughts about
23 additions, we will then, you know, draft some
24 language to cover that, and we can talk about it.

1 MR. FLORINA: This is Florina. I don't have
2 a comment as to how to deal with the original
3 process that was established, but clearly if an
4 existing current member is no longer participating,
5 the replacement for that member should fill that
6 person's spot that was vacated.

7 MR. CHAIRMAN: Correct. I mean, that's my
8 logic, too.

9 MR. URSO: The only thing I think the
10 by-laws speak to right now if there was a complete
11 vacancy and therefore then the board chair picks
12 the members that have -- let's say there is only 18
13 members and we want to fill the 19th slot and there
14 is nobody, you know, there is nobody in the wings
15 so to speak. The board chair, the mother board
16 would then pick that member. So we speak to that
17 aspect of it.

18 You are asking a different question, though.
19 I think you are talking about when you have -- like
20 we have now, we have six members who are not
21 designated in a slot; how do they get chosen for
22 the particular term, correct?

23 MR. FLORINA: Yep. Well, you need to get a
24 starting point, and you need to assign everybody up

1 to 19 into one of these spots or 15 I should say
2 after you take out the four state personnel.

3 MR. URSO: I think when you think back and
4 maybe some of the other members that were here at
5 the time, when we first designated these staggered
6 terms it was who wanted to take what term, and it
7 was basically a volunteer kind of thing.

8 Then if there were people who didn't have
9 preferences, then I think the Chair said okay, you
10 know, you are going into that slot.

11 MR. CHAIRMAN: Correct.

12 MR. URSO: Sometimes it was just because you
13 only had -- I think we had six, six and seven at
14 the time, six slots, and first term six slots and
15 second term and seven slots. Wherever there was a
16 slot opening somebody was left, the Chair said
17 well, you got to take that term basically.

18 MS. AMIANO: Judy Amiano. The original
19 intent was not to have this go on forever and ever,
20 the work of this group, correct?

21 So that's why there was nothing, John, in
22 the original by-laws.

23 MR. CHAIRMAN: Tim?

24 MR. PHILLIPPE: I'm just wondering if we

1 could just propose maybe the same thing. Rather
2 than spending an hour and a half talking about this
3 here and trying to get people to volunteer and
4 figure out by video, can we just let the Chair,
5 like you said before, decide the slots that people
6 go in. I know he is very good at talking to people
7 and getting their buy-in and let you do that so we
8 don't have to do all that at the meeting. If we
9 need to change by-laws to do that, we should go
10 ahead and do it and don't have to spend time in our
11 meeting talking about it.

12 MR. CHAIRMAN: I'm fine with that except --
13 and I accept your compliment, except it didn't work
14 with Mr. Scavotto.

15 MR. PHILLIPPE: I tried also for a couple, a
16 few months. Didn't work for me either. But the
17 rest of it I think you're capable of handling so we
18 don't have to spend a lot of time trying to
19 organize it through a conference call.

20 MR. CHAIRMAN: I'm fine with that.

21 Do I see a hand in Springfield or just
22 fuzziness without my glasses?

23 Okay. So are we done with this subject
24 matter?

1 Courtney and I will kind of go over all of
2 this, and we will put people into --

3 MS. BURMAN: This is Claire Burman. I think
4 that we need a vote on the idea of having perpetual
5 membership for representatives from the state
6 agencies.

7 MR. CHAIRMAN: I need a motion to the effect
8 that we will create four perpetual memberships for
9 the state agencies listed on the sheet.

10 MR. PHILLIPPE: I will so move.

11 MR. FOLEY: I will second. Second by Foley.

12 MR. CHAIRMAN: A motion from Tim. Motion
13 from Tim and a second from Chuck. All in favor?

14 (Ayes heard.)

15 MR. CHAIRMAN: Any opposed? One opposed,
16 Cece Credille.

17 From what I have heard I think the motion
18 carries.

19 Frank, do we need to do a show of hands or
20 are we okay?

21 UNIDENTIFIED: You could do roll call, too.

22 MS. AVERY: This is Courtney. I was just
23 clarifying with Claire that this motion does not
24 change the by-laws at this point, correct?

1 MR. URSO: I don't know if -- the committee
2 has not discussed the proposed by-law amendment.

3 You are just talking about concept, or are
4 you talking about --

5 MS. BURMAN: Well, yes. This is Claire
6 Burman again. Yeah, I think technically speaking
7 it should be a by-law change.

8 MS. AVERY: It should be.

9 MS. BURMAN: So we can rephrase.

10 MS. AVERY: I don't think we need a motion
11 for it. When we had the discussion about the
12 members that we just agreed on, we can put that,
13 and then that has to come back to the Board, right,
14 and we can do, have the amendment at that time in
15 the by-laws. So it is two separate things. It
16 doesn't change the by-laws at this point.

17 MR. CHAIRMAN: Do we want the committee to
18 agree upon the concept of four?

19 MR. URSO: I think we are talking about a
20 concept, correct me if I am wrong, because the
21 by-law amendment that's proposed that was sent to
22 everybody has not been put on the table yet for a
23 discussion.

24 So you are just talking about a concept

1 right now, and according to the current by-laws,
2 any revisions to the by-laws requires 12 votes out
3 of the 19.

4 MR. CHAIRMAN: Tim, are you okay if your
5 amendment, if your motion is changed to accept the
6 concept of?

7 MR. PHILLIPPE: Yes, that's fine.

8 MR. CHAIRMAN: Okay. Mr. Foley, second?

9 MR. FOLEY: Yes.

10 MR. CHAIRMAN: Okay.

11 MS. CREDILLE: This is Cece Credille. Can
12 we have a discussion about what my concern is?

13 MR. CHAIRMAN: Sure.

14 MS. CREDILLE: I'm not opposed to the
15 concept of these individuals from these
16 departments, but we, as other members, have
17 restrictions that we can only miss two meetings a
18 year or we are not on the committee.

19 I would be concerned that if people just
20 come in and out of the committee, then they don't
21 have all of the information. So I would want
22 parameters. I would suggest that we have some kind
23 of parameters around it.

24 MR. CHAIRMAN: I certainly agree with your,

1 with your point, and we've also established via the
2 by-laws that there is a process for someone who is
3 not able to attend a meeting to send a proxy.

4 So I think that process should also extend
5 to the four agencies so that there is someone from
6 all four agencies at our meetings. I agree with
7 you, Cece. Thank you.

8 MR. URSO: Cece, I can tell you that
9 although we have not discussed the proposed by-law
10 change setting this in motion, there is no language
11 in that proposed by-law change saying that those
12 four members are excluded from other by-laws.

13 So the rest of the by-laws would apply to
14 them unless we, unless this committee decides to
15 restrict it in some respect.

16 MS. CREDILLE: This is Cece Credille again.
17 My notes may be incorrect, but I thought we -- it
18 was mentioned that the department would be on the
19 committee but not the individual. That's what I
20 thought. I could have misunderstood.

21 MS. AVERY: This is Courtney Avery. The
22 idea comes from inconsistency with the Board,
23 overall Board. By statute there are three
24 departments that are represented as ex-officio

1 members that we work closely with.

2 So these agencies also we work closely with in
3 this, in the long-term care subcommittee. That's
4 what we have decided that we can have, those four
5 as the standing members.

6 But the people that are appointed, I'm not
7 sure how they were appointed, if the director of
8 those agencies appointed them or someone else
9 appointed them.

10 So I guess we would have to work closely
11 with them to make sure that it is consistent and
12 when they aren't available to attend, they give us
13 ample notice for a proxy and those people be
14 brought up to speed.

15 Everything is always on the web site, and we
16 had a conference call with three, three of the four
17 who agreed to that like if they had to send
18 someone, they will bring those people up to speed
19 so there won't be any rehashing or not knowing what
20 is going on.

21 MR. URSO: These would be four voting
22 members.

23 MR. CHAIRMAN: Cece, are you okay with what
24 is being said?

1 MS. CREDILLE: Well, so -- this is Cece
2 again. So is it really the department, or is it an
3 individual on the committee?

4 MS. AVERY: It is really the department, but
5 the person, the individual should be appointed by
6 either the director or the division person, the
7 division head.

8 MR. CHAIRMAN: And they have to follow the
9 same rules as everybody else; that if the person
10 appointed is not there, that they do send a proxy,
11 and the proxy is sent to the committee and approved
12 in the normal process. So there is continuity and
13 regular attendance, accountability.

14 Okay. Let's just make sure that we are all
15 in the same place. There is a motion to accept the
16 concept of making the four state agencies perpetual
17 members. We have a motion from Tim, approved by
18 Chuck.

19 Can I ask everybody to vote again. All in
20 favor aye?

21 (Ayes heard.)

22 MR. CHAIRMAN: Any opposed?

23 Are you opposing or are you late aye-ing?

24 Is there one opposition?

1 MR. ROATE: I think everybody is in
2 agreement here, sir.

3 MR. CHAIRMAN: Oh, I heard a late, a delayed
4 transmission. We heard, we heard one aye late.

5 Okay. Thank you, all. The motion carries.
6 Wow, that was fun.

7 Is there anything else that we have to do,
8 agenda item?

9 MR. URSO: I don't want to belabor the fact,
10 but Mr. Florina had an idea perhaps that the
11 ability of the subcommittee chair to make
12 assignments in various terms.

13 Your thought, if I understood you correctly,
14 was perhaps to have that as an amendment to the
15 bylaws; am I right?

16 MR. FLORINA: Florina again. Just to
17 clarify, when there is opening and a replacement
18 for that opening, the replacement member would
19 serve the remaining term the person they are
20 replacing.

21 MR. URSO: This is Frank Urso. We can put
22 some language together for the next meeting to
23 hopefully address what your thoughts are about the
24 assignments being made by the subcommittee chair.

1 MR. FLORINA: I guess --

2 MR. URSO: Is that okay?

3 MS. AMIANO: This is Amiano. Just for
4 clarification, Frank, is that that once a member is
5 identified, the Chair slots it into a one, two or
6 three-year term, or the Chair has unilateral
7 authority to pick any member?

8 MR. URSO: You mean pick a new member?

9 MS. AMIANO: A new member.

10 MR. URSO: New members have to be chosen by
11 mother board chair. So this would be the second
12 level. The subcommittee chair would then say okay,
13 this new member that's already been chosen by the
14 board chair is going to go and do this particular
15 term.

16 MS. AMIANO: Thank you for the
17 clarification.

18 John, is that okay with you?

19 MR. FLORINA: That's fine with me. You are
20 still working through the original way you set this
21 up to fill all of the spots. We have not gone
22 through the first three-year term --

23 MR. URSO: We have not gone through all the
24 three-year terms where everybody that would be on a

1 three-year term. We have not done that.

2 MR. FLORINA: I didn't mean to bog anything
3 down with this, I was just trying to --

4 MR. CHAIRMAN: This is your first official
5 meeting, John, so be careful.

6 Frank, are we done with this topic?

7 MR. URSO: I believe so. Claire?

8 MS. BURMAN: Yes, I think connected to this
9 are draft changes to the by-laws.

10 MR. CHAIRMAN: That's the next agenda item.

11 MS. BURMAN: Yes.

12 MR. CHAIRMAN: Okay.

13 MS. BURMAN: Sorry. John?

14 MR. FLORINA: John Florina again. Item 5-7,
15 I just want to make sure it is clear what a quorum
16 is and how many votes you need to make a decision.

17 As brought up if we are going to discuss
18 by-laws, it appears that you need eight in a
19 quorum, to form a quorum, but in Section 5-7 it
20 says that if you only have six that you can vote
21 and pass something. So that seemed inconsistent
22 with the requirement.

23 MR. CHAIRMAN: Frank, do you have a
24 response, or are we inconsistent?

1 MR. URSO: John, we will take a look at it
2 and clarify 5.2 as discussed in the quorum in
3 relation to 5.7 We will do that and bring it to
4 your attention.

5 MS. CREDILLE: This is Cece Credille. Do we
6 need to -- and I don't know if it is today or at
7 another point we talk about a change in the quorum
8 or whatever. If there are four permanent
9 department people on the committee and it only
10 takes six votes --

11 (Neyna Johnson now present.)

12 MS. CREDILLE: You know what I'm saying,
13 Mike?

14 MR. CHAIRMAN: While Frank is figuring this
15 out, can we roll call Neyna into the meeting,
16 please.

17 In Springfield isn't that Neyna?

18 MS. JOHNSON: It is. I apologize for my
19 lateness.

20 MR. CHAIRMAN: Just identify yourself for
21 the minutes.

22 MS. JOHNSON: Neyna Johnson.

23 MR. CHAIRMAN: Please identify yourself for
24 the minutes, please.

1 MS. JOHNSON: Neyna Johnson.

2 MR. CHAIRMAN: Thank you. I'm sorry.

3 MR. FOLEY: We all got you, Neyna.

4 MS. AVERY: Courtney Avery. Can we go to
5 Cece?

6 Is there a concern, Cece, that it might be a
7 way of the state departments having more power than
8 the rest of the subcommittee because it only takes
9 --

10 MS. CREDILLE: I may be articulating -- this
11 is Cece Credille. I may be articulating it
12 incorrectly, but the thought is if it only takes
13 six people to vote but four are permanently from
14 the state, then that just seems different than how
15 the committee functions.

16 MS. AVERY: Okay.

17 MS. CREDILLE: But I don't know if I am
18 articulating -- Frank, you may need to help me in
19 what I am saying.

20 MR. URSO: I think the by-laws say that it
21 is 40% of the 19 membership is what the quorum has
22 to be. Those are eight members. So to pass
23 anything, there has to be, or not pass something,
24 there has to be eight votes.

1 So maybe the confusion with the six that you
2 are talking about has to do with what John Florina
3 brought up in terms of 5.7, but the quorum is
4 designated by the bylaws as eight. You recall that
5 it was a majority, and we weren't getting enough
6 people to have a quorum. So we, the committee,
7 decided to reduce that to 40% which is eight
8 members, once again, if my math is correct.

9 MR. CHAIRMAN: We have a new attendee in
10 Chicago. Would you please identify yourself?

11 (Mr. Ourth now present.)

12 MR. OURTH: Joe Ourth, Arnstein & Lehr.

13 MR. URSO: Cece, did that answer your
14 question?

15 MS. CREDILLE: Yeah.

16 MR. URSO: I don't know if it addresses your
17 concern.

18 MS. CREDILLE: It still remains a concern,
19 then, because -- so I don't know if we need to
20 change the quorum or something if there is four
21 permanent departmental and individuals are in that
22 slot but it is really the department.

23 MR. URSO: There have always been four
24 representatives from those state agencies. They

1 have always been voting members.

2 Making them perpetual members, does that
3 cause a concern for you?

4 MS. CREDILLE: I mean, we had trouble
5 getting to a quorum before. So I know why we got
6 in this situation, but we have more members now.

7 MR. CHAIRMAN: More active members.

8 MS. CREDILLE: Active members, yeah.

9 MR. CHAIRMAN: So your basic fear is that
10 the four agencies could significantly influence a
11 vote?

12 MS. CREDILLE: Correct.

13 MR. URSO: But that's no different --

14 MS. CREDILLE: It is not a fear, it is just
15 a --

16 MR. CHAIRMAN: A question.

17 MS. CREDILLE: It is a question.

18 MR. URSO: Cece, is that any different than
19 these four members being on the committee anyway?

20 MS. CREDILLE: No.

21 MR. URSO: Do you understand my question?

22 MS. CREDILLE: Right.

23 MR. URSO: They have always been on the
24 committee.

1 MS. CREDILLE: Right.

2 MR. URSO: All we are talking about is
3 changing, taking them out of a specific term.

4 MS. CREDILLE: Right.

5 MS. AVERY: This is Courtney. I was just
6 asking Mr. Waxman, what if we looked at some kind
7 of way to reconfigure the number of members and
8 make the state departments ex officio and
9 consistent with the board. So we can make, we can
10 do some different scenarios and bring them back.

11 MR. CHAIRMAN: My understanding historically
12 is that the original 19-member concept came from
13 someone who is not longer here, right?

14 And I think it was an attempt to kind of --

15 MS. AVERY: It was to mirror the other
16 long-term care boards that were in existence I
17 think.

18 MR. CHAIRMAN: Okay.

19 MS. CREDILLE: This is Cece. So what you
20 are suggesting mirrors the way the others -- I
21 don't have any experience.

22 MS. AVERY: Just the board. Like the board
23 has the nine members and then three ex officio
24 departments.

1 MS. CREDILLE: Okay.

2 MS. AVERY: So they are non-voting. The
3 state departments are-non voting. They are there
4 to provide input, and they can join in the
5 conversation, they offer things, but they don't
6 vote on the actual applications. So that can be
7 possible.

8 MR. CHAIRMAN: That will solve the problem.
9 Any problem with --

10 MR. URSO: The statute that created the
11 subcommittee does not address the number of members
12 that need to be on the subcommittee. That was an
13 arbitrary number that was designated in the
14 beginning as having the right people, I guess,
15 around the table that represented, you know,
16 various important aspects of long-term care, but
17 the 19 is not in the statute. So it is not
18 mandated that there be 19 members.

19 MR. CHAIRMAN: I'm fine with that. I mean,
20 sometimes when you say it is a 19-member committee,
21 they say that's impossible. So going down to 15 is
22 fine.

23 MS. AVERY: So we will write the different
24 scenarios.

1 MR. URSO: Maybe you should put that out as
2 a concept, and then we will have to change the
3 bylaws, put it as a motion as a concept, see if
4 everybody is comfortable with the approach that you
5 are discussing. This is Frank Urso.

6 MR. CHAIRMAN: Would someone be kind enough
7 to make a motion to a concept that the four state
8 agencies becomes ex officio members with no voting
9 rights and that the subcommittee itself be a 15
10 member committee? Tim?

11 MR. PHILLIPPE: Can I make a comment before
12 we do that?

13 MR. CHAIRMAN: Sure.

14 MR. PHILLIPPE: I have been here since the
15 beginning. Actually, the people from the state
16 agencies have certainly not been aggressive in
17 trying to control things, and I don't -- we have
18 never had any concern with that.

19 If they don't show up for meetings, the same
20 thing works for the other people. I mean, the same
21 concern. You could have, you know, one or two
22 people show up for a meeting. So the vote would be
23 very much skewed toward whatever influence of
24 non-state.

1 MR. FOLEY: We still need eight votes.

2 MR. PHILLIPPE: We still need eight people
3 of some kind, but the second -- the more -- this is
4 more the concept. I would actually prefer if what
5 we are proposing and want to do kind of is they
6 feel like will that work or if they don't support
7 it, I prefer to know those issues on the table to
8 be talked about when we are working on issues
9 versus kind of what -- if I were a person that was
10 a state agency leader and didn't like something, I
11 would be more likely to talk about it after the
12 meeting. So it helps actually to know all of the
13 groups involved are supporting something.

14 So certainly they have not been too
15 aggressive because they are actually sometimes slow
16 to express their opinion.

17 MR. CHAIRMAN: I hear what you are saying.
18 Any other opinions, please?

19 MS. CUNNINGHAM: Hi. This is Kelly
20 Cunningham from HFS, and I definitely appreciate
21 the conversation about this topic and whether this
22 state agencies are ex officio non-voting or not. I
23 understand all of the concerns presented.

24 I do agree with what Mr. Phillippe just

1 stated. If the role of the state agency is to
2 attend and provide expertise or policy
3 interpretation or something along those lines, you
4 know, I think that's an important role that state
5 agencies' staff play.

6 I guess I agree with what Mr. Phillippe
7 said, and I would appreciate the opportunity to
8 present, you know, to present that during the
9 meetings as salient topics, you know, come up.
10 Whether we can vote on it or not I think is a
11 different question.

12 I am a member of several different both
13 governor and director appointed boards. For the
14 most part state agency staff are considered ex
15 officio non-voting members in those other
16 categories, but that does not, that does not limit
17 our input, our ability to participate or
18 communicate --

19 MR. FOLEY: That's good to know.

20 MS. CUNNINGHAM: -- on topics where we might
21 have expertise or interpretation to act.

22 MR. CHAIRMAN: Thank you very much. Judy?

23 MS. AMIANO: This is Amiano. Kelly, thank
24 you for stating that because I think that the state

1 agencies provide a terrific perspective in an area
2 where some of us, you know, where we might be
3 lacking in that perspective.

4 I think the most important thing is that
5 there is open and robust conversation at the
6 meetings and that we can discuss items thoroughly
7 and appropriately at the meetings.

8 MR. CHAIRMAN: Totally agree, Judy. Again,
9 thank you for your comments. They are very
10 helpful.

11 Anybody else?

12 MR. URSO: Can I ask Kelly a question?

13 MR. CHAIRMAN: Of course.

14 MR. URSO: And Neyna also. As two agency
15 representatives, do you, do you think that your
16 roles are diminished or there is less conscientious
17 going on if you're ex officio versus a voting
18 member?

19 MS. JOHNSON: I'm probably one of the least
20 talkative people on the board, and I think I was
21 supposed to rotate off last month, but I'm having a
22 hard time finding someone to take my place.

23 You know, I'm supposed to be representing
24 the consumer, the resident's side. So I have no

1 problem with not having a vote, I just appreciate
2 having the ability to respond and then questions
3 and comments as I feel appropriate. But it is not
4 going to make or break me.

5 I don't know if the director is going to
6 appoint someone else. I don't know at this point
7 what's going to happen with me being over here. I
8 just don't know, so I can't really speak. I will
9 just speak for myself. It doesn't matter to me
10 either way.

11 MS. CUNNINGHAM: I, too, agree with Neyna,
12 Frank. I don't have concerns about being an
13 ex-officio non-voting member. That's frankly what
14 I am used to when I participate in other
15 committees. As long as there is an opportunity to,
16 you know, express concerns and participate in
17 dialogue, I think that's really the role of the
18 state employee in this, in this setting.

19 MR. GAFFNER: This is Alan Gaffner. Having
20 heard from the two department members, I would move
21 that we consider the concept of having the
22 subcommittee consist of 15 members with the four
23 state agencies being ex officio but would ask that
24 my motion include within the minutes that that ex

1 officio designation encourages their active
2 participation at the table.

3 And that's how I have always understood, at
4 least from my committee experience, that ex officio
5 does not limit and should not limit their input,
6 participation and all of the dialogue that takes
7 place.

8 MR. FOLEY: I second that.

9 MR. CHAIRMAN: We have a motion, and we have
10 a second. I thank you both for saying it so well.
11 All in favor?

12 (Ayes heard.)

13 MR. CHAIRMAN: Any opposed? Any opposed?

14 (No response.)

15 MR. CHAIRMAN: Hearing none, the motion
16 carries. Thank you very much. Frank is busily
17 writing all these adjustments.

18 MR. URSO: The only thing that I would say
19 in response to that is I think we have to run it up
20 the flagpole so to speak to the board chair who is
21 actually in charge of appointments and whatnot and
22 make sure that she and the board are comfortable
23 with reducing the size of this subcommittee.

24 Of course, I have no response, so I don't

1 know. So that's my only observation about that
2 motion.

3 MR. CHAIRMAN: That's fine. So now we are
4 back to or once again we are going to attempt to
5 get to agenda item 5.

6 So is this Claire, Frank, Courtney?

7 MS. AVERY: I think it is null and avoid
8 right now.

9 MR. CHAIRMAN: We need to do item 5 for the
10 next meeting?

11 MR. URSO: So let me just say something. A
12 proposal was sent out to redraft Section 1.2, and
13 based upon our discussion just now there is
14 probably going to be some more revisions to that
15 section.

16 But the new language that is underlined
17 probably just goes along with the concept that was
18 had approved a little bit earlier, but there is
19 some more revisions that need to be, that need to
20 be drafted in terms of Section 1.2.

21 So it is up to the committee if they want to
22 discuss this section at this point or wait until we
23 include all of the revisions that we talked about.

24 MR. CHAIRMAN: What is the pleasure of the

1 committee?

2 Do you want to wait to have all amendments
3 presented at one time, or do you want to look at
4 the draft of what was presented for today's
5 meeting?

6 MR. FOLEY: I would prefer that we do it all
7 at one time so that way we can have the total
8 picture right in front of us.

9 MR. CHAIRMAN: Okay. So we will ask staff
10 to, whenever they are prepared, to bring it to the
11 most appropriate meeting, whether it is next
12 meeting or the one after that.

13 Okay. Does anyone have anything that, that
14 they want to have Frank look at or staff look at in
15 terms of by-laws and adjustments while we are doing
16 by-law adjustments that has not been codified also.

17 Whatever is going on in Springfield, I am
18 glad it is there.

19 Frank? John?

20 MR. FLORINA: Florina again. I would just
21 say to be consistent, make sure we take a look at
22 the other portions of the by-laws that would be
23 affected by changing the voting members from 19
24 down to 15, that your quorum and your voting change

1 also. I would assume that will be done anyway, but
2 I want to make that --

3 MS. AVERY: Okay.

4 MR. CHAIRMAN: That being done, then, we are
5 up to item 6, revisions to the long-term care CON
6 rules and application.

7 Claire, is that you?

8 MS. BURMAN: That would be Mr. Scavotto, and
9 I will join in.

10 MR. CHAIRMAN: Okay. Mike, you are up.

11 MR. SCAVOTTO: Thank you. When Cece and I
12 presented our report at the last meeting there were
13 two areas that we felt could use a little bit of
14 work. So we went back at it, and I will go over
15 those adjustments now.

16 The first one concerns the use of the
17 referral letters, and from the last discussion it
18 was pretty clear that there is just two factions on
19 the committee, and it doesn't really matter which
20 one you are in. We have two factions. One thinks
21 that the referral letters are useful, the other
22 thinks that the referral letters are useless.

23 So we are trying to find a compromise to
24 that, and what we've come up with is to split the

1 use of referral.

2 First of all, we're suggesting that we
3 change the use of the term "referral" to support,
4 and there is some method behind that madness. We
5 broke the facilities up into two groups. One was
6 the existing facilities and the new facilities.

7 If we stop to think about it, the existing
8 facilities already have the historical data that is
9 being requested in the referral letters, and that
10 would be the resident origin by zip code, name and
11 specialty of the referring physician or other
12 referral source and name and location of the
13 recipient long-term care facility which presumably
14 is the applicant.

15 So since the existing facilities already
16 have this information, just haven't given it to
17 you, if they are not giving it to you now, they can
18 certainly augment that with letters of support so
19 you can see what they're -- how well they are
20 serving the community.

21 The discussion that we had at the last
22 committee meeting really got bogged down in the use
23 of hospital data, and that's -- we looked at this.
24 Primarily this is my observation. The hospital

1 data is good for Medicare, but that's it. Most of
2 our admissions don't come from the hospital. We
3 get a fair amount of important admissions from the
4 hospital with Medicare, but there are private pay
5 admissions, Medicaid admissions, come off the
6 street.

7 So you can use the letter as a support, but
8 it is not giving us an idea of the depth of
9 commitment that the hospital has. You are missing
10 a lot of your market share, if you will.

11 So for the existing facilities, just give us
12 the last three years of what your admissions look
13 like, and you have basically got the referral
14 letter requirement right there.

15 For new projects involving additional beds,
16 what we are recommending is we just go to the bed
17 need methodology. I say that with some hesitation
18 because I notice that on the next agenda item we
19 have got a buyer seller presentation coming, and
20 there is some, some concern about the utility of
21 the bed need methodology.

22 That being said, the bed need methodology is
23 in place, and if you decide to change it in the
24 future, that's fine, go ahead and do it, but, you

1 know, if you are going to be looking at a new
2 project that flies in the face of the bed need
3 methodology, I think there has got to be a strong
4 rationale. I think for the purposes of determining
5 whether a new facility is necessary, the bed need
6 methodology could serve a useful purpose.

7 The second point that we have concerns the
8 use of a one size fits all standard, a 30 minute
9 drive time. The discussion that we were having was
10 that the 30-minute drive time might be appropriate
11 in a rural area. In a very dense market,
12 particularly in Chicago for example, a 30-minute
13 drive time doesn't make much sense.

14 So our suggestion was that we break that
15 requirement into two divisions. We have one for
16 urban markets and one for rural markets, and we
17 arbitrarily defined an urban market as any county
18 with a population of over 200,000 or any primary
19 service area with a population of 200,000 or more.

20 And I thought that that second distinction
21 was important because there is -- you have some
22 service areas that overlap from one county to
23 another. So where we decide to draw that line
24 ultimately is a matter of debate, but 200,000 I

1 thought that was a pretty good place to start.

2 So what our methodology recommends is that
3 if you are an applicant from an urban market, give
4 us the primary zip code served in the admission
5 from each of the last three years, give us total
6 population by age cohort.

7 We have broke it down into three cohorts.
8 You have got 65 to 74, 75 to 84 and 85 plus. Then
9 go ahead and calculate the use rate in terms of
10 resident age per thousand population for each of
11 those last three years for each of those cohorts.

12 Then you have got a chance to use a forecast
13 population whether you want to use Woods & Poole or
14 Scan USA, Claritas. Whatever you want to use, pick
15 a current one and calculate the use rate and then
16 forecast, use that to forecast the use rate for the
17 next five years. That should give us a pretty good
18 idea.

19 I do the same thing for secondary service
20 area. So at that point the staff can verify
21 whether or not the applicant is providing a good
22 assessment of demand in the application.

23 The real problem in trying to solve this is
24 that there is just so darn many excess beds in

1 Illinois we are not going to -- it is just
2 unrealistic to think that this one item is going to
3 solve that. There is no way that we can resolve
4 that discrepancy. So what we are trying to do is
5 figure out is there a realistic assessment of what
6 the usage is going to be within that market.

7 Now, for the rural markets we would use the
8 same methodology, do the same calculation, only use
9 a 30-minute drive time as the barometer for your
10 population calculation, and those two things, we
11 think, will complete the work of this subcommittee,
12 and we can ride off into the sunset in a blaze of
13 glory.

14 MS. CREDILLE: This is Cece Credille. I
15 just want to comment that really Mike Scavotto did
16 the bulk of this work. I want to thank him, and he
17 is moving on, but he really kept on this.

18 And it started with Eli, Mike and I, and
19 then it became just Mike and I, but Mike was very
20 instrumental in continuing to address the issues,
21 and these really were the two outstanding ones.

22 MR. SCAVOTTO: So thank you, Cece, but this
23 is open for discussion.

24 MR. FOLEY: This is Charles Foley.

1 Are you then suggesting a market study,
2 then, that would basically give you all of this
3 information?

4 MR. SCAVOTTO: A market study would give you
5 a lot of this information. I think we recommended
6 a market study in another part of our report, but a
7 market study would give you this.

8 I mean, the whole -- the standard calls for
9 an indication that there is not going to be a
10 maldistribution of beds. So the idea of the use
11 rate would be if you are sitting there in a certain
12 market and you know your utilization, you already
13 know what your existing utilization per 1,000 is
14 albeit you might have an outdated population
15 forecast. If days per thousand are going down,
16 which is generally the case, and you have got an
17 application where your utilization is going up, you
18 have a disconnect that needs more review at the
19 staff level.

20 That would be -- that's the direction that
21 we're taking with this thing. A market study could
22 show you the same thing, but I think you would have
23 to have your market researcher specifically
24 commissioned to calculate the use rate because a

1 lot of them don't do that.

2 MR. FOLEY: So if we do have a market study
3 as you said might come up in another part of your
4 discussion, if we are going to require a market
5 study, then I believe that we need to include, as
6 you just said, instructions as to what the market
7 study should exactly or specifically include
8 because you know there is market studies out there
9 and then there is market studies out there.

10 MR. SCAVOTTO: Some will do use rates, some
11 don't.

12 MR. FOLEY: So if you want use rates, then I
13 think we should have it outlined somewhere in the
14 application if they require a market study,
15 detailed components of what needs to be in that
16 market study.

17 MR. SCAVOTTO: I have no objection to that,
18 no.

19 MR. FOLEY: I'd like to hear from staff if
20 at all possible as to what their thoughts are on
21 this.

22 MR. SCAVOTTO: George is sitting over there
23 being real quite.

24 MR. ROATE: It looks -- I mean, from the

1 notes and everything that I hear, it looks well
2 thought through. The market study --

3 MR. SCAVOTTO: Say that loudly. Project
4 when you say that.

5 MR. ROATE: The market study is something --
6 Mike, if I may speak for the two of us, the market
7 study is something we have always thought would be
8 a good representation of that.

9 So, Mike, any comment?

10 MR. CONSTANTINO: I have been in favor of
11 the market study for quite awhile instead of the
12 referral letters, something that we would design
13 and require as part of the application. I have
14 been in favor of that.

15 MS. BURMAN: This is Claire Burman. In
16 terms of the market study, we had already discussed
17 the idea of having explicitly stated requirements
18 for the study. I think that is a very good idea.

19 My question is which review criteria would
20 this be put under?

21 MR. FOLEY: Need demand.

22 MS. BURMAN: We have talked about
23 unnecessary duplication and maldistribution. That
24 was one of the two sections that we are working on.

1 MR. SCAVOTTO: While you were talking,
2 Claire, Charles made the comment down here that a
3 market study would probably go under the demand
4 section, and you can extend it to this
5 maldistribution.

6 I agree with that. You and I have had this
7 discussion. I'm not going to leave without making
8 this comment. There is -- the semantics of
9 unnecessary duplication really bother me. It
10 implies there is necessary duplication, and I would
11 just love to see us get back to duplication. But
12 nonetheless, that's not going to happen. That and
13 fifty cents won't get me a cup of coffee.

14 MS. BURMAN: It is a term taken from the
15 statute.

16 MR. SCAVOTTO: I know. You know my position
17 on that. If it is in the statute, it doesn't mean
18 the statute can't be changed.

19 MS. BURMAN: Well --

20 MR. SCAVOTTO: So anyway, the market study
21 can go in the demand section.

22 MS. BURMAN: Then how should the
23 maldistribution and unnecessary duplication
24 requirements be handled?

1 MR. FOLEY: The market study can be
2 referenced there.

3 MR. SCAVOTTO: I agree with that, what he
4 said.

5 Did you hear that?

6 The market study can be incorporated. You
7 can incorporate the data from the market study into
8 this section.

9 MR. FOLEY: Or just reference it, make
10 comments about it.

11 MS. BURMAN: Yes, maldistribution is then
12 even distribution of services.

13 MS. AVERY: This is Courtney. I'm
14 wondering, thinking out loud if the conclusion can
15 be reached from the review of staff if a market
16 study dictates either one of the two are needed.

17 MR. SCAVOTTO: Say that again. I'm not with
18 you.

19 MS. AVERY: The staff, when staff reviews
20 the application and a market study, could there be
21 a question that would address this; does the market
22 study dictate a maldistribution or unnecessary
23 duplication or neither. So is that a requirement?

24 MR. SCAVOTTO: You could do that, but I

1 would, I would hope we'd be more realistic than
2 that because right now we are looking at a
3 situation in the State of Illinois where we have
4 lots of excess beds, like over 20,000 excess beds.

5 So I don't think we should be trying to
6 solve that problem. We are not going to be able to
7 solve that problem. It is just massive. It
8 doesn't really matter how we got to a position of
9 having excess beds. It is huge. We are never
10 going to convince so many providers to go out of
11 business.

12 I think what you want to, I think what you
13 want to accomplish is whether or not there is a
14 realistic, realistic forecast of the utilization in
15 the area, and that's what -- you know, if you are
16 looking at maldistribution, the answer -- if you
17 looked at maldistribution in the context of the
18 number of excess beds right now, nothing would
19 happen. It is just there is just no way any new
20 project should be built. One could take that
21 position. I don't think you should.

22 MS. BURMAN: This is Claire Burman again.
23 In terms of maldistribution, if you take a planning
24 area and let's say you have a big square as a

1 planning area, that means that if you have ten
2 health care facilities and eight of them are in the
3 upper northwest corner and the remaining ones are
4 scattered, that is a type of maldistribution.
5 It is linked to the too many services, but this is
6 different kind of focus.

7 MR. SCAVOTTO: Well --

8 MR. FOLEY: Claire, at the same time --
9 excuse me, Mike.

10 MR. SCAVOTTO: Go ahead, Charles.

11 MR. FOLEY: Before I forget it because I
12 have a tendency of forgetting things real fast --
13 see, I forgot already what I was going to say.

14 No, but Claire, on your suggestion there, if
15 you have a cluster of facilities in a specific
16 geographic area, that can mean one thing and one
17 thing only. That is because that's where the
18 population is.

19 Down here you may have no facilities at all
20 or just one, and that's only because there is no
21 bodies there.

22 So just because they're all clustered up
23 here, that really and truly does not represent a
24 maldistribution? I would not think --

1 MS. BURMAN: This is Claire again. It could
2 be the population issue that you just mentioned or
3 it could be because of a better payer mix in
4 certain --

5 MR. FOLEY: That is what the market study
6 will determine. That's what -- you are absolutely
7 correct. That's what the market study will show
8 hopefully.

9 MS. BURMAN: If you require that as one of
10 the pieces that should be part of that study.

11 MS. AVERY: This is Courtney. I think it
12 would be because when you were saying that I was
13 thinking it could be there are facilities there,
14 but are there beds for Medicaid/Medicare which goes
15 to the payer mix.

16 MR. SCAVOTTO: Let's stay with Claire's
17 example for a minute. Tim, you can relate to this.
18 So let's say you have got a cluster in one of those
19 corners. You are coming in at about 15,000 days
20 per 1,000 population. You -- some guy, Jason, the
21 guy in the blue shirt comes along with an
22 application to put another facility up there and
23 his utilization is going to be 17,500 per thousand.
24 He is out of step with reality. Your market study

1 should show that, and it should trigger a comment
2 from the staff.

3 On the other hand, if Jason has got more
4 sense, he'd put his facility down in the area where
5 there is less competition, and it would be a more
6 targeted location.

7 MR. FOLEY: If the bodies are there.

8 MR. SCAVOTTO: If the bodies are there,
9 correct.

10 MR. FOLEY: Right.

11 MR. SCAVOTTO: We rest our case.

12 MR. FOLEY: But Mike, aren't you also
13 mentioning that you want to get rid of the 90%?

14 MR. SCAVOTTO: Well, 90% was out the last
15 time. For modernization and renovation the minimum
16 occupancy was dropped. I'm not aware that it's
17 back in.

18 MS. BURMAN: It is not.

19 MR. SCAVOTTO: Good.

20 MR. CHAIRMAN: Well, first of all, I want to
21 thank Mike and Cece for all of the work they have
22 done. It's been a tremendous amount of time and
23 effort put into a very, very difficult subject, and
24 I think they have done an incredible amount of work

1 with staff support, and wherever it goes, you know,
2 it will have a final destination.

3 But again, thank you to the two of you, and
4 Eli, you know, did start with the two of you. So,
5 again, on behalf of the committee I want to thank
6 you all for doing that.

7 MR. URSO: Thank Eli, too.

8 MR. CHAIRMAN: Thank Eli, too. I'm sure he
9 is listening.

10 MR. URSO: I have a question. Mike and
11 Cece, maybe you said this or from the documents,
12 but who would be doing the market study?

13 I think -- you know, is it a formal company
14 or would it be an internal marketing study?

15 Did you give any thought to that, and, you
16 know, what is the preference?

17 MR. SCAVOTTO: Let me go first. Cece can
18 respond on her own. But I don't see where there is
19 any credibility to an internal market study. It
20 needs to be independent, and I just, I just can't
21 see any public policy relying on internal data if
22 you want, if you want an independent analysis and
23 one that can be verified by your staff. That's my
24 thought.

1 I'm not saying, I'm not saying that there
2 aren't people that are capable of doing an internal
3 market study. I recognize that there are plenty of
4 places that can do a fine market study internally,
5 but what is going to get examined in the public
6 like this is, i think it needs to be independent.

7 MR. FOLEY: For transparency.

8 MS. AMIANO: This is Amiano. There are
9 certainly -- my company is one of them. We have
10 adequate internal resources. We do this for other
11 companies.

12 So there would be -- you know, I think it is
13 -- you can't set criteria on who you use. I think
14 the board's role is to set criteria for what
15 elements need to be evaluated and up to the
16 applicant to evaluate those in a manner that they
17 see fit rather than to dictate who does it. It is
18 really what is the data that you are looking for
19 and let the applicant figure out how they are going
20 to get that data.

21 Not all facilities are single site
22 facilities. You know, particularly over the last
23 several years there's been lots and lots of
24 consolidation, and there is many companies in the

1 State of Illinois that have the internal ability to
2 do this, so --

3 MS. CREDILLE: This is Cece Credille. I
4 concur with Judy that you would have some people
5 who would need to hire from the outside and some
6 organizations would have the ability to meet the
7 criteria themselves. I agree that the Board, then,
8 we would need to, I don't know us, to review what
9 needs to be in the market study. I don't know how
10 this plays out.

11 MS. AMIANO: This whole thing might change
12 when we go to the next section of the conversation
13 here.

14 MS. BURMAN: This is Claire Burman again. I
15 don't know if anyone had the chance to read the
16 one-pager sent out with your materials, and under
17 overall consideration -- it is at the top -- there
18 is one fact that everybody remembers. That's we
19 have an excess of beds in Illinois.

20 Part of this also is -- and I guess we will
21 find out more when Judy gives her presentation on
22 buy/sell and development. There is a chance that
23 there will be some kind of moratorium in the
24 package. If that does happen, then the concerns

1 over these rules are minimized. You know, if it is
2 a full moratorium flat out, then we are not using
3 these rules. It just depends how that is going to
4 be structured.

5 So the other thing -- and I don't want to
6 rehash this, but I just want to remind you that
7 what I have learned from participating in these
8 meetings, and it's been a great learning experience
9 for everyone, was managed care is now in effect in
10 long-term care, and because of the way, if I am
11 understanding correctly, when a facility makes an
12 agreement with a managed care organization, the
13 referrals, the bulk of their referrals are going to
14 come from who they have agreements with. That's a
15 built-in referral source who can give you their
16 estimates of future referrals.

17 So I don't know if that is not true or if it
18 is more complicated.

19 MS. CREDILLE: Way more complicated.

20 MR. SCAVOTTO: I would say more complicated.

21 MS. BURMAN: Basically what we are trying to
22 find out from the applicant is how did you figure
23 out how many beds you are asking for, how did you
24 estimate that number, how did you estimate the

1 number of people that will be coming to you in a
2 year. That trickles down into when you figure out
3 how many and what kind of staffing that you are
4 going to need.

5 So sharing with the Board how you figured
6 this out, that's the bare bones of it.

7 MS. CREDILLE: This is Cece Credille. I'm
8 going to put on my hat of my job that I do on a
9 daily basis, and I work for HCR Manor Care, and I
10 have information from our organization. We operate
11 in 38 states, and this is the only state that
12 requires referral letters.

13 So letters, letters of support is what we
14 are accustomed to in working with and working with
15 whether it is a managed care organization,
16 hospitals, physician offices, home health agencies,
17 supportive living, whoever it is. The number of
18 agencies that letters of support are more
19 meaningful than referral letters, and as the health
20 care climate has changed with ACO's and managed
21 care contracts, the whole climate has changed.

22 So the concept of referral letters just
23 doesn't even work anymore quite honestly. We are
24 not doing it in any other state but this state.

1 MS. BURMAN: This is Claire again. It is a
2 means of how you estimated your numbers, and it is
3 not a problem for everyone. You know, if you are
4 talking about hospitals as a main referral source,
5 it may be or may not be. They know how people are
6 disposed. They know where people go, so --

7 MS. CREDILLE: So back to Mike's comment
8 that we can use Medicare data from the hospitals.
9 That's not all inclusive, but that data is already
10 there in terms of referral sources in a community.

11 MR. SCAVOTTO: Agreed.

12 MS. BURMAN: Just one more thing. This is
13 Claire. Discharge planning is not based just
14 around Medicare. Yeah, they have a commission on
15 all the patients. They have full departments doing
16 this. They have for quite awhile. So that's all
17 that I am going to say.

18 MR. SCAVOTTO: Claire, I think Cece and I
19 are going to stick to our position on this. If you
20 want to use the hospital data, go ahead. That's
21 fine. Just recognize that it is a limited data
22 set. You get 25% of the admissions from a
23 facility, fine. Maybe you get 30. But, you know,
24 you are missing a large percentage of the

1 admission, the admission experience of the
2 facility.

3 So at this point, at this point, I mean,
4 that's -- to me that's the way it is. We can't
5 change that. That's the business, and, you know,
6 if you look at referral letters from hospitals to
7 represent 100% of your patient population, that dog
8 ain't hunting.

9 MS. BURMAN: Excuse me, we don't ask for
10 hospital referrals, we ask for information from
11 your referral sources. That's the term, "referral
12 sources". It could be hospitals, it could be
13 social services, it could be people that live in
14 the neighborhood, you know, you could have a list
15 of people who know about your facilities.

16 Let's say you have more than one facility
17 and they think gee, it would be great. You know,
18 you took care of my mother. It would be great if
19 we had a facility from your operation but have one
20 located in our area because I have an aunt that is
21 going to be needing something soon. There is -- I
22 would assume you hear from people in the
23 communities.

24 MR. SCAVOTTO: Yes, you do.

1 MS. BURMAN: No?

2 MR. SCAVOTTO: Yes, you do. You do hear
3 from people in the community. You hear from them
4 all of the time.

5 MR. FOLEY: Can I make a comment? Charles
6 Foley.

7 Go ahead, Claire. I am sorry.

8 MS. BURMAN: No, I was going to say that
9 would be another type of information that would be
10 useful in terms of showing how you ran into your
11 estimate. You know, the question again is how did
12 you estimate your numbers.

13 MR. CHAIRMAN: It seems to me that in a
14 demand market study you are incorporating all of
15 this together.

16 So a referral letter -- having been in the
17 business maybe not quite as long as some but longer
18 than most, a referral letter sometimes is just a
19 phone call to someone in your Rolodex that says
20 give me a referral letter because I'm doing X, Y
21 and Z. It doesn't mean they will ever commit a
22 resident to you, it just means they are doing you a
23 favor of giving you a letter. It means nothing.

24 A market study, to me, has a great deal of

1 research to it and a quantitative determination of
2 what will come through your doors.

3 So I would certainly support and use
4 Michael's term and Cece's term, support concept
5 rather than referral concept because, again, I have
6 been around a long, long time. I have called a lot
7 of people asking for referral letters. It is
8 nothing more than sometimes a favor to you without
9 any commitment to follow through. For real.

10 MS. BURMAN: Okay. Well, I speak from
11 experience on the acute side. I have worked with
12 hospitals for quite a long time.

13 MR. CHAIRMAN: I can say health care in
14 general is different than hospitals.

15 MS. BURMAN: The hospitals that I was
16 employed by did not handle it in that manner.

17 MR. CHAIRMAN: That's my opinion. Certainly
18 anyone else sitting around the table is welcome to
19 share what they think.

20 MR. FOLEY: This is Charles Foley. Sorry.
21 Go ahead. Carolyn, want to say something? Go
22 ahead, Carolyn.

23 MS. HANDLER: This is Carolyn Handler. I
24 can support, you know, Michael's comment about from

1 the receiving end. I have been on the receiving
2 end of that request, you know, can I write a letter
3 of referral to support a CON application and really
4 didn't, wasn't in a position to necessarily deliver
5 on or couldn't commit that we would deliver.

6 I mean, if it was the right thing we would
7 deliver a referral, but if was not the right thing
8 there was not a referral delivered. But I have
9 been requested to write those letters.

10 MR. CHAIRMAN: Thank you. Chuck?

11 MR. FOLEY: I understand completely where
12 Claire is, where she is actually coming from. A
13 referral letter is not gospel. All it is is just
14 simply an indicator. It gives somebody just an
15 indication that there could be this number of
16 potential referrals. It is not, it is not intended
17 in any way, shape or form to be gospel.

18 It is a way, it is a mechanism, as Claire
19 has stated, to tell the planning board this is how
20 we arrived at 120 beds versus 99 beds versus 150
21 beds.

22 I also agree with the fact that if we have a
23 market study, a market study could, in fact, show
24 the same information. So within a market study if

1 you are going to have an indicator, you are going
2 to have to go to a hospital, that provider.

3 I think it is -- you know, again, it is not
4 a commitment in any way, shape or form. It doesn't
5 have to be a hospital. It can be a group of
6 doctors, it can be a local -- there is other
7 referring agencies. I think the staff has received
8 letters from different kinds of agencies, not just
9 hospitals.

10 Our office has never -- maybe I shouldn't
11 use the word "never". Maybe once we had a problem
12 of getting a letter, a referral from different
13 sources, but by and large in general we have never
14 had a problem in getting referral letters.

15 We try to tell them that it is not a
16 commitment. You can use a range of 1 to 3, 3 to 5
17 per month, 5 to 7 per month, you can use the word
18 "approximately". So thereby you are not -- the
19 person writing the letter is not committing
20 themselves that they are going to send that many
21 patients to your facility each month.

22 So it just depends on how you sit down and
23 talk with that provider, whoever that provider may
24 be. But again, if it is -- if we are going to have

1 a market study and if we determine what needs to go
2 into that market study, all we are trying to do is
3 just reaffirm the Board's numbers anyway; that the
4 Board is saying there is a need or if there is not
5 a need, there is not a need because -- you know,
6 you are going to address an issue, say of
7 maldistribution, and we talked about this cluster
8 up here in this corner, that may mean there is not
9 a need for beds because you have got all these
10 facilities, but yet that may not be true either
11 because you have to look at each and every single
12 facility and see who they are, what they are doing.

13 If there is a cluster of private pays over
14 here and no private pay, then you have got access
15 issue, and that is how you document a variance
16 under that access issue.

17 So you can still go to a referral source and
18 say we need, you know, a referral from the
19 hospital, not a commitment of any way, shape or
20 form. I don't think that's a major issue.

21 MS. CUNNINGHAM: Hi. This is Kelly
22 Cunningham from Healthcare and Family Services, and
23 I certainly am coming from a different perspective
24 maybe than most everyone around the table, but

1 there are just a couple of thoughts that I'd kind
2 of like to share about this.

3 In terms of the concept of support, I think
4 that that is something that would be very important
5 to, you know, include in any kind of application
6 process, especially given there's been a lot of
7 illusions to the changes in the long-term care
8 arena and health care arena now.

9 I think that the facilities or applicants
10 that are considering applying for new nursing home
11 beds or to build a new facility, I think there are
12 many more factors at play than the concept that the
13 referral letter was designed to address, take into
14 account.

15 Those might be things like the greater
16 availability of home and community-based services
17 in an area that are outside the realm of a
18 facility, the whole role of managed care and
19 coordinated care and the decisions that those
20 entities are going to make and how and for how long
21 individuals that are sent to long-term care
22 facilities are going to be in residence there.

23 I also think, too, it is really important
24 this whole concept of the market study, and I would

1 agree. I think Judy made the comment it may not
2 matter who does the market study. It is really an
3 interpretation of the data and in terms of the
4 state and the Board setting out what the
5 requirements are for the market study in terms of
6 qualifications because I think a market study, if
7 you don't have very strict parameters about the
8 data, about what you're measuring, how you are
9 calculating it, a market study can say about
10 anything you want it to.

11 MR. SCAVOTTO: That's true.

12 MS. CUNNINGHAM: And I do know that from
13 experience with the supportive living program. If
14 you set your catchment area very, very wide, you
15 can manipulate your market penetration rates.

16 MR. SCAVOTTO: You can justify anything.

17 MS. CUNNINGHAM: You can justify anything.

18 So I just wanted to sort of point out that I think
19 this whole concept of moving towards some concept
20 of a support letter, something that exhibits that a
21 relationship is there and that it is a positive
22 relationship and that it is less about a commitment
23 to a specific number of residents or individuals
24 being sent because I would think honestly even in

1 the hospital world with just all of the changes in
2 health care, that that has to be a very difficult
3 position for any provider in health care to make
4 right now.

5 MR. CHAIRMAN: Yes?

6 MR. GAFFNER: Alan Gaffner. The market
7 study would be a very valuable and objective tool.
8 I think there is great credence for what they
9 propose.

10 I do not believe that we should overlook the
11 importance, however, of the subjective data that
12 does come either under the umbrella of a letter of
13 referral or a letter of support in that.

14 We all know that there are many factors both
15 objective and subjective that will determine the
16 ultimate success of any facility expansion or a new
17 one.

18 So certainly the objective data from the
19 market study, although it would indicate that the
20 numbers are there, that does not indicate that
21 facility will ultimately be filled if there are
22 some underlying factors that will not allow it to
23 be successful in the marketplace.

24 The other thing that I would caution us

1 about is not to rely heavily on what managed care
2 is going to do to the long-term care community when
3 we are simply standing, waiting for that train to
4 arrive.

5 Yes, we know it is coming, but unfortunately
6 the managed care concept in the state has not
7 proven to be successful. Those of us that have had
8 acute care experience know that those managed care
9 entities fled the state, threw up their hands, said
10 can't do it.

11 So although we know it is coming, it is
12 going to certainly come more quickly in urban areas
13 and less quickly in rural areas. I don't believe
14 that we can model it on what all other states are
15 doing. I think we should take a very deliberate
16 approach and look at what is being done well and
17 not well in other states.

18 But Illinois is very unique in that it has a
19 very large urban concentration very far north, and
20 it has a very rural concentration in other areas
21 where managed care is going to get to likely much
22 less quickly. They will not be able to be a good
23 indicator of what is going to happen from a
24 referral standpoint.

1 I'm not discounting at all what you have
2 suggested, Mike. I think it has good staff support
3 and has importance, but I want to not bank too
4 heavily on managed care and not overlook the
5 importance of subjective data as well. That's why
6 we have staff, and that's why we have the
7 nine-member board. Those skill sets and talents
8 come together, sort through all of this and end up
9 with the final product. Thank you.

10 MR. FOLEY: Very well said.

11 Mr. Chairman?

12 MR. CHAIRMAN: Yes, sir.

13 MR. FOLEY: This is what even Kelly was
14 saying. Our own application form does specifically
15 state, provide letters from referral sources,
16 parenthesis, hospitals, physician, social services
17 and others.

18 So you can go to other agencies. It does
19 not have to even be a hospital because there are,
20 in fact, other referral sources out there.

21 So I still think that as an indicator of
22 need, I still believe at least that something
23 should be provided either in a separate letter with
24 any application or even part of the market study.

1 MR. CHAIRMAN: I guess at this point of the
2 discussion I'm getting confused. When I am trying
3 to flip back in my mind, I think we are all saying
4 the same thing. We all agree that there needs to
5 be some documentation that demonstrates how we
6 arrived at our numbers. Whether it is a market
7 study that incorporates support letters or a market
8 study that incorporates referral letters, we are
9 all saying the same thing.

10 Are we not? Am I missing something?

11 MR. GAFFNER: This is Alan Gaffner. The
12 only reason I said what I did contrasting objective
13 and subjective, I thought and perhaps
14 misunderstood, that some were suggesting that
15 either the referral letters would go away or that
16 that would no longer be part of the process.

17 I would not support incorporating of the
18 full blown market study would be done at the
19 exclusion of those other types of justifications.

20 MR. SCAVOTTO: Support letters always
21 welcome.

22 MR. GAFFNER: But I think there can be value
23 -- excuse me. Go ahead, Mr. Chairman.

24 MR. CHAIRMAN: I don't know how you can do a

1 market study without the inclusion of support
2 letters or referral letters. That's a key piece of
3 a market study.

4 Michael, am I wrong?

5 MR. SCAVOTTO: No, I think we are saying the
6 same thing, although I think for -- in our parlance
7 we were thinking that a support letter would be a
8 better characterization than a referral letter.
9 You are not going to get it all with referrals.

10 MR. CHAIRMAN: So Michael, what do you need
11 from us to move forward?

12 I want to make sure we have enough time for
13 Judy and her report and her committee to report.

14 MR. SCAVOTTO: As far as I'm concerned you
15 have got our report, and I would add to it today
16 Charles' comment on the market study.

17 I would -- you know, we are circling the
18 wagons on this thing as we did the last couple of
19 meetings. I think vote it up or vote it down.

20 MR. CHAIRMAN: So unless someone has
21 something else that they want to add to this
22 discussion, because I think we are going in circles
23 right now -- we are basically in agreement with
24 what is being said.

1 I would like for a motion to accept the
2 report from Michael and Cece that incorporates two
3 changes to what was previously done.

4 Michael, do you want to make a motion since
5 it is coming from your --

6 MR. SCAVOTTO: Well said. I make that
7 motion.

8 MR. CHAIRMAN: Will someone second it?

9 MS. CREDILLE: I second it.

10 MR. CHAIRMAN: Okay.

11 MR. FOLEY: You going to have discussion?

12 MR. CHAIRMAN: The motion is basically to
13 accept Michael's report.

14 MS. AVERY: Which report?

15 MR. CHAIRMAN: The one he just gave an hour
16 and a half ago.

17 MS. AVERY: So to get rid of letters of
18 referral, put in market studies overall?

19 MS. BURMAN: Incorporate it into the market
20 study.

21 MS. AVERY: We will have to get rid of that
22 and then put it into the market study.

23 MR. CHAIRMAN: Sorry. Say it again.

24 MS. AVERY: We will have to get rid of that

1 section and then make sure it is spelled out in the
2 market study.

3 MS. BURMAN: Before we revise it, we will
4 essentially get rid of it.

5 MR. CHAIRMAN: Michael, did you hear what
6 was being said?

7 MR. SCAVOTTO: I think so. I think I could
8 paraphrase it maybe a little differently.

9 Courtney, I think we are suggesting that the
10 market study be incorporated into the demand
11 sections of the application.

12 MR. CHAIRMAN: Yes, sir.

13 MR. OURTH: Joe Ourth. A couple things on
14 the market study.

15 As Mike Constantino probably remembers,
16 twenty years ago. It was not uncommon to have
17 market studies as part of that. Then what would
18 happen is you get the market study, everyone would
19 take the good part of the market study out and
20 leave all of the rest of it, Xerox it, submit the
21 good stuff, and then Mike and others started saying
22 no, if you are going to give us a market study, you
23 need to give us the whole market study.

24 there became a little bit of a cottage

1 industry where you would do -- there were market
2 studies that were done for the bankers and making
3 the real decisions and market studies done to give
4 to the planning board. Every market study ever
5 submitted founded a need for.

6 So if you are going to do that market study
7 kind of thing, you know, some people are thinking
8 about is this an independent thing, is it going to
9 be basically an argument for that. It makes a
10 difference.

11 The other is others can probably give you a
12 better estimate, but if you are going to look for
13 an independent market study that's good, you know,
14 you may be talking 20, \$30,000 to do that.

15 So that, you know, you may want to consider
16 for the community do you want -- if you are wanting
17 a market study that's worth anything, it is going
18 to add 20 or \$30,000 to the price of that and, you
19 know, whether or not you want to do that.

20 MR. CHAIRMAN: But you are talking about
21 multi-million projects. To build a nursing home
22 you are talking about millions of dollars, so
23 20,000 is nothing. So I don't have a problem with
24 that. I don't.

1 MR. FOLEY: Well, Mr. Chairman, I understand
2 what Joe is saying. Joe is absolutely correct.
3 Our intent originally was try to keep the initial
4 cost for an applicant down to a minimum until such
5 time when he got a permit.

6 Twenty, \$30,000 up front plus an application
7 fee up front, you are talking before an application
8 can be filed and depending on the size of the
9 project, you could be talking \$100,000 on up, okay?

10 You also have the option on the land that
11 has to be included in that cost. There are going
12 to be some attorney's fees, going to be other fees.
13 So we are talking about a substantial amount of
14 money.

15 However, still supporting a market study and
16 understanding where Joe is coming from because what
17 he said was absolutely correct, if we could --
18 maybe a market study is the wrong word to use also.
19 -- but if we can have a document that could
20 incorporate certain aspects that are usually found
21 in a market study, that would help, you know, to
22 determine the need further.

23 Maybe that's what is needed so that we can
24 keep that cost down of a market study so it is not

1 20, 30, 40. I have seen them up to \$75,000, you
2 know, for a market study.

3 What increases the cost of a market study is
4 if one has to go out and do a lot of legwork. When
5 you are in Chicago and you have got a planning area
6 where you have got competition within 15 miles or
7 within 15 minutes you have got 40 facilities, and
8 you go out and you got to do an assessment on each
9 and every single one of those facilities, you are
10 jingling a lot of money.

11 MR. SCAVOTTO: You are really looking at
12 demand.

13 MR. FOLEY: Absolutely correct. You have
14 got profiles give you a lot of that information
15 that is usually also in terms of a facility
16 analysis. That's all right in the profiles. We
17 don't have to have that kind of a market study.

18 MR. SCAVOTTO: Don't have to do the secret
19 shopper routine. You look strictly at demand.

20 MR. FOLEY: That is absolutely correct. So
21 if we are going to have a market study, we need to
22 define what a market study is going to include.

23 MR. CHAIRMAN: All right. Chuck, hold on.
24 Frank?

1 MR. URSO: Mr. Chair, maybe if this
2 subcommittee is accepting the report of
3 Mr. Scavotto and Cece, maybe staff can then step
4 back, take a look at what has been proved and then
5 maybe come up with some parameters and some
6 verbiage that could be incorporated into the demand
7 section if that's where everyone thinks it should
8 fit and then, you know, put that on the table and
9 have this committee discuss it at the next meeting
10 or something.

11 MR. CHAIRMAN: Michael, as the lead in this
12 are you okay with that?

13 MR. SCAVOTTO: Yeah.

14 MR. FOLEY: One more meeting, Michael.

15 MR. SCAVOTTO: That's sufficiently vague to
16 be workable.

17 MS. AVERY: This is Courtney. I just want
18 to know a little bit of a snapshot.

19 When providers or owners of a facility are
20 looking to expand beds, add beds, discontinue beds,
21 whatever, what is used in lieu of?

22 Is it a strategic planning document or is it
23 a market study that's kept internally?

24 What do providers use to make the

1 determination?

2 MR. CHAIRMAN: I think what Courtney is
3 asking, Judy, if you are going to build a new
4 facility, how, where, what are you going to start
5 with?

6 MR. FOLEY: Bed need. If there is bed need
7 in a planning area, that's where they start.

8 MR. CHAIRMAN: Hold on.

9 MR. FOLEY: I'm sorry. My apologies.

10 MR. CHAIRMAN: I'm not going to allow you in
11 Springfield anymore.

12 MS. AMIANO: So, you know, clearly we would
13 go through some of the same machinations that are
14 being talked about here in terms of what is, what
15 is needed in the marketplace, you know, what needs
16 are being unmet in that market place, how might we
17 fill them in.

18 I will go back to the referral or support
19 letters. They are, I would just say, absolutely
20 useless. We would never do those just for internal
21 because we know what the marketplace is, and it is
22 an exercise and a lot of time that doesn't yield
23 you anything because there is no guarantee of those
24 at all. It is all about relationships and types of

1 services that you provide.

2 So I would just add one more layer that I
3 would support that we go away from those, but we do
4 look at, you know, what is the population, what is
5 the age banding of the population.

6 That is not as specific as it used to be,
7 though, because now with managed care we get a lot
8 younger people as I'm sure Cece does in her company
9 as well.

10 So the dynamics keep changing. You know, it
11 used to be a three-day stay and deal with
12 hospitals. We have several of our places that have
13 waivers on that. We have direct admits from ER's.

14 So all of the rules keep changing, and so
15 that part is very difficult.

16 MR. URSO: You have to keep in mind that you
17 have to justify --

18 MS. AMIANO: We always have to justify. We
19 have a board.

20 MR. URSO: Let me finish. You have to
21 justify, however you come up with your decision,
22 you have to justify it to the Health Facilities and
23 Services Review Board, and they may be looking at
24 it differently than your board, of course, because

1 your board is going say are we going to make money
2 or is it going to be successful, you know, whatever
3 the parameters.

4 MS. AMIANO: That would not be our first
5 question but --

6 MR. URSO: I don't know if it is, but I'm
7 thinking that your board would be looking at it
8 differently than the Health Facilities and Services
9 Review Board which has to take a look at need and
10 access to care and unnecessary duplication and
11 things along that nature which may be different and
12 I think would be very different than what your
13 board, your banker, your supporters would be
14 looking at.

15 So something needs to come into the mix when
16 you present the package to the Board, to the Health
17 Facilities and Services Review Board, how do you
18 justify this to them.

19 We are not going to be looking at it the
20 same way your internal strategies, you know, would
21 look at it and your business plan and your
22 documents to the bank and your board.

23 MS. AMIANO: Right, although many elements
24 would be very similar.

1 MR. URSO: Yes, I agree.

2 MS. AMIANO: You know, no one wants to build
3 an unsuccessful project. I think everyone does
4 their best to be -- to do their proper diligence to
5 be sure you are going to be successful.

6 Now, is that at the cost of another
7 provider? It may be, and that goes into
8 innovation.

9 What does the market want? What does the
10 consumer want? Where should the consumer be in
11 this conversation?

12 We have very different inventory in the
13 State of Illinois, and I think that was one of our
14 initial premises of this committee is how do we
15 move forward and allow for innovation and trying to
16 update inventory and trying to meet the needs of
17 the consumer of today. So we are all challenged by
18 this.

19 MS. AVERY: My second part, of course, I was
20 a toddler 20 years ago, but did providers welcome
21 the market study?

22 What happened that it went away?

23 Do you know why we changed to a letter?

24 MR. OURTH: Mike, you were around then.

1 MR. FOLEY: I think that it was a little bit
2 of expense, and it was also a little bit of every
3 market study -- because what would happen, every
4 market study would cherry pick all the right
5 materials to show that, and so I think it was a
6 combination that it kind of fell away. It was
7 always optional.

8 MS. AVERY: Even with the cost minimum on a
9 multi-million dollar projects, that that would go
10 against what the Board is charged with on another
11 aspect with cost.

12 I was wondering if people were saying these
13 market studies cost us too much, you are supposed
14 to be about cost containment but you are adding
15 another level, and this is going to cost us
16 probably up to \$75,000 extra.

17 MR. OURTH: I don't remember all of the
18 reasons it fell away.

19 MS. AVERY: Okay. Thanks.

20 MR. CHAIRMAN: Steve, your client base, how
21 do you feel about this whole discussion about
22 market studies and costs and investment, all that
23 good stuff?

24 MR. LAVENDA: Sure. This is Steve Lavenda.

1 You know, most of our clients have not built any
2 new places in quite some time. I mean, I can think
3 of one in the last ten years. Mostly the clients
4 who we deal with are in the acquiring mode. They
5 are -- you mentioned consolidation before. I think
6 the thing to build a new facility currently is just
7 so expensive that people are just acquiring new
8 facilities and modernizing them.

9 If you build a new facility, looking at it
10 from a Public Aid rate standpoint, the most that
11 you can get is close to \$50,000 a bed for your
12 reimbursement basis whereas the actual cost of
13 building one is well over 120,000 per bed. A huge
14 disparity there.

15 If the goal of this committee is to help
16 serve the Public Aid population, you know,
17 something has to be done on the reimbursement end
18 to encourage new construction.

19 MS. AVERY: And the \$120,000 fits into not
20 just the actual room but the overall facility? So
21 if you have whatever amenities, fancy ice cream
22 shops, waiting rooms, things of that nature?

23 MR. LAVENDA: If you are going to go that
24 route, it may be a little bit higher. I have not

1 looked at it in awhile.

2 Also, don't forget that at one time you
3 could build a 250-bed facility and maybe the cost
4 per bed would be a little bit less, but I believe
5 most of the projects now have to be 200 beds or
6 under. So that cost per bed is going to go up.

7 MS. AVERY: I understand totally that you
8 have to have those amenities outside of the room in
9 order to attract people to want to come there. Got
10 to have some kind of attraction.

11 MS. LAVENDA: Even from what we see, urban
12 area homes have done an awful lot the last number
13 of years to modernize or make their facilities more
14 attractive.

15 I mean, I see it because one of the things
16 that we do is we file for rate increases based on
17 their capital improvement spending, and I know that
18 our homes we are filing about 40 or 50 of these a
19 year. I know we are not the only firm doing it.
20 So I know there are homes out there that are
21 investing, you know, in their property.

22 Now, some of it the last two years has to do
23 with the sprinklers, but, again, it is not --
24 again, I see a lot of this. It is not all

1 sprinklers. It is some of the things that Courtney
2 just mentioned, you know, the ice cream shops or
3 the theaters or the barber beauty, just things to
4 make it a little more home like.

5 But certainly the new construction, most of
6 our clients have shied away from it.

7 MR. CHAIRMAN: How much time do you need for
8 your --

9 MS. AMIANO: Depends how much discussion
10 there is.

11 MR. CHAIRMAN: I want to make sure you have
12 enough time.

13 MS. AMIANO: A lot of it dovetails.

14 MR. CHAIRMAN: Unfortunately -- if we were
15 in our usual mode, you know, then there wouldn't be
16 a time that we are up against. Today we are up
17 against 1:30, right?

18 So I would like to then take Frank's
19 suggestion and put this back -- Michael and Cece,
20 this is incredible work -- give it back to staff,
21 let them kind of redesign it.

22 For the purpose of the court reporter, would
23 you recognize that Bill Casper has joined?

24 (Bill Casper now present.)

1 MR. CHAIRMAN: And if no one has any
2 objections, then I would propose that we take
3 Michael's and Cece's suggestion, give it to staff,
4 let them incorporate it into some language and
5 bring it back to our meeting and then take a 15 or
6 20-minute lunch break and then let Judy and her
7 group go to town.

8 MS. AMIANO: Even a five or ten-minute break
9 if people need to get something.

10 MS. AVERY: Are you all going out for lunch?
11 Did you order lunch in?

12 MR. FOLEY: There is no place to order from.

13 MR. SCAVOTTO: No, we didn't order anything.

14 MR. CHAIRMAN: Do you want to take a
15 ten-minute potty break, phone break and stand up,
16 stretch, then those that are eating lunch, we will
17 work through lunch? I'm fine with that, too.

18 MS. AVERY: I apologize. Next time we will
19 have a menu there in the beginning to order from.

20 MR. CHAIRMAN: So we will --

21 MR. GAFFNER: May I ask a question as to
22 what we are recommending to staff?

23 Does that include their consideration of the
24 letter of referral issue, or is that not part of

1 it?

2 MR. SCAVOTTO: Yes, it is part.

3 MR. GAFFNER: So they would be considering
4 whether to let them remain or to remove them; is
5 that correct?

6 All right. Thank you. I was getting an
7 explanation from Michael. You couldn't hear it.
8 Thank you.

9 MR. CHAIRMAN: Anyone have any problem with
10 what we are suggesting?

11 (No response.)

12 MR. CHAIRMAN: Not hearing any, then we will
13 take a ten-minute break.

14 (A lunch break was taken.)

15 MS. AVERY: Okay. We are ready. I have got
16 it.

17 MR. CHAIRMAN: Okay. We are going to -- we
18 are turning the meeting over to Judy and her group
19 or just Judy?

20 MS. AMIANO: Well, I think we will all
21 participate, so thank you.

22 First I want to acknowledge the team
23 members. Tim Phillippe has been participating, and
24 we are glad to see you back.

1 MR. PHILLIPPE: Thank you.

2 MS. AMIANO: Cece and then Bill Casper and
3 myself. So the four of us have met several times
4 in person and by phone. And really to put it in
5 context, our goal was to be able to maybe put these
6 together in a way that we could move forward
7 because we seemed to be rather circular over the
8 last few years in some of these issues that we were
9 stuck on.

10 So what you will hear from us today is
11 probably nothing earth shattering, but we tried to
12 put it within a context that when you see the
13 whole, folks might be able to have maybe a
14 different picture of it then get stuck on each
15 little point.

16 I think what we'd like to do is walk through
17 the document that you have in front of you, and we
18 will just maybe hold questions to the end so we
19 don't get knotted up on any one singular issue
20 until we have a chance to go through it.

21 So if you turn to page 2, we really start
22 our first section saying let's go back to the
23 beginning; what problem is it that we are really
24 trying to solve here.

1 As you can see with the sides of the bubble
2 so to speak, the thing that we tried to keep
3 centralized -- I think one of the original people
4 on this group. How many years has it been?

5 So four years that, you know, one of our
6 major charges was how do we allow for innovation in
7 the State of Illinois given all of the other
8 concerns that we have in the long-term care field.

9 We also were looking at access. So we know
10 that access for the poor is an important issue and
11 how do we ensure there is proper access throughout
12 the state.

13 This bubble should be bigger, but the excess
14 bed is probably the 100-pound elephant in the room
15 or 1,000-pound elephant in the room.

16 I went back to my original notes. Job
17 creation was one of the other things, although that
18 probably has become more minor over time, but
19 generation of construction and new jobs was one of
20 the special interest groups that were originally
21 represented.

22 Then this whole notion of lack of capital.
23 There is no funding, you know, there is not enough
24 money in the system to recapitalize what is there,

1 how do you build new. It all goes back to
2 innovation and how do we provide residents in the
3 State of Illinois new and better services given
4 some of these constraints.

5 That was just kind before we get into a
6 discussion let's all agree on this piece. I just
7 wanted to share with you that was our framework
8 that we started with as we went forward.

9 I will tell you that the four of us are not
10 in complete agreement with everything that you will
11 see here, but we believe that it is important
12 enough that we put it together this way so that it
13 gives the group an opportunity to weigh in and each
14 of us to learn from one another and be able to move
15 this forward.

16 So flipping over to the kind of the decision
17 tree, if you will. So the buy/sell, I think the
18 group has pretty well agreed based on the last
19 couple of meetings that buy/sell is the way that we
20 want to go.

21 So we are saying if we implement buy/sell,
22 if a decision -- would you guys mind muting on your
23 side for a minute? There is a lot of background
24 noise.

1 So the group talked through that for some
2 reason and decided buy/sell was a no, then this
3 group should really disband. That would be our
4 recommendation because we are not -- we won't be
5 able to move forward.

6 MS. AVERY: The work group or the
7 subcommittee?

8 MS. AMIANO: Probably the broader group.

9 MS. AVERY: Remember, it is more than
10 buy/sell you all are charged with.

11 MS. AMIANO: We know that, so --

12 MS. AVERY: So don't disband.

13 MS. AMIANO: It was just a strong point.
14 How do we get change? How do we get off the dime?

15 So if the answer is yes, our recommendation
16 would be that we implement a freeze on the
17 long-term care beds. When we went through all of
18 the ramifications of what that meant and what the
19 existing variances are that are allotted to
20 providers in the state, we decided to kind of get
21 rid of all the variances with the exception of CCRC
22 and the religious exemption.

23 That was based off of, you know, in talking
24 with Claire. There's been very little in that

1 bucket anyway, and so it didn't seem to upset the
2 apple -- why upset that apple cart if it is not
3 being utilized type of thing. So that variance is
4 in there.

5 So if you move onto the next page, you know,
6 --

7 MR. CASPER: I think the other element of
8 that, implementing a freeze, we have had a lot of
9 discussion about that and came really to the
10 conclusion that just about every state we looked at
11 with a buy/sell program had a freeze in place, and
12 if there was not a freeze, then there really was no
13 reason for people to buy or sell beds, and it
14 really then dodged the entire bullet of the excess
15 bed issue.

16 MR. URSO: Do you mean a moratorium? Is
17 that the same thing?

18 MS. AMIANO: Moratorium and freeze.
19 I will tell you that all of us -- and we represent
20 different groups -- went to our various groups and
21 are in 100% support of this particular piece of our
22 recommendation. So coming from providers that's
23 big. That was a big step.

24 MS. AVERY: Can you tell me the groups?

1 MS. AMIANO: We have a consensus on that
2 issue.

3 MS. AVERY: What was the groups, Cece -- I'm
4 sorry, Judy?

5 MS. AMIANO: Pardon?

6 MS. AVERY: Which group?

7 MS. AMIANO: Went through Leading Age,
8 Illinois Health Care.

9 MS. AVERY: Okay.

10 MR. LAVENDA: What about HCCI?

11 MS. AMIANO: They are not in this work
12 group.

13 So we will kind of keep on. So in terms,
14 you know, kind of how do we get there, what does it
15 look like if we implement the buy/sell and we have
16 a moratorium in place, our recommendation would be
17 to buy beds without restrictions of geography.

18 We talked about and looked at that, and
19 several of us work in multiple states. So, you
20 know, some of that very early research that was
21 done, some places restricted it, some places
22 didn't. It looked like it was effective with no
23 restriction. So our recommendation would be let's
24 go in open minded and not have restrictions in

1 terms of geography in the buy/sell.

2 We also tried to think about, you know, what
3 are we doing with the excess bed issue, and there
4 are a couple -- you will see a couple of
5 recommendations in here on how to start to begin to
6 address that piece of it.

7 One would be in the buy/sell program provide
8 for a premium, if you will. So if I am selling
9 beds, that I have to give 15% back to the state
10 with any of those transactions, and it would be on
11 the sell side of things is what we talked about for
12 that.

13 Does that make sense?

14 So we went through all these issues on what
15 do you do with rounding and then said, you know,
16 kindergarten rules apply. If it is --

17 MR. CASPER: I thought they were tax rules.

18 MR. LAVENDA: We can ask Steve. I don't
19 know.

20 MR. CHAIRMAN: Judy, just to make sure I
21 understand, if I sell 100 beds, I have to give 15
22 of those back to the state, take them out of --

23 MS. AMIANO: In addition. So however you
24 want to think about that.

1 MR. CHAIRMAN: Or sell 100, then 15 back to
2 the state on top of that or sell 85 and 15 back?

3 MS. AMIANO: However you want to think about
4 that, but the state gets 15% with any transaction
5 back and standard rounding rules apply. MR.

6 OURTH: Fifteen percent of 85 would not 15. I
7 can't do that math in my head but -- MS.

8 CREDILLE: Other states have had similar kinds of
9 programs.

10 MS. AMIANO: I want to say if you guys want
11 to take off mute now that all of the lunch papers
12 are done. We don't want to exclude you guys from
13 the conversation.

14 so keeping on through this, one of the other
15 concerns was access. So when we looked at this, we
16 said well, how do we begin to address that if
17 buy/sell is going only go in the marketplaces that
18 it is certain payer that is being sought.

19 So we looked at it and said what if we
20 offered that for anything that triggered over 100
21 beds, because sometimes it is smaller, with smaller
22 facilities to be able to survive on the Medicaid
23 rates in the State of Illinois, but 100 seems
24 reasonable because you have got enough density, if

1 you will, that anything that was over 100 beds
2 licensed facility at 20% of them at a minimum would
3 have to be certified for Public Aid.

4 We also said implementation. I know there
5 has been a lot of conversation around, you know, do
6 we pilot this in certain areas. We said, you know,
7 that's probably a recipe for disaster. If we do
8 it, we jump straight in and do it immediately and
9 do it statewide. That is our recommendation on
10 that. Moving to the next page, we have had a
11 lot of conversation around how does this get
12 started, who pays the price. Price will be
13 dictated by the market. We will just let the
14 marketplace do that. The states where they --
15 in our evaluation the states that tried to impose
16 metrics around that seemed to falter a little bit.
17 So let the market reign.

18 For those of us that have experience in
19 multiple states, we didn't find where folks were
20 way on one end, way on the other. It tends to
21 migrate to market and that we would look at that
22 happening.

23 On the CON review process, what does that
24 look like if you have a buy/sell? So it really

1 would be very expedited. So a transaction between
2 parties would be, you know, essentially a 60-day
3 review, but things that would fall into a more
4 substantive type of review would be anything that
5 was a new facility.

6 We define new facility as any project that
7 adds beds where none currently exist. So it wasn't
8 really by size or anything like that. If you are
9 putting brand new beds somewhere, that's going to
10 get a more substantive review than if you are just
11 modifying, adding, deleting through the buy/sell
12 program.

13 We talked about, you know, when, if Cece
14 sells beds to me, when do I own them, what does
15 that look like in that transaction.

16 So we really felt that the CON review
17 process was the determinate for that. So once you
18 were awarded within that 60-day time frame, then
19 that's when the actual transaction would happen.

20 We also talked about, you know, how -- what
21 would happen if people tried to hoard beds type of
22 thing. And we have all kinds of conversation
23 around that; how do we legislate to the lowest
24 common denominator.

1 So we tried to take some of that into
2 account here. We said, you know, really that if
3 you don't put a shovel in the ground in 18 months,
4 then those beds all come back to where they came
5 from.

6 MS. AVERY: Part of it -- this is Courtney.
7 Sorry. Part of it with new construction is that
8 someone can purchase beds to establish a new
9 facility?

10 MS. AMIANO: Yes, we have to buy them from
11 someone somewhere without restriction to geography.

12 MS. AVERY: But you still have to look at
13 the need formulas?

14 MS. AMIANO: Let me keep going. Let me keep
15 going. We will go back to that.

16 So the next page is -- you know, the big
17 elephant in the room is what do you do to get
18 unused beds out of service, and that's really an
19 elephant.

20 This is one point we don't have agreement
21 within our group necessarily, but we put this forth
22 as a recommendation acknowledging that there has to
23 be a mechanism at some point in time get these
24 mechanism at some point to get the 20,000 extra

1 beds out of inventory because the whole bed need
2 formula doesn't currently make sense with all the
3 excess beds.

4 So if we were being very honest, then, you
5 know, we would recommend that the department
6 implement rules regarding how long you can, the
7 operator can have beds without operating them.

8 So we would make that as a recommendation.
9 So all of the beds that are out there that are not
10 in service, how do you begin to do that?

11 We talked about perhaps offering a premium.
12 So that, for example, in the first 24 months if we
13 implement the buy/sell program, that providers at
14 the end of 24 months would be at risk of losing
15 some of their licensed beds if they didn't sell
16 them.

17 So at the end of 24 months if you are below
18 the 80% occupancy, which the state's average is
19 what, 79%, right?

20 MS. AVERY: Seventy.

21 MS. AMIANO: So we talked about establishing
22 a threshold.

23 How do you get buy/sell starting to work?

24 What is going to motivate people to do that

1 if they are at risk of losing some of those beds or
2 making a profit off of those beds in that 24
3 months?

4 That would be an excellent way to kick start
5 the program. It would be risk free for the
6 providers, and it would help to start shuffling
7 this process.

8 So, you know, we talked about we have got
9 80% in there as a number. So if you are below 80%
10 occupancy, then you might be at risk of losing 10%
11 of the beds that are above that down to the 80%
12 level type of thing.

13 So, you know, it would force people to look
14 at what are the licenses that they have that are
15 not being used and do I sell them to another
16 operator or do I risk them being called back by the
17 state at some point in time.

18 So we looked at that as something as a
19 biennial or every other year type of process. You
20 have kind of a two-year window of time because the
21 acknowledgment if you are running a Medicare
22 population, that can be wildly fluctuating, you
23 know. But a two-year period of time is a good
24 period of time to look at an average of occupancy

1 and to start to address that.

2 Then our last point which is not new to
3 anyone is that the bed need formula needs to be
4 revised but for four different reasons that you
5 will see here.

6 If we implement buy/sell, if we implement
7 the fall back, then fundamentally the existing
8 formulas, we are going to create artificial demand.
9 When you start to take beds out of service
10 occupancy is going to come up to 90% when it would
11 have been 70 before. So, you know, does that make
12 sense, then?

13 So the whole bed need formula we believe
14 needs to be evaluated in the context of if you do
15 buy/sell, if you are doing a retrieval of excess
16 beds, then you have to revisit the entire bed need
17 formula.

18 Bill or Tim, did you want to add anything?

19 MR. PHILLIPPE: That was a great summary.
20 Very well put together. Thank you.

21 MR. CHAIRMAN: I will open the floor up to
22 questions from anybody or comments.

23 MR. GAFFNER: Thank you, Mr. Chairman. This
24 is Alan Gaffner.

1 About the time it was muted, I think the
2 question was asked about the provider constituency
3 and their support. I believe I heard it indicated
4 that IHCA had either weighed in or approved, and
5 then the question was asked what about HCCI. I
6 didn't hear an answer on that. And then I would
7 also just ask about the Council on Long-Term Care,
8 if they have weighed in as well, please.

9 MS. AMIANO: They were not part of the
10 subcommittee, so we were just referencing that the
11 participants on this went up the flag pole with
12 their, who they were representing.

13 MR. GAFFNER: I know this is my first
14 meeting here today.

15 Am I, then, assuming that since those two
16 groups which comprise almost 50% of the Medicaid
17 beds have not seen or been exposed to this, this is
18 going on the table today and it is not an action
19 item?

20 MS. AMIANO: It was just a work group of the
21 committee, and we were reporting back on
22 recommendations not too dissimilar, Alan, to what
23 Mike and Cece presented. It is just a subgroup to
24 try and, try and take some of these concepts and

1 work them through and think them through without
2 all of the -- I don't know what word I want to use
3 here.

4 This is your first meeting, you know, and it
5 has been challenging on any singular one of these
6 concepts to be able to move it forward, either to
7 accept it or reject it. It's been in inertia for
8 some period of time. It was really an effort from
9 the last meeting we had, a group of us that just
10 said let us just see if we can work on this and
11 come back and talk about it.

12 This is really just a discussion. This is
13 not a motion for accepting in totality or anything
14 like that. It was really just meant as if we put
15 all of these disparate things together and put it
16 to see where -- this is gave and take. It is -- as
17 I said, not all of us agree with every aspect
18 that's in here, but we agree it is important enough
19 to bring it forward to say if it looked like this,
20 maybe we didn't quite get it right, but it is a
21 place to start where it puts some of these very
22 touchy subjects all together.

23 MR. GAFFNER: Great. That's a helpful
24 explanation because I have been attempting to

1 follow the work from the sidelines and stay as
2 current as I could about where things were, and
3 then I know this was passed out this morning.

4 Great. I have a greater comfort level with
5 that because I would not have supported our
6 consideration of an action item when we have
7 obviously a very large constituency that have not
8 seen or made comment about the document.

9 I can really appreciate where the work group
10 went similarly to what Mike and his work group had
11 done earlier. I think that makes great sense, but
12 I don't believe there would be logic in moving
13 forward without some input from those two groups.

14 The only other thing I would add at this
15 point is I do not support the moratorium concept
16 even if the buy/sell program moves forward. I
17 think Illinois has some unique differences from the
18 other states that would not be in the best
19 interests of the long-term care residents we serve,
20 especially, again, speaking about rural areas.
21 Thank you.

22 MR. SCAVOTTO: Do you want to clarify what
23 those would be, what those unique characteristics
24 for Illinois would be like?

1 I would like to know what they are.

2 MR. GAFFNER: Sure. One of those that I
3 would begin with as a driving force in where we are
4 with this is centered on the state's very low
5 Medicaid rate. I mean, that is bundled into part
6 of where we were today.

7 Secondly, I think Illinois has historically
8 been challenged to have an accurate bed inventory
9 as it relates to areas.

10 Thirdly, as I mentioned earlier, I think the
11 state's unique geography and population
12 distribution makes it very difficult not only from
13 long-term care service but in others where you do
14 have high concentration pockets of population and
15 then largely rural areas.

16 So those are three things that I see that
17 would differ from a number of other states that
18 don't encompass a state that is almost 300 miles
19 long from north to south and have those population
20 discrepancies.

21 MR. SCAVOTTO: So does the -- let me follow
22 up on this, please. This is Mike Scavotto.

23 Does a moratorium, does the presence of a
24 moratorium prop up the price?

1 MR. GAFFNER: I have not thought through
2 that part it, Mike, whether it is going to prop up
3 the price, but I think to say that there is no
4 opportunity for beds to be used or to put in place,
5 if I'm understanding the moratorium concept
6 correctly, that it could only be done through bed
7 buy/sell and not by authorization of the full
8 nine-member committee, I have concerns about that.

9 MR. SCAVOTTO: Okay. All right.

10 MR. PHILIPPE: Can I just join in?

11 I remember a discussion we had at the last
12 meeting or two meetings ago where the new bed need
13 numbers came out, and what I remember is there
14 actually is very little bed need across the state
15 as a whole already anyway.

16 MR. SCAVOTTO: That's right. That's right.

17 MR. PHILLIPPE: I'm thinking maybe one or
18 two places, but the state as a whole, very little
19 bed need using the formula.

20 So the more practical issue with this is
21 that it forces people to buy or sell because what
22 would be confusing is if you could go to the Board
23 where there is no bed need and still justify a
24 reason to build which is happening today. It's

1 happened in the last few years. There is no
2 official bed need, but it is approved anyway.
3 Doing that would really confuse the whole process.

4 MS. GILES: I was just wondering how the
5 group, how implementing a moratorium, if the group
6 had considered what that does to the price per bed,
7 and I was actually thinking when I was framing that
8 question in my head thinking about the rural
9 providers who some of them may -- it would just add
10 to their cost where they might be able to get beds
11 through the normal process.

12 MR. GAFFNER: If I can go back a minute. In
13 trying to review some of the comments from the
14 August meeting, I would reference those made by
15 John Florina. I thought he made some good points
16 relative to occupancy levels and total bed counts.

17 I think that we cannot lose sight of the
18 fact that an excess bed is not a problem from the
19 standpoint that it is an excess bed because all of
20 us as providers today know that an excess bed does
21 not increase the cost of the Medicaid program. If
22 it is a staffed bed it does, but it if is not a
23 staffed bed, there is no cost.

24 So -- and, John, you know, I wasn't there in

1 the context of what you referenced in August other
2 than I think we need to make sure the bed buy/sell
3 program is also addressed from a universe of all
4 these things regarding the overall census occupancy
5 level throughout the state as well as what really
6 occurs in the harm of an excess bed and with that,
7 then, what will be the demand.

8 I think, John, that was one of the things
9 that I really was taken by that you commented which
10 was trying to look at the future need that's going
11 to occur in Illinois or at least that's what I was
12 catching from the written word on the page. If
13 that is not what you were trying to say, I
14 misinterpreted.

15 But what is going to be long-term planning
16 need, and if we reduce these beds, what really does
17 that do from a delivery position standpoint?

18 MR. FLORINA: This is John. Just real
19 quick. Alan, I think you read my comments
20 appropriately, at least as far as -- there is a lot
21 of questions that I had more than answers of this
22 whole thing. Some of them go back to, you know,
23 why do we have an excess bed situation now. Do we
24 know the cause of it to know why we need to address

1 it? You know, secondly, what is, you know, what is
2 the future need?

3 And one thing we have always been wrestling
4 with here even before the subcommittee dealt with
5 it is where are the so-called unused beds, and why
6 can't we find a way to get them out of the
7 inventory if they are not being used?

8 You know, those are some of the key points.
9 All these details in here are very helpful for
10 discussion, but they go one direction versus
11 another, and we may not all have the same opinion
12 of them.

13 MS. CREDILLE: Well, the current occupancy
14 in the state -- this is Cece Credille -- somewhere
15 between the number 75 and 78%.

16 So if, if there was some mechanism and
17 unoccupied beds went back to the state today but we
18 maintained the current bed need formula, then there
19 would be a need for more beds.

20 I mean, the bed need formula is counter to
21 -- if we gave beds back today and the current bed
22 need formula was in place, then we would -- and
23 there is no moratorium, then more buildings would
24 be built all over the place, and we'd have this

1 excess of beds. We'd continue in the same loop
2 that we're in.

3 MS. AMIANO: This is Amiano. One of the
4 premises that we worked off of was the fact that we
5 were given which was all beds --

6 MR. CHAIRMAN: Claire?

7 UNIDENTIFIED: Can the person who has got
8 paper --

9 MS. BURMAN: Thank you.

10 MS. AMIANO: So when we started, when we
11 said in our work group we had some data from staff,
12 that was a map that was entirely red with the
13 exception of just a couple of handfuls, two, three,
14 four, I can't remember, but it was not -- the map
15 was exceptionally red, and red was an indication by
16 this state's current formula of overbedding. So it
17 was statewide pretty much with a couple of pocket
18 exceptions.

19 So, again, it was just one of the
20 foundational documents we had in trying to address,
21 you know, if we do have so much excess inventory,
22 how -- what is a process. There is no current
23 process for working excess beds out of inventory.
24 That was our premise.

1 MR. CHAIRMAN: Mike?

2 MR. SCAVOTTO: Tim, go ahead.

3 MR. PHILLIPPE: This is Tim Phillippe. Two
4 things. One is that we talk about the price which
5 is a very good question, you know, because it would
6 cost to buy beds to be able to build new. That
7 would add to the cost of the project we talked
8 about earlier today.

9 So that is partly -- that is probably the
10 biggest reason we went statewide because as Mike
11 said earlier, if we have 20,000 unused beds and it
12 is statewide, we have a lot of unused beds to be
13 sold, potentially could be sold, and with this
14 two-year kind of deal, you are going to lose them
15 if you don't. It motivates people to sell them.
16 That should push the prices down.

17 The second point is really the unused beds
18 do not cost the state. They may -- I agree they
19 don't cost the state, but they create a policy
20 problem.

21 So there are locations where, because people
22 have downsized the staff number, their census is
23 lower. Their census may be running 80% or lower.
24 However, there is not access for people into that

1 market who need beds. So there is not good access
2 because people have artificially downsized the size
3 of their building, but if you run the numbers their
4 census is low so it says there is no need.

5 It all has to do and is really driven by the
6 desire on payments to have more private pay and
7 Medicare versus Medicaid. This doesn't happen in
8 every area, but it does happen across the state.

9 MR. SCAVOTTO: Question.

10 MR. CHAIRMAN: Beyond the issues we have
11 talked about forever is that owners are reluctant
12 to give you the correct number of beds because
13 licensed beds is probably securing their loans.

14 So even though they may be operating with 20
15 fewer beds, they need to maintain the license
16 number because it is securing collateral for their
17 borrowing. Otherwise, why would you pay bed tax on
18 a bed that is ultimately unoccupied or may not be
19 in existence? But yet they won't come forward with
20 those numbers.

21 MR. CASPER: This is Bill. We had some
22 discussion about that. I think, I can't remember,
23 we need some additional research because there are
24 many examples of states that have policies in place

1 where if you have you an unstaffed, unoperated bed
2 that's not being operated can only be in place for
3 a certain period of time before the license gets
4 extinguished. Lending rules in this state can't be
5 so different from other states that that is a true
6 statement.

7 So again, it may be collateral, but the real
8 test of your financing is whether you are making
9 your payments or not.

10 MR. CHAIRMAN: Definitely agree.

11 MR. CASPER: I think some more research
12 needs to be done to that.

13 MR. SCAVOTTO: I have a question, Tim. My
14 recollection is when we were first talking about
15 the buy/sell program was that it was something that
16 owners could do, they could take advantage of.

17 What I am reading about this one is a little
18 bit different. If you have got excess beds, you
19 have got 24 months to move them or start paying a
20 penalty.

21 MR. PHILLIPPE: I'm not the right person to
22 answer that because I did not attend those
23 meetings. I was having my bones chopped off about
24 that time, so that came up later.

1 MR. SCAVOTTO: So Judy, we will give it to
2 Judy or Bill or Cece.

3 MS. AMIANO: What was the question?

4 MR. SCAVOTTO: I forget. When we, when we
5 first started talking about buy/sell, my
6 recollection was that it was an optional program.
7 The operators who wanted to move beds could sell
8 them, people who wanted to hang onto them could
9 keep them.

10 I read this a little differently. I may be
11 reading it incorrectly. I read this as that there
12 is a grace period in which you can move your excess
13 beds without paying a penalty.

14 So there is a real incentive to take excess
15 beds and redistribute them; is that correct?

16 MS. AMIANO: We tried to put some incentives
17 in place to help get the program and start it and
18 to incentivize folks who have excess beds.

19 So yes, it is a -- yes, there were premiums
20 or incentives built into our recommendations.

21 MR. CASPER: Let me address that also.
22 I think there were -- quite frankly, this is the
23 element of this that is sort of beyond pure
24 buy/sell that we don't have full agreement among

1 the folks that were on the small subcommittee, but
2 I think as I, as we thought about it, it has been
3 mentioned as an elephant in the room.

4 There are really two elephants in the room
5 in this entire issue. One is the Medicaid rate in
6 this state, and I don't think that's within our
7 ability to do anything about.

8 And the other is the number, the bed
9 inventory is so skewed in relation to the bed need
10 formula by the fact of this unquantifiable number
11 of beds that are not currently being operated in
12 the system.

13 We know there is access issue. That's maybe
14 largely a factor of the Medicaid rate. We know
15 there is no bed need anywhere in the state. That
16 may only be a factor of the fact that there is beds
17 that are out of service and we don't know how many
18 there are.

19 So the more we talked about it, the more we
20 came to some consensus that something -- we all
21 know about the Medicaid rate, but it is not part of
22 this even the Health Facilities and Services Review
23 Board purview. The total number of beds is
24 something that can be addressed by policy within

1 the scope of what this subcommittee is able to make
2 recommendations about.

3 MR. SCAVOTTO: So it sounds -- I'm not
4 finding any fault with that, I just want to make
5 sure I was reading it correctly. Sounds like I am.

6 But I would also like to say that I think
7 this group ought to be commended for putting this
8 on the table. They did a good job with a tough
9 issue, and I know Cece and I can relate from our
10 experience with the work group that it sometimes
11 takes awhile get the stuff out on the table. I
12 think you did a great job, and it is a place to
13 start. I can't imagine this could be much better.

14 MS. AMIANO: I appreciate that comment. We
15 tried to be mindful and thoughtful of various
16 different interests in this process, and we are
17 probably certain this is not perfect, but it is a
18 place we can say can we conceptually kind of agree
19 with this and work through what all the nits are.

20 MS. AVERY: This is Courtney. Judy, anybody
21 else that worked with the work group, give me an
22 idea of the discussion behind the new construction
23 concept, because I think from the start pretty much
24 said that should not be an option in this program.

1 MS. AMIANO: Yeah, I think it was really
2 more around some of the special interest groups who
3 were at the table who new construction led to new
4 jobs.

5 I don't think the group is making a
6 recommendation for wholesale new construction.
7 We'd like to have that opportunity obviously
8 through the innovation piece of it because I think,
9 you know, we do -- you know, Illinois is behind.
10 You know, we don't have the types of services for
11 our residents that many of the other states do, and
12 that's a reality. So that's something that we
13 shouldn't be very proud of.

14 MS. AVERY: When you say programs, do you
15 mean like the innovative care or something like the
16 bed sale?

17 MS. AMIANO: I mean it more around the
18 physical plant issues.

19 MR. URSO: Can you give some examples?

20 MS. AMIANO: I think the movement towards
21 all private rooms. You know, we just came back
22 from a national conference, and, you know, I mean,
23 the type of buildings that are happening in other
24 places are not happening in Illinois. We just now

1 have our small house in Illinois being constructed
2 right now. That's been going on for what, ten,
3 maybe more years in other places.

4 So we just have not had that ability due to
5 some of the constraints in the State of Illinois.

6 MS. AVERY: But I think that the single room
7 concept is what got us into this with the access
8 beds because facilities decided to convert those
9 rooms but never took the beds, two or three in a
10 room, out of the inventory.

11 MS. AMIANO: There are at least some of us
12 that are supporting the notion that the state would
13 take those back at either -- I mean, our
14 recommendation is to be evaluated, maybe set a time
15 frame.

16 There is probably 100 different ways to go
17 about it, but we thought if we went to the buy/sell
18 and we implemented a moratorium, while there is a
19 moratorium the moratorium doesn't mean the industry
20 is static, it means that it is now going to move
21 through this buy/sell program.

22 So you are still going to have all of those
23 beds, but they might be recast in a different way
24 as people are buying and selling them. But we just

1 wouldn't award any more through the current
2 process. So you just freeze that up, and it forces
3 this other one to start to work. But it is going
4 to take some incentive and stuff to get people to
5 feel comfortable doing that.

6 MR. CASPER: Courtney, of the things we
7 clearly didn't address here but we talked about was
8 the fact that if it was merely adding to an
9 existing building it would be an expedited review,
10 but that if it was a new, totally new building or
11 building of beds where there were no skilled -- we
12 were adding to the system, that would require full
13 review so that you could --

14 Again, we didn't say what criteria we
15 applied, but we would hope there would be
16 innovation, and we would hope there would be
17 certain other criteria involved around.

18 MS. AVERY: We have said innovation a couple
19 of times. That's how this all started. You know,
20 we wanted to bring this group together to get it
21 back and write rules to have innovation, and then
22 the bed sell exchange popped into the picture.

23 So I'm still not seeing the innovation part
24 of it. It will come to me, I'm sure.

1 MR. CHAIRMAN: Did you incorporate existing
2 rule of 10 beds or 20%, or are you saying that rule
3 goes away?

4 MS. AMIANO: That is the CCRC variance, and
5 that --

6 MS. AVERY: No, it is different.

7 MS. AMIANO: Oh, oh, ten beds, I'm sorry.

8 MR. CASPER: We talked about that, and we
9 felt that this would replace that.

10 MR. CHAIRMAN: So that rule goes away.

11 MS. CUNNINGHAM: I just -- this is Kelly
12 Cunningham in Springfield. I just wanted to
13 address Courtney's point. I just had this pop in
14 my head.

15 In terms of this proposal as innovation, I
16 think as much as anything this is sort of about
17 rightsizing, you know, maybe this particular
18 profession, and I think that can be looked at as
19 something that's very innovative.

20 MR. FOLEY: What is innovative again? I
21 didn't catch that.

22 MS. CUNNINGHAM: May be some rightsizing. I
23 mean, it is some reallocation. It is -- you know,
24 I think there are a number of, you know, pretty

1 complex things incorporated into this proposal. I
2 think at the heart of it really it does speak to
3 making some significant changes to the bed need
4 formula itself, but I think that many of the ideas
5 in this are very innovative and not that maybe it
6 creates something brand new but it makes something
7 more appropriately sized.

8 MS. AMIANO: Let me add, I think as we were
9 thinking about it, you know, you don't -- I guess
10 the way we were thinking, and I will speak for the
11 group, is when you are buying a bed, you are not
12 doing that to replicate exactly what it was. You
13 are wanting to do something new and different with
14 it.

15 So we came from the framework of you are not
16 just going to buy it just to replicate exactly what
17 it was, that it becomes something new. You know,
18 this gives people the ability to do that, you know,
19 whether you are transferring within your ownership
20 or, you know, you are moving them around in the
21 marketplace, you are building some new inventory,
22 you are doing all those things. So by the virtue
23 of buying it, the new owner has a desire for
24 something for that bed that didn't previously

1 exist.

2 MR. OURTH: Judy, a question. What role
3 does the Review Board play in this? What is the
4 standard?

5 Okay. You have an application. If there is
6 already a buy/sell in place, is the Board supposed
7 to look at that, or is that a forgone conclusion
8 that it happened and sold, or is there any real
9 review criteria role for the Board in this kind of
10 transaction?

11 MS. AMIANO: We probably didn't get down
12 into nits of that, but based on it being an
13 expedited review, it was check the box, did it meet
14 certain things in terms of, you know, governance
15 and those kinds of things.

16 MR. CASPER: Ownership suitability, nature
17 of expedited.

18 MS. AMIANO: That kind of thing, but, you
19 know, that could be another avenue that it reduces
20 workload of the Board by having that in a very
21 expedited fashion because then it really becomes a
22 marketplace type issue.

23 MR. CHAIRMAN: We had always talked about we
24 would want to make sure that a buyer was not

1 operating with deficiencies. That has been
2 discussed over the time period. So I assume that's
3 part of your check box thing?

4 MS. AMIANO: Well, that was suitability of
5 the buyer.

6 MS. AVERY: This is Courtney again. I'm
7 still kind of stuck on new construction. When you
8 all meet, again, take it into consideration. I'm
9 pretty sure that whatever beds have been sold is
10 going to, again, increase the cost of the facility
11 I was purchasing.

12 How do I finance that I'm buying these beds
13 and demonstrate that I have the capability to
14 finance the purchase of the beds and the overall
15 construction project?

16 I'm not asking for an answer today, just to
17 think about because, again, we have heard --

18 MR. PHILLIPPE: That's true.

19 MS. AVERY: -- within the group and outside
20 of the group that if we change anything on our
21 documents, it will cost us an extreme amount of
22 money. I can't quote. I think it was like
23 \$100,000 or something to change those documents for
24 the financing of it.

1 MR. CHAIRMAN: We had an attorney at one of
2 the meetings who said that if you change the
3 collateral, that to rewrite the loan documents
4 could be upward of 50,000. I have heard people
5 laugh and say it is outrageous, but he did say it.

6 MR. LAVENDA: One other thing mentioned, the
7 leases. Sometimes the lease is based on number of
8 licensed beds also. So if you are going to change
9 the number of licensed beds, the landlord is going
10 to be getting less money potentially because they
11 are leasing out based on what their license is. I
12 don't know how many homes there are in the state
13 that have these.

14 MR. CASPER: The landlord is owner of the
15 beds. The landlord would have to be the seller.

16 MS. AMIANO: Right, not the operator, the
17 landlord.

18 MR. LAVENDA: I can tell you there are
19 landlords that aren't going to.

20 MS. AMIANO: Then they don't have to
21 buy/sell. It is optional.

22 MS. AVERY: So I'm a facility operator. I
23 lease the building from you or beds from you?

24 MS. AMIANO: But he owns the bed.

1 MS. AVERY: But you own the bed?

2 MR. LAVENDA: I own the building, I own the
3 real estate.

4 MS. AVERY: Okay.

5 MR. LAVENDA: But I'm not operating. The
6 license is with the --

7 MS. CREDILLE: But the lease agreement is
8 based on number of beds being operated.

9 MR. LAVENDA: Some of them. The ones that I
10 have seen, that's what it is based on.

11 MS. AMIANO: It is a good thought for
12 consideration.

13 MS. GUILD: This is Ann Guild. For a
14 facility that is selling the beds, did you talk at
15 all about whether they should be able to sell other
16 beds effectively closing their facility or whether
17 this was strictly aimed at, you know, selling some
18 20, 40, whatever, some useful number of beds for
19 like a modernization project or something that
20 someone was willing to purchase for?

21 MS. AMIANO: I don't think we thought about
22 that, but if they wanted to sell all of them, they
23 would sell all of them and go down the path of
24 closing the facility.

1 MS. AVERY: Which would require a CON. So
2 that's a catch-22.

3 MR. PHILLIPPE: Judy, this is Tim. I think
4 we did talk about it briefly, if most of my memory
5 is not gone in the last few weeks, because it came
6 up as more of a practical discussion. If you have
7 a building that's operating with 70 beds, you are
8 not just walking away from the beds, you are
9 walking away from the building.

10 So it is more of a practical issue. How
11 often is somebody going to actually walk away from
12 an investment that's full?

13 It doesn't seem like it would come up very
14 -- it would come up rarely maybe but --

15 MR. LAVENDA: I think it comes up. It comes
16 up every now and then. I was looking through the
17 inventory thing. I think there was three homes in
18 here that they mentioned they just closed the
19 facility.

20 MS. AVERY: County owned facility, do you
21 remember?

22 MR. LAVENDA: I think one may have been, and
23 the other two were for profits that the owner was
24 not able to sell, and they just decided to close

1 them. They walked away.

2 MR. CASPER: In which case those beds go
3 somewhere else. But you are right, closure would
4 have to go through a CON process.

5 MR. GAFFNER: This is Alan Gaffner. Excuse
6 me. Steve?

7 MR. LAVENDA: Can I point out one other
8 thing you probably didn't think about with
9 reimbursement with the cap rate for nursing homes?

10 Anytime, you know, you file for one of these
11 capital changes, they look at what the current bed
12 amount of beds is, and if your number of beds have
13 gone down, the first reaction of the reviewer is to
14 reduce the building reimbursable building costs
15 based on number of beds that it went down.

16 So you have to jump through this hoop to let
17 them know that you actually didn't stop using part
18 of the building, but that, you know, you just
19 reduced the number of beds.

20 I'm just saying that there is -- you have to
21 be careful with this. I understand what is going
22 on here, but in the process of this there is a
23 danger of lowering everyone's capital rate. As we
24 discussed, the Medicaid rates in the state are low

1 enough. There would have to be some type of thing
2 in there to make sure that capital rates wouldn't
3 go down.

4 MR. AMIANO: So we have Mr. Foley sitting at
5 the table hearing this. So that's one of those
6 unintended consequences that could happen for us so
7 that people weren't harmed.

8 MR. LAVENDA: I know in our office would
9 write something like that. I don't know if other
10 people filing these are really aware that there is
11 a remedy. You know, just show them the floor plan
12 of the place and before and after that you really
13 are not, not using part of the building.

14 MR. PHILLIPPE: Mr. Chair?

15 MR. CHAIRMAN: Yes, sir.

16 MR. PHILLIPPE: Could I -- the task force,
17 the work committee actually was useful, efficient
18 with Judy's leadership because we sort of took the
19 steps one at a time. So we kind of started and
20 worked through it. I would encourage actually the
21 full subcommittee to do that because otherwise we
22 will bounce around between different topics.

23 For example, the core, you know, the idea of
24 taking beds away after two years or giving up or

1 selling, you know, the premium, giving 15% back to
2 yourself, those don't have to be core features.
3 They do not exist in other states necessarily,
4 that's just something that is brought up. It would
5 be more useful to actually start at the beginning.

6 For example, the 10% rule expansion and the
7 moratorium, they were all based -- in building new
8 buildings, based -- really the idea is if we
9 continue to allow people to expand 10%, 20 beds,
10 whatever it is, and anyway we have no new
11 buildings, so can't buy to build, really then it is
12 a very limited function here because all we are
13 talking about, then, is buying beds between that
14 range, between what you can get free by expanding
15 but can't build anyway.

16 So it is a fairly small issue practically to
17 do all of this just for that one little niche area
18 which would be important to some people but would
19 not have a big impact.

20 So I suggest we kind of start at the
21 beginning, if we can, whenever the Chair is ready
22 and the subcommittee is ready and kind of walk
23 through the things because otherwise we will just
24 get stymied by the most difficult ones such as

1 taking the beds away after two years.

2 MR. FOLEY: We have only got eight minutes
3 to do that.

4 MR. PHILLIPPE: We can start it at the next
5 meeting.

6 MR. CHAIRMAN: We have about seven minutes,
7 and before we adjourn I certainly want to thank
8 Judy and the rest of the committee for doing an
9 incredible job.

10 Those of you that have been around know that
11 we have talked about these subjects for months, if
12 not years, and I think your document has put things
13 into perspective, and for that we are grateful.

14 Clearly there needs to be a little more
15 discussion. I think in the next few minutes I
16 think we need to determine how we want to proceed.

17 Obviously one way is to let the committee
18 continue working and bring back further ideas to
19 us, or the other way to do this is for it to become
20 a discussion of the committee as a whole.

21 Maybe Judy or Bill, Cece, what do you think
22 should happen next?

23 MS. AMIANO: We all had a genuine desire to
24 move something forward.

1 MR. CHAIRMAN: I think some of us who have
2 been here a long enough time have that same desire.

3 MS. AMIANO: So whatever, you know, is the
4 pleasure of the group. It is not meant to be
5 exclusionary. It is -- so we will do whatever will
6 help move this forward.

7 MR. CHAIRMAN: Again, for those of you that
8 are new, the reason it was four people is to avoid
9 Frank coming after us with the Open Meetings Act.
10 He is vicious, and we don't want Frank mad at us.
11 It wasn't that we chose to exclude people, it was
12 we wanted to be productive without having to go to
13 jail over the number of people working on it. So
14 please don't feel that you are left out, but it
15 obviously has worked. To that we are very happy
16 about it.

17 So, again, what are the thoughts that are on
18 the table about next step for the next meeting?

19 MR. CASPER: This is Bill. I would have one
20 comment. I think maybe the thought I'm having
21 right now is that a good -- after people have had
22 time to digest this, it would be a good idea for
23 the entire subcommittee to have a discussion about
24 it because, again, today a couple questions or

1 areas for additional research have surfaced.

2 Following that discussion we could then
3 decide whether it made sense for the smaller group
4 to get back together to process all that and come
5 back or whether we have made enough progress for
6 the subcommittee to make a recommendation without
7 them. Does that make sense?

8 MR. CHAIRMAN: Does make sense. Does anyone
9 have any objection?

10 MR. GAFFNER: If that process is followed, I
11 guess the only thing that I would urge us to do,
12 and I understand the transparency and Open Meetings
13 Act issues, is that we somehow be able to actively
14 involve the other long-term care associations in
15 the subcommittee's work. I think that will speed
16 up the process and avoid any issues that might
17 arise later.

18 So I don't know whether there is a decision
19 to actually go beyond the four and then we have a
20 transparency issue, or if not, as long as there is
21 a mechanism to get Illinois Council and HCCI, any
22 others involved, I'm comfortable with that.

23 MR. CHAIRMAN: I think there is an easier
24 way to do this. Terry Sullivan, who used to be a

1 member of this, is the executive director of one
2 group and at one time --

3 MR. FOLEY: No, that's not correct.

4 MR. GAFFNER: He has left. He is not there
5 any longer. You are correct, Mr. Chairman, he was
6 in the past.

7 MR. CHAIRMAN: Time out. Terry is in charge
8 of the Illinois Nursing Home Administrators
9 Association.

10 MR. GAFFNER: He is of that.

11 MR. CHAIRMAN: And Illinois Council
12 supposedly was -- my belief there is a lot of
13 Illinois Council members who do belong to IHCA.
14 Not all, but I think there is significant numbers.
15 I think we may have some representation that way,
16 and, again, Alan, I'm not sure what other group you
17 are talking about.

18 MR. GAFFNER: Well, there has been
19 significant change in that no longer are council
20 members, at least that I am aware of, members of
21 IHCA. There was a division of the two under the
22 same advocacy umbrella in July of 2013. There are
23 some --

24 MR. CHAIRMAN: I'm aware merger didn't go

1 through, but what is other acronym you are using?

2 MR. GAFFNER: Health Care Council of
3 Illinois has some members within that group that
4 are not member of Council on Long-Term Care. I'm
5 not trying to muddy the waters.

6 MR. CHAIRMAN: For years I have never heard
7 of that group.

8 MS. AVERY: It is Pat Comstock, isn't it?

9 MR. FOLEY: Yes.

10 MR. CHAIRMAN: That is a lobbying group.

11 MR. GAFFNER: No, not any longer. John can
12 probably explain it. I know he is familiar with
13 it. I don't want to take up valuable time.

14 MR. CHAIRMAN: I will talk to Steve or John,
15 I don't care.

16 MS. AVERY: Well, two things and, again, I
17 heard all of the concerns that we have heard from
18 the outside about not being inclusive in this small
19 work group, and we are taking the brunt of it. I
20 voiced to both the Chair and Co-Chair a lack of
21 staff member being there, but we will have to
22 figure it out about the smaller work group. We
23 have had people complain about it.

24 MR. CHAIRMAN: You never make everybody

1 happy.

2 MS. AVERY: No, you don't.

3 MR. CHAIRMAN: I think this has been a
4 productive meeting. I think the two subcommittees
5 have done an incredible job, and that on behalf of
6 the entire board I want to thank them. And we do
7 need to pick another meeting date.

8 Ms. AVERY: Yes. Is it your wish --
9 what is your wish about location?

10 MR. CHAIRMAN: My wish is whatever makes
11 people happy.

12 MS. AVERY: Okay.

13 MR. CHAIRMAN: You know, attendance is the
14 most important thing. So if attendance is improved
15 by doing it this way, then I'm in favor of it.

16 MS. AVERY: You will suffer through.

17 MR. CHAIRMAN: I will suffer through. God
18 only knows what parking lot my car is in.

19 UNIDENTIFIED: Take the train.

20 MR. CHAIRMAN: I have places to go next.

21 MS. AVERY: Sorry. Our next board meeting
22 for the planning board, Health Facilities and
23 Services Review Board, is November 12th, and then
24 the following one is December 16th, and then we are

1 into the first of the year.

2 MR. CHAIRMAN: So probably don't want to
3 meet in December because of the holidays?

4 MS. AVERY: No, it is hard.

5 MR. CHAIRMAN: We will go to January.

6 MS. AVERY: Okay. Dates? Do we stick to
7 that, what is this?

8 Didn't we do Tuesdays, second or third
9 Tuesday or something?

10 MS. CREDILLE: I'm not available either one
11 of those.

12 MR. CHAIRMAN: In December?

13 MS. CREDILLE: No, January.

14 MR. CHAIRMAN: January, sorry.

15 MS. CREDILLE: Can we do January 27th?

16 UNIDENTIFIED: What day is that?

17 UNIDENTIFIED: Fine with me.

18 MR. CONSTANTINO: We have a board meeting
19 that day.

20 MS. AVERY: How about first of February?
21 One of those holidays. We get a lot of days off.
22 Those are Mondays.

23 UNIDENTIFIED: Martin Luther King is January
24 19th.

1 MS. AVERY: Did you want to go into February
2 or try another date in January?

3 MR. FOLEY: Let's try another date in
4 January. We have been holding off on this for too
5 long.

6 MS. AVERY: The 19th or 26th?

7 UNIDENTIFIED: January 19th is Martin Luther
8 King.

9 MS. AVERY: I would prefer not to have a
10 board meeting the next day. I think the 12th is
11 what, nothing.

12 UNIDENTIFIED: It is Monday. Monday?

13 MS. AVERY: Yeah, we are out of Mondays.
14 Tuesdays?

15 UNIDENTIFIED: How about Thursday, January
16 15th?

17 UNIDENTIFIED: I cant.

18 MS. AVERY: The 8th, January 8th?

19 UNIDENTIFIED: I can't.

20 UNIDENTIFIED: Going to February.

21 MS. AVERY: What about the 21st, January?

22 UNIDENTIFIED: I'm out of town.

23 MS. AVERY: 14th, January 14th?

24 MR. PHILLIPPE: Yes.

1 MS. AVERY: January 14th?

2 MR. CHAIRMAN: What day is it?

3 MS. AVERY: It is the 14th. January 14th,
4 location to be announced. Video conference, but we
5 need to schedule a room.

6 Okay. We need to move out quickly or else
7 we will get a bad reputation. Thank you, everyone.

8 (Concluded at 1:35 p.m.)

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