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

**LONG-TERM CARE ADVISORY SUBCOMMITTEE**

**MEETING**

**NOVEMBER 29, 2011**

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**NATIONWIDE SCHEDULING**

OFFICES: MISSOURI Springfield Jefferson City Kansas City Columbia Rolla Cape Girardeau ■ KANSAS Overland Park ■ ILLINOIS Springfield

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STATE OF ILLINOIS  
HEALTH FACILITIES AND SERVICES REVIEW BOARD  
525 West Jefferson Street, 2nd Floor  
Springfield, Illinois 62761  
217-782-3516

LONG-TERM CARE ADVISORY SUBCOMMITTEE  
MEETING

The meeting of the State of Illinois Health Facilities and Services Review Board, Long-Term Care Advisory Subcommittee was held on November 29, 2011, scheduled to begin at the hour of 10:00 a.m. by video conferencing from the following locations: 122 South Michigan, Chicago, Illinois and 535 West Jefferson, Springfield, Illinois.

1 MEMBERS PRESENT AT CHICAGO LOCATION:

2 Michael Waxman - Chairman  
3 Eli Pick - Vice-Chair  
4 Stephanie Altman  
5 Cece Credille (for Mike Bibo)  
6 Carolyn Handler  
7 Greg Will (for Dave Lowitzki)  
8 Phyllis Mitzen

9

ALSO PRESENT:

6 Frank Urso - HFSRB Legal Counsel  
7 Courtney Avery - HFSRB Administrator  
8 Cathy Clarke - Assistant to Administrator  
9 Claire Burman - HFSRB Staff  
10 Don Reppy

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13 MEMBERS PRESENT AT SPRINGFIELD LOCATION:

14 Teri Dederer  
15 Timothy Phillippe  
16 Michael Scavotto  
17 Neyna Johnson  
18 Rick Dees

19

ALSO PRESENT:

20 Michael Constantino - HFSRB Staff  
21 Bill Dart - IDPH  
22 Charles Foley  
23 Jason Speaks

24

Reported by:  
Karen K. Keim  
CRR, RPR, CSR-IL, CRR-MO  
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AGENDA

CALL TO ORDER

1. Roll Call
2. Approval of Agenda
3. Approval of September 27, 2011 Minutes
4. Public Participation
5. Work Group Report
6. Review of LTC CON Application
7. Other Business
8. Next Meeting
9. Adjournment

1 START TIME: 10:11 a.m.

2

3 CHAIRMAN WAXMAN: I would like to call the  
4 meeting to order.

5 Can we go around each table and introduce  
6 ourselves, please? We'll start with our guests in  
7 Springfield.

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

10 MS. DEDERER: Teri Dederer, Department of  
11 Human Services.

12 MS. JOHNSON: Neyna Johnson, Department on  
13 Aging.

14 MR. FOLEY: Charles Foley.

15 MR. SCAVOTTO: Mike Scavotto.

16 MR. SPEAKS: Jason Speaks with Life Services  
17 Network.

18 MR. PHILLIPPE: Tim Phillippe.

19 MR. DEES: Rick Dees with the Department of  
20 Public Health.

21 MR. DART: Bill Dart, also Department of  
22 Public Health.

23 CHAIRMAN WAXMAN: Is that everyone there?

24 MR. DART: That's everyone here.

1 CHAIRMAN WAXMAN: Thank you very much. We'll  
2 go around our table.

3 MR. WILL: Greg Will, SEIU Healthcare.

4 MS. BURMAN: Claire Burman, Health Facilities  
5 and Services Review Board.

6 MR. URSO: Frank Urso.

7 CHAIRMAN WAXMAN: Mike Waxman.

8 MR. PICK: Eli Pick.

9 MR. REPPY: Don Reppy.

10 MS. CREDILLE: Cece Credille for Mike Bibo  
11 with Illinois Healthcare.

12 MS. MITZEN: Phyllis Mitzen, Health and  
13 Medicine Policy Research Group.

14 MS. AVERY: Hi. Courtney Avery.

15 CHAIRMAN WAXMAN: If our official count is  
16 correct -- and we only had six people counting, so I think  
17 it's correct -- we are one vote short of our quorum. So,  
18 we will move on without voting at this point in time, if  
19 that's okay with everybody.

20 MS. DEDERER: Was there anybody else who said  
21 they would be here that's not?

22 CHAIRMAN WAXMAN: The opposite of that  
23 question is we only know of three who said they won't be  
24 here.

1 MS. AVERY: I think we had counted  
2 (unintelligible), but she's not able to make it today, and  
3 Kelly Cunningham.

4 CHAIRMAN WAXMAN: And Pat O'Dea sent an  
5 e-mail late last night, saying she was traveling to  
6 Florida. So, we only know of three that aren't coming, so  
7 hopefully we will get our quorum before we adjourn.

8 That being said, then we have to skip approval  
9 of agenda and approval of the minutes.

10 Chuck, are you the only public person out  
11 there?

12 MR. FOLEY: Looks like it.

13 CHAIRMAN WAXMAN: Do you have anything you  
14 wish to say before we get into the meeting?

15 MR. FOLEY: Oh, gosh, no.

16 CHAIRMAN WAXMAN: There is a rare sight.  
17 Good morning, Chuck, how are you?

18 MS. DEDERER: He hasn't had enough coffee yet.

19 CHAIRMAN WAXMAN: We also have a guest in our  
20 room. Don, would you like to introduce yourself?

21 MR. REPPY: I'm Don Reppy from HCR ManorCare.  
22 Hi, Chuck.

23 MR. FOLEY: Well, hi, Don. How are you doing,  
24 Bud.

1 MR. REPPY: Nice to see you.

2 MR. FOLEY: Nice to see you, too.

3 CHAIRMAN WAXMAN: Okay. We have our quorum,  
4 but we'll let her sit down first and take her coat off.

5 When you are comfortable, just introduce  
6 yourself to the table and to Springfield.

7 MS. HANDLER: Carolyn Handler.

8 CHAIRMAN WAXMAN: And Carolyn is our quorum,  
9 so congratulations, you win today's prize.

10 CHAIRMAN WAXMAN: Okay. Stephanie, please  
11 introduce yourself.

12 MS. ALTMAN: Hi. Stephanie Altman. Sorry I'm  
13 late.

14 CHAIRMAN WAXMAN: So we have a quorum plus  
15 one, so if someone needs to run to the potty, we're still  
16 in good shape.

17 Going back to the agenda now, I need someone  
18 to approve our agenda.

19 MR. PICK: So moved.

20 MS. MITZEN: Second.

21 CHAIRMAN WAXMAN: All in favor?

22 (Ayes heard)

23 CHAIRMAN WAXMAN: Opposed?

24 (No response)

1 CHAIRMAN WAXMAN: I need a motion to approve  
2 the minutes of September 27th.

3 MR. PICK: Eli Pick so moves.

4 CHAIRMAN WAXMAN: We have a motion by Eli to  
5 approve the minutes of September 27th. I need a second.

6 MR. PHILLIPPE: Second.

7 CHAIRMAN WAXMAN: All right. Tim seconds the  
8 motion. All in favor?

9 (Ayes heard)

10 CHAIRMAN WAXMAN: Any opposed?

11 (No response)

12 CHAIRMAN WAXMAN: Motion carries. Thank you.

13 Don, do you wish to have anything -- I gave  
14 Chuck an opportunity. Do you wish to address the  
15 Committee?

16 MR. REPPY: No, no comment. Thank you.

17 CHAIRMAN WAXMAN: Just as a housekeeping task,  
18 we will break somewhere around the noon mark and run out  
19 and grab lunch and come back. So, I don't know if that's  
20 your plans in Springfield, but it's our plans here to do  
21 that. So, again, just a housekeeping task.

22 The Work Group report, I would officially go  
23 on record to thank Tim for chairing the Committee, the  
24 sub-subcommittee. I did allow myself to participate in

1 both of the conversations. They were conference calls. I  
2 think the group worked very, very hard. They did a great  
3 job.

4 At this point, Tim, would you be kind enough  
5 to make a report?

6 I would like to suggest that we let Tim cover  
7 all of the subjects in his report and we can go back and  
8 talk about various topics afterwards, but I would  
9 appreciate letting Tim go through his whole report first.

10 MR. PHILLIPPE: Okay. I appreciated the  
11 opportunity to work with this group. I thought everybody  
12 participated very well. We had a number of people that  
13 helped access outside information to help the work group,  
14 and that was useful. I -- it was interesting to try to do  
15 a discussion with this many people on a conference call,  
16 but we had plenty to say. So, that worked. The -- so, it  
17 seems like the meeting was useful. We did have a summary  
18 at the end of the meeting, and people thought the meeting  
19 was worthwhile.

20 I reviewed in the report I sent some of the  
21 materials we looked at, to look at some other ideas. I  
22 think in looking at the issues we covered, one is I think  
23 in our work group, we tried to stay focused on the bed-need  
24 formula itself, but it was hard to keep it from being other

1 topics having to do with the Certificate of Need process.  
2 And the bed-need formula is more limiting, it seems like,  
3 as I've asked people, right now the way it's structured  
4 than the bigger discussion about the application process.  
5 I assume if we meet in the future we'll have more  
6 discussion about that.

7           We did look at other states. We also looked  
8 at the operational beds versus licensed capacity, to try to  
9 see if there's some way that could be worked into the  
10 bed-need formula. It's a challenge. It looks like it's a  
11 challenge to get the numbers in the correct fashion to fit  
12 into the formula. It seems like people thought it was  
13 worthwhile. We didn't take a vote on it, making a  
14 recommendation, because there were some just outstanding  
15 issues of how to gather the information correctly and to  
16 ensure it was accurate information that we used in the  
17 process.

18           We also looked at assisted living, supported  
19 living and home and community-based services and how they  
20 might fit into the formula. That also seemed to be even  
21 more challenging. The goal was, I think, of the group -- a  
22 lot of people were interested in how that could fit into  
23 the process, how we could recognize other sources of --  
24 other locations for serving long-term care residents and

1 providing similar services that are provided in a nursing  
2 facility, but it was difficult yet to find a way that would  
3 actually -- could gather information and use it within the  
4 formula.

5 And so I think that's kind of where we are.  
6 Others can -- I tried to summarize the meetings. I may  
7 have gone a little too strong one way or the other for a  
8 couple people in our group, but I'm open for anybody's  
9 comments on it.

10 CHAIRMAN WAXMAN: Thank you, Tim.

11 Is there anybody that wishes to address the  
12 report that Tim has submitted or comment on the report  
13 before we decide how -- what we're going to do with the  
14 report?

15 MR. SCAVOTTO: I have a question for Tim. Do  
16 you see your work being finished?

17 MR. PHILLIPPE: Well --

18 MR. SCAVOTTO: What's the end result?

19 MR. PHILLIPPE: I have to say, when I started  
20 I hoped it would be finished, but I think when we had an  
21 open discussion about that at the end of our last meeting,  
22 there was a determination we're not finished.

23 Is that fair, for others that are involved?

24 MS. DEDERER: I agree. Phyllis, yes, do you

1 agree our work is not finished?

2 MS. MITZEN: I certainly agree. I mean, I  
3 appreciated the report. Tim, this was really very helpful.  
4 But it seems to me that we have more work to do. It's not  
5 a report -- I mean, it's not a recommendation. It's a  
6 summary, which is great, very helpful.

7 MS. DEDERER: For example, on operational  
8 beds, people who know the data said we needed a definition,  
9 and coming up with a definition could be challenging, but  
10 if we had a definition, the data might be more consistent  
11 and more usable. I think that's a fair thing to say. And  
12 then there was an issue of following up on data that's  
13 being reported by nursing homes, to see if it's accurate.  
14 We did have some discussion about that, I thought. Yes?

15 MS. MITZEN: Yes.

16 MR. PICK: Yes.

17 MS. DEDERER: And I thought there was some  
18 suggestion that maybe it would be worth the effort to be  
19 following up on data in some way to check on the accuracy.  
20 Is that a fair statement?

21 MR. PICK: Mike, if I'm not mistaken, you had  
22 shared that in the past the Staff had followed up on  
23 hospitals reporting having beds available or set up and the  
24 prior experience. You indicated that it wasn't until the

1 follow-up occurred that accurate calculation of beds being  
2 available in the acute arena started to change. Is that  
3 correct?

4 MR. CONSTANTINO: Yeah, we did an annual  
5 survey. The initial survey -- we discontinued quite a  
6 number of hospital beds after we did the initial survey,  
7 the Board did, discontinued those beds. We could do the  
8 same thing for long-term care.

9 MR. PICK: My personal, professional  
10 experience is that rather than reinventing the wheel is to  
11 take advantage of those kinds of efforts that have yielded  
12 a positive outcome, to apply them to other arenas, and it  
13 would seem to me that that would be one of the things  
14 should be considered, since it worked in the acute arena.

15 MS. DEDERER: Plus, I would think that  
16 everybody would want an accurate count, whether it's used  
17 for bed-need formula or just in general, to know what the  
18 state of the State is.

19 MS. MITZEN: Yeah.

20 MS. AVERY: So, in doing so, Mike, in  
21 conducting a survey, are we just going to design a special  
22 tool? We wouldn't go into, like we do with the hospital  
23 surveys, the financial?

24 MR. CONSTANTINO: No. We have a special,

1 annual bed survey that we do every year for the hospitals.  
2 It's a separate instrument. So, we would do the same for  
3 long-term care, a separate instrument.

4 MS. AVERY: So we'll just tailor it to  
5 long-term care?

6 MR. CONSTANTINO: Right.

7 MS. BURMAN: If I can interject, before we did  
8 that and had success with that, we did draft a set of rules  
9 that were adopted, which contained the definitions for the  
10 different categories of beds, outlined a structure, and  
11 that was distributed a couple of meetings ago.

12 CHAIRMAN WAXMAN: Before we go too far, I  
13 personally think we need to ask Frank. Frank, can we  
14 establish that kind of survey on our own, or does it have  
15 to go back to the Mother Board?

16 MR. URSO: It would be a recommendation from  
17 this subcommittee to the Board.

18 CHAIRMAN WAXMAN: Okay. All of you heard  
19 that.

20 MS. DEDERER: Is there anything that we can do  
21 on our own without the Mother Board?

22 MR. PICK: Conduct our meetings.

23 CHAIRMAN WAXMAN: We're an advisory group.

24 MS. DEDERER: That's what I thought. I was

1 just checking.

2 MS. MITZEN: My only question about the  
3 hospital bed survey tailored to long-term care, are  
4 there -- is there anything in that -- I mean, not knowing  
5 what that survey is or the details of that survey, is there  
6 something in that survey that is not applicable to  
7 long-term care? I just don't -- it's a question. I just  
8 don't know, and I think before we make the recommendation,  
9 we should be clear.

10 MR. PICK: Might be helpful for us to see the  
11 instrument and to understand it so that we can better  
12 discuss it.

13 MR. PHILLIPPE: Yes.

14 MS. MITZEN: I think so.

15 MS. CREDILLE: Can I ask a clarification? If  
16 we are looking at operational beds versus licensed beds,  
17 then what we would do with that information?

18 MS. DEDERER: Use that as the basis for the  
19 occupancy rate, I think. Right? We have a 90 percent  
20 rule. So, we take 90 percent of operational, I think.

21 MR. PHILLIPPE: That's the first idea that  
22 people had talked about.

23 MR. PICK: I thought the first step was to  
24 determine how many beds are actually in operation before

1 you even get to occupancy, because the discussion we had  
2 was how many licensed beds are in the inventory that are  
3 not even set up, and the only information we have today is  
4 the long-term care questionnaire, where administrators are  
5 reporting how many beds they have that are operational --  
6 not operational but -- the questionnaire asks the number of  
7 licensed beds and how many are operational, meaning that --  
8 if my memory serves me right, it's the number of beds that  
9 are currently available or available within, I think, 24 or  
10 48 hours. There's a short time frame that allows you to  
11 include beds that you could quickly set up. So -- and I  
12 believe that's the only source of information we have right  
13 now in long-term care, based on the questionnaire.

14 So, the question or the issue that was raised  
15 is that -- I know from informal or anecdotal information  
16 that administrators routinely report all licensed beds  
17 being operational, and that that's not necessarily true.  
18 So, we're trying to ferret out how many beds are actually  
19 used beds.

20 MR. PHILLIPPE: To go along with what Eli  
21 said, this is just personal experience, but if we looked at  
22 the data that Claire produced for us that compared -- I  
23 think that's the data that showed the operational beds from  
24 that questionnaire. We were using that information and

1 then looking at licensed beds. The number in most  
2 places -- the difference was too small to sound like what  
3 it's really like out there, at least when we talked to  
4 people. I think that's what Eli is saying maybe. So there  
5 were a couple of markets where it was a big number, but  
6 there were other places where the number was very small and  
7 it doesn't match my own knowledge of those markets.

8 Is that what you're saying, Eli?

9 MR. PICK: Yes.

10 MS. HANDLER: So, my question is, if we're  
11 only asking for the difference of licensed and operational  
12 on an annual survey and we're not feeling that we're  
13 getting an accurate reflection of what is truly  
14 operational, how do you think designing another survey  
15 would solve that problem? If it's not being correctly  
16 reported today, or we continue to believe that it is, why  
17 do we think that another survey is going to correct that?

18 CHAIRMAN WAXMAN: Claire?

19 MS. BURMAN: Mike, please correct me if I'm  
20 off course on this. But in our survey, we don't ask for a  
21 year's worth of operational beds. We ask for a one day,  
22 the peak number of beds on one day during that year. So,  
23 that would have to be changed as well. It doesn't  
24 represent the whole year.

1 MS. CREDILLE: Are we ultimately suggesting  
2 that we would change a bed-need formula based on  
3 operational beds versus licensed beds?

4 MS. BURMAN: The only change would be at the  
5 very end of the formula where you subtract the existing  
6 beds. Instead of subtracting the existing licensed beds,  
7 it would be the number of existing operational beds, or  
8 whatever term you want to use.

9 MS. DEDERER: My recollection of the long-term  
10 report -- and I haven't looked at it in a while -- I  
11 thought there was a difference of like 10,000 beds between  
12 licensed and operational in the state. But it doesn't  
13 matter. I think that operational beds has to be a point in  
14 time. You can give an average across the year. I mean,  
15 that would be one number, but ultimately, operational beds  
16 is what you have at the end of the year, I think. Yes,  
17 Mike? No, Mr. Constantino?

18 CHAIRMAN WAXMAN: I agree with you. I think  
19 operational beds is really the count we're looking for,  
20 because if you're trying to determine the number of needed  
21 beds, a licensed bed that is sitting in a warehouse ten  
22 miles away is of little value, so -- but we are counting  
23 them.

24 MS. DEDERER: One other comment. Is it

1 Carolyn I think that asked what other survey we would do?  
2 I thought the survey was the on-site, follow-up that you do  
3 to see -- or however you do it, to see if what's been  
4 reported is accurate.

5 MR. CONSTANTINO: We don't do any on-site.

6 MS. DEDERER: But you do for hospitals.

7 MR. CONSTANTINO: No, we do not.

8 MS. DEDERER: How do you do it?

9 MR. CONSTANTINO: We send out another survey  
10 and rely upon the administrators' attestation that the  
11 information is true and correct.

12 MS. DEDERER: Well, I would have to ask too  
13 then, why would they fill out the second survey differently  
14 than they the first survey.

15 MR. CONSTANTINO: They did it for the  
16 hospitals.

17 MR. PHILLIPPE: One issue could be how it's  
18 defined. I mean, the definition, if it's clear and  
19 concrete, that could help some.

20 MS. DEDERER: If that's the case, then change  
21 the first survey so it's clear and concrete and then get  
22 the right results the first time.

23 CHAIRMAN WAXMAN: Chuck?

24 MR. FOLEY: Well, I guess I thought we were

1 trying to identify the dead beds that we have, and the only  
2 way accurately that one could do that that I'm aware of is  
3 basically work in very close cooperation with Licensure and  
4 just have them going there and start counting beds when  
5 they do an annual survey period. I mean, that's the only  
6 way that you're going to do it. Otherwise, those  
7 operational beds could fluctuate several times and really  
8 doesn't mean anything.

9 MS. DEDERER: Mike is smiling.

10 MR. FOLEY: I hate to put IDPH on the spot  
11 with Licensure, but we need to have some cooperation.  
12 Rick?

13 MS. DEDERER: Do we go out annually to do  
14 licensure?

15 MR. DEES: Not every facility. If it's a  
16 license-only facility that qualifies for a (unintelligible)  
17 license -- and there's a small number of them -- we would  
18 be there every other year. But certified facilities, we're  
19 out annually, at least.

20 MS. DEDERER: But you don't count beds while  
21 you're there.

22 MR. DEES: No. It's a sample based survey  
23 process.

24 MS. DEDERER: How can you check staffing

1 ratios if you don't count beds, or do you?

2 MR. DEES: We get a census, and it's based  
3 upon the resident census as of that day, and the facility  
4 provides us with that. We don't go room by room and count  
5 beds.

6 MS. DEDERER: Okay. So that's occupancy as  
7 opposed to operational.

8 CHAIRMAN WAXMAN: Sorry, guys. I have a  
9 request over here to speak.

10 Eli?

11 MR. PICK: If I may, what I would suggest is,  
12 rather than going from problem to solution, I think we  
13 should focus on data. We seem to go in circles, talking  
14 about perceived issues and then trying to solve them, and  
15 do some inquiries on how the process works. What I am  
16 finding is much more productive is for us to first identify  
17 the issue, which I think we have, and that is how many  
18 beds, licensed beds are out there that are non-functional,  
19 and then try to gather data about approaches and  
20 interventions that may have been employed in other  
21 circumstances that have yielded better, more reliable  
22 information than what we have now. And so, rather than  
23 prescribing different ways to solve the problem, I think it  
24 would be more fruitful for us to first agree on an

1 approach, and I think the first step is let's take a look  
2 at this hospital instrument as one potential approach, and  
3 once we agree on an approach, then I think we can start to  
4 design a process around that approach to make sure that the  
5 information is accurate, reliable, and hopefully we can  
6 start to build some consistency.

7 CHAIRMAN WAXMAN: I would suggest that not  
8 only do we need to see the hospital document, we  
9 probably -- the Committee probably all needs to see the  
10 document that's currently being used in the long-term care  
11 buildings, too.

12 MR. PHILLIPPE: That would be wise.

13 CHAIRMAN WAXMAN: Mike, is there not a  
14 penalty or a consequence for inaccurate information on the  
15 current survey you are doing?

16 MR. CONSTANTINO: Yeah, if we find out about  
17 it, Mike, but we do not do on-site surveys -- or on-site  
18 inspections. I'm sorry.

19 CHAIRMAN WAXMAN: Is your gut feeling that  
20 the information you are receiving is accurate?

21 MR. CONSTANTINO: Well, it was until Don spoke  
22 up at the last meeting. I felt the attestations we were  
23 receiving was true and correct. That's what they were  
24 telling us. And Don said it most likely is not.

1 MR. URSO: The Board has issued sanctions to  
2 non-compliant respondents.

3 CHAIRMAN WAXMAN: Really? Okay. Hospital or  
4 long-term care or both?

5 MR. URSO: Everybody, anybody in any form.

6 MS. MITZEN: So this group -- I really like  
7 what Eli just said. We've identified a problem, and now we  
8 need to go toward, how we then get the accurate data that  
9 we need to get, which may imply both instruments and also  
10 methodology, and I think the method --and if there are  
11 sanctions for incorrect reporting, but then the reporting  
12 is flawed -- I think we need to look at the whole bundle.  
13 We have to make recommendations based on accurate data, and  
14 clearly this is not available to us now.

15 CHAIRMAN WAXMAN: Tim? And then I'll come  
16 back to Don.

17 MR. PHILLIPPE: I agree with getting the  
18 information. Let's look at the questionnaire, let's see  
19 how it's defined in the questionnaire, look at the  
20 hospital -- so we can learn more first, because I don't  
21 want people to jump to conclusions that people are lying.  
22 It's very possible that the way it's defined in the  
23 questionnaire -- the way we talked about it in our work  
24 group, if it's 24, 48 hours, that means if you have access

1 to furniture and you have a need, you can move it in and  
2 set it up. That's very different than I think we're doing  
3 here, when it may have never been needed it in that  
4 building, because there's no option, they don't have --  
5 there's not enough census potential or they are wanting to  
6 keep them private rooms. And so we shouldn't assume people  
7 are lying. It's very possible it's how it's defined and  
8 we're thinking of it differently, and I think getting the  
9 data would help us do that.

10 CHAIRMAN WAXMAN: Tim, I'm assuming that no  
11 one around either table is believing that people are  
12 purposely filling out their surveys inaccurate. I just  
13 wanted to make sure that people were aware that they are  
14 attesting to it and there are penalties involved for not,  
15 as a means for people to understand why they would be  
16 filling it out correctly. So, I don't think that  
17 assumption exists. Maybe it needs to, but right now I  
18 don't think it does.

19 Don?

20 MR. REPPY: I just have a question of  
21 clarification. It appears that what we're looking at is  
22 keeping the existing formula and just changing to  
23 operational beds, and I'm wondering if the general  
24 consensus is that that's the only problem with the existing

1 formula.

2 CHAIRMAN WAXMAN: I don't think that's a  
3 correct assumption. I think we're trying -- I think we all  
4 recognize that there are several areas that need to be  
5 looked at, and we're trying to narrow down our areas to  
6 look at, and one which -- one of those that have been  
7 identified is bed count and what beds are we really  
8 counting. I assure you that this group is very vocal in  
9 other areas, and what we have to do is make sure we kind of  
10 focus on one issue at a time, because we discovered in past  
11 meetings that trying to focus on multiple issues at the  
12 same time does not lead to progress. So, no, we are -- we  
13 clearly have a list of things that we're going to look at,  
14 but we are trying real, real hard to narrow each meeting to  
15 a different purpose or parts of meetings to different  
16 purposes.

17 MR. REPPY: Thanks.

18 CHAIRMAN WAXMAN: If that -- yes, ma'am?

19 MS. DEDERER: I was going to add that we've  
20 been told there's a difference between the bed-need formula  
21 and the Certificate of Need process and that the bed-need  
22 formula would be extremely difficult to change on any kind  
23 of a meaningful basis, other than something like  
24 operational versus licensed beds, and that we would be

1 better off making recommendations regarding the Certificate  
2 of Need process, right, like variances and that kind of  
3 stuff that could be put into the process but not  
4 necessarily into the formula. Is that correct, other  
5 people who are --

6 MR. PICK: If I can comment, I think your  
7 characterization, while it addresses some aspects of what  
8 we've been discussing, is not accurate.

9 MS. DEDERER: Okay.

10 MR. PICK: I think one of the things that I've  
11 learned from Claire is the bed-need formula is one  
12 component of the CON process. It is not the whole thing.

13 MS. DEDERER: That's what I meant.

14 MR. PICK: So, operational beds or licensed  
15 beds is certainly one subset of the bed-need formula, and  
16 we determined that that's an area we need to look at more  
17 closely. I think one of the things I would caution -- and  
18 I think what, Teri, you're trying to say is that we have  
19 interchangeably been using bed-need formula for how to  
20 determine whether there's a need, and as Claire has  
21 reminded us, the bed-need formula is only one aspect of  
22 that process.

23 MS. ALTMAN: And that's what I was going to  
24 bring up about 3 and 5. I think, Tim, you accurately said

1 that a lot of us had just spent time in the work group  
2 discussing how facilities could provide information or  
3 should provide information about other community-based  
4 services and other even facility-based services like  
5 assisted living, supported living, and home and  
6 community-based services, in order to show that there is  
7 actually a need for nursing home beds or increase in  
8 nursing home beds as compared to what's available in the  
9 community, and I think was strong support for there being  
10 some sort of showing in the CON process what else is in the  
11 area in terms of showing need. I don't totally agree, Tim,  
12 that, as you put, gathering the data in both of those areas  
13 seems to be very difficult. I think that we -- I don't  
14 think that we agreed that it was necessarily too difficult  
15 to do. It just wouldn't be part of the bed need, which, as  
16 Claire said, the actual formula, but perhaps could be part  
17 of that larger CON process, the way the other states had  
18 all of those factors. And our state does have those other  
19 factors.

20 So, maybe what we're talking about is a  
21 component to the bed-need formula, other factors that need  
22 to be in the CON process, and maybe the bed-need formula  
23 has taken too high a prominence in Illinois in the CON  
24 process, compared to some of the other states where you see

1 other factors, and weigh them more heavily.

2 MS. BURMAN: I'd just like to remind  
3 everybody -- and hopefully this is not overkill, but this  
4 is the only category of service, long-term care, that has  
5 variances to computed bed need, and they have been in place  
6 since day one. So, what we've been talking about off and  
7 on are adding to the types of variances that are available,  
8 so that in case the bed-need formula isn't the way that you  
9 can show the need, you can move into a variance and make a  
10 very good case.

11 MS. ALTMAN: I also meant like the opposite,  
12 not that they needed a variance from the bed need in order  
13 to get it, but also the opposite, that in order to get  
14 approval for need, that you had to show these other  
15 factors -- not the opposite but the corollary.

16 MR. PHILLIPPE: I agree, I do agree with all  
17 of that. Our work group, as I understand it, is focused on  
18 the bed-need formula. Those other things are important. I  
19 think they're very important in the application process,  
20 and I think we can talk about those. And so I didn't mean  
21 to say that those were too hard to gather in the process.  
22 What I meant was I think, as we talked about it, it's very  
23 hard to try to fit those into the bed-need formula, because  
24 we don't have some of the same information available. We

1 know licensed, assisted living beds. We don't really know,  
2 as far as I know, census of assisted living.

3 MS. DEDERER: I think we can get that. I  
4 don't think that's a big problem.

5 MR. PHILLIPPE: Accurate?

6 MS. DEDERER: Well, as accurate as nursing  
7 home.

8 MR. PHILLIPPE: Anyway, so if we can get it,  
9 that's fine. I think we all agree, I think all of those  
10 other things should be an important part of the bed need  
11 and the whole Certificate of Need process. But I think at  
12 least starting out, I agree with whoever said we should  
13 start simple, and the bed-need formula is probably the  
14 simplest place to start, because it's nice and clear and  
15 concrete, and then if we can move from there to the things  
16 that are more complicated, it seems it would be easier for  
17 us to accomplish things.

18 CHAIRMAN WAXMAN: I have a sense -- and,  
19 again, I apologize for kind of doing this, but I think  
20 based on past experience, I have a sense we're going into  
21 the world of too many variables again. So, I'd like to  
22 come back and focus back on bed need, operational versus  
23 licensed, get closure on how we're going to fix that, and  
24 decide whether that issue should go back to Tim's committee

1 and let them look at everything and come back to us in the  
2 future with a recommendation about how to get it, how to  
3 survey it, and once we have closure on that discussion, I  
4 am willing to open up on some of the other topics. But I  
5 would like to get some closure on that subject first,  
6 please.

7 MS. MITZEN: So the process would be that  
8 very narrow, that one piece? Have we defined all of the  
9 other pieces that go into the -- that we'll be looking at?

10 CHAIRMAN WAXMAN: We have not, but I don't  
11 want to start defining -- I don't want to open up so broad  
12 that we're going to spend two hours not getting anywhere.

13 MS. MITZEN: Yeah, I understand what you're  
14 saying. I guess my concern -- I mean, I'm very willing to  
15 participate in a conversation that's very narrow, as long  
16 as I was sure that we were going to be able to then, before  
17 our final recommendation is made, get to these other  
18 topics.

19 CHAIRMAN WAXMAN: Absolutely. I just want to  
20 get closure on one thing so we can move on to the other  
21 variables.

22 MS. MITZEN: And there's not a possibility of  
23 doing parallel?

24 CHAIRMAN WAXMAN: I don't know why we would

1 want to. I personally would like to get closure on the  
2 thing that we started with, which is operational versus  
3 licensed, get it assigned on to somebody to work with and  
4 get back to us and then the table is available for wherever  
5 you want to go.

6 MR. REPPY: Question for Frank. You indicated  
7 that the Board has a sanction, has sanctions on reporting  
8 beds, correct? Is the sanction for not reporting, or is  
9 the sanction for not reporting correctly?

10 MR. URSO: Not reporting, because we are  
11 assuming, because there's certifications and attestations  
12 with the surveys, that -- you know, that we're accepting it  
13 as being true and accurate. So, it's for not reporting or  
14 being delinquent in reporting.

15 MS. DEDERER: But do you have sanctions if you  
16 find out that what's been reported is not true?

17 MR. URSO: If we found that out, we would  
18 definitely take a look at that and investigate it, yes.

19 MS. ALTMAN: Can you revoke the certificate or  
20 something or license?

21 MR. URSO: That's an extreme remedy. We would  
22 probably investigate it, take a look at all of the factors,  
23 bring it to the Board, and the Board would decide what they  
24 want to do.

1 MR. PICK: Again, I think it would be helpful  
2 to look at the questionnaire itself, because my  
3 recollection is that there is something on there that says  
4 there are consequences -- it's not the term that's used --  
5 for providing false information.

6 MR. URSO: That's correct.

7 MR. PICK: So, whether the attestation is  
8 false or whatever, there are consequences for providing  
9 inaccurate or false information.

10 MR. URSO: We would have a very difficult time  
11 with our limited resources to check the accuracy -- what is  
12 it Rick, about 1,100 nursing homes?

13 MR. DEES: Yeah.

14 MR. URSO: So that's why we put the  
15 attestation clause on surveys, with the assumption that  
16 people are going to tell you the truth. If we found that  
17 to be not the case, we would take a close look at it.

18 MR. PICK: Again, I think short of turning  
19 this into a police state, I think there are other solutions  
20 for getting accurate information. So regardless of the  
21 fact that we certainly don't have the resources to deploy  
22 people and go physically count beds, I think there are many  
23 other approaches that could be used to shore up how to get  
24 accurate information, one of them being just making sure

1 that the terms and the way it's phrased on the form is  
2 clear and then everyone understands that we are -- that the  
3 question is clear and the answer is clear.

4 MR. URSO: I think that's what was done in the  
5 hospital survey, is definitions were created for different  
6 types of beds and it left very little room for error in  
7 that regard. You read the definition. Okay, this is  
8 what -- and I forget what the different labels are. Claire  
9 and Mike know what the labels are, but we spent a lot of  
10 time defining what a particular bed was. People looked at  
11 it like we're crazy. "Why do you have so many definitions  
12 of beds?" We want to make sure people understand that one  
13 bed is different than another bed, depending on what it's  
14 used for and where it's at and who's in it.

15 MS. MITZEN: That's why I think we should  
16 probably take a look at that and see whether or not those  
17 definitions are the same as --

18 MS. HANDLER: I'm sure the definitions are  
19 going to be different, but we should be able to get some  
20 guidance around whether they brought clarity and focus to  
21 the hospitals. The hospitals have way more types of beds  
22 than --

23 MR. URSO: As I recall we said, "Okay, what  
24 other different kinds of beds are there?" And I can't

1 remember how many we came up with. And then we defined  
2 them, and we thought that fit all of the different  
3 categories.

4 MS. BURMAN: It's not based on service. It's  
5 based on operational status.

6 CHAIRMAN WAXMAN: Tim, do you feel like this  
7 question is a continuation of your subcommittee?

8 MR. PHILLIPPE: Does that mean I have to lead  
9 more meetings? I think it is. I think that's where we  
10 started.

11 MR. PICK: Tim, you know the reward for good  
12 work is getting more.

13 MR. PHILLIPPE: I think we started with that,  
14 so it makes sense to continue.

15 CHAIRMAN WAXMAN: Mike, would you -- I guess  
16 it's you -- send out to all of the members then a copy of  
17 the current survey form for long-term care?

18 MR. CONSTANTINO: Sure.

19 CHAIRMAN WAXMAN: And then a copy of the  
20 hospital survey to all of the Board members and then --

21 MR. PICK: If I may, if we still have a copy  
22 of the prior iteration of the hospital reporting form, so  
23 that we see how it changed from the way it was to way it  
24 is, I think that would also be helpful.

1 MS. HANDLER: Is the hospital form an  
2 additional, or is it a revision to something that was  
3 already being done?

4 MS. BURMAN: It was a revision.

5 MS. AVERY: But it's separate now.

6 CHAIRMAN WAXMAN: I think once everybody has  
7 those same documents, then, Tim, you can pull your  
8 subcommittee again and start writing some definitions or  
9 looking at those forms and decide whether you want to  
10 recommend a new form, or a new set of definitions, if you  
11 are okay with that concept.

12 MR. PHILLIPPE: Okay. That makes sense.

13 CHAIRMAN WAXMAN: Mike?

14 MR. SCAVOTTO: I had a question for Tim. In  
15 your meetings, when you were discussing the formula, did  
16 you get into the different types of operational beds? And  
17 this could be important for your -- I'm going back to a  
18 prior discussion. There was quite a bit of concern where  
19 you could have -- you could basically have a group of  
20 operational beds that were undesirable, like the eight-bed  
21 wards. There are not that many out there, but they're  
22 still there. Four-bed wards, they're still out there, and  
23 they may still be -- they may be dead, but they're  
24 certainly licensed. Whether they're desirable or not is

1 another story.

2 MR. PHILLIPPE: We did have a discussion -- I  
3 think Don brought up some of these ideas. But it really  
4 has to do with what people mean by "operational," and  
5 there's operational according to the questionnaire and  
6 there's the way the providers think about operational. So,  
7 that is part of the issue I think. You're right.

8 MR. SCAVOTTO: So we could subdivide and ask.

9 MR. CONSTANTINO: I'll send you our  
10 definitions.

11 MR. SCAVOTTO: Whether it goes anywhere, at  
12 least you've got the data.

13 MR. PHILLIPPE: I should mention one thing, I  
14 guess representing what some providers might be concerned  
15 about, is that I have heard conversation before -- I don't  
16 know if it's in this group -- about should a facility be  
17 able to keep their licensed number if they're operational.  
18 number is so much lower. Okay?

19 MR. SCAVOTTO: That was here.

20 MR. PHILLIPPE: Okay. It may be here. And I  
21 know there's other discussions that people have pointed  
22 out. So, there are ideas about selling beds. People have  
23 talked about your financing often is tied to bed capacity  
24 and it's difficult -- you need to get approval to change

1 it. I want to make sure -- right now from my perspective  
2 we're not talking about big picture here, we're talking  
3 about the bed-need formula.

4 MR. FOLEY: Tim, that's excellent. I think  
5 what we were talking about was getting that difference in  
6 beds and putting it over here, like in a bank, so to speak,  
7 and that would also be the buy/sell beds as well. They  
8 don't lose those beds. They're still licensed by that  
9 facility, but they're not counted in the bed-need formula.  
10 They're just banked over here, and the facility has the  
11 right to go back and get those beds if they want, but those  
12 beds that are in the bank would also be used to buy/sell.

13 MR. PHILLIPPE: So, my position is -- I'm not  
14 taking a position on that. I'm saying that's a talk for  
15 another day. What we're talking about here is the bed-need  
16 formula and how to understand if there is truly a need in  
17 the community.

18 CHAIRMAN WAXMAN: I agree.

19 MS. MITZEN: That's our responsibility.

20 CHAIRMAN WAXMAN: I think the whole concept  
21 of buy/sell is a whole different conversation. I think  
22 right now we're just trying to get an ability to count beds  
23 and to distinguish between operational and licensed, and I  
24 think that's all we're looking for right now.

1 Tim, thank you.

2 MR. PHILLIPPE: Thank you.

3 CHAIRMAN WAXMAN: Okay. In my mind, we now  
4 have a process to define and moving -- getting a solution  
5 to that piece of the puzzle. I am now willing to take any  
6 of the other variables open for discussion that you want  
7 to.

8 MR. PICK: Before you do that, Michael, if I  
9 may, one of the things we ran into as part of the  
10 sub-subcommittee was the number of participants who were  
11 not officially part of that group but willing to  
12 participate, which then caused us to have to fall within  
13 the Open Meetings Act and you have a stenographer. So, I  
14 think what I would like to suggest -- and perhaps we could  
15 open it up for discussion again in this group -- is that if  
16 we establish a subcommittee with a charge, it's the  
17 subcommittee that should be working on that charge rather  
18 than a larger group, which includes the subcommittee. The  
19 reason for the subcommittee is so that the whole group  
20 doesn't have to work on it again, and somehow it morphed  
21 into a large group again. So, I think from a procedural  
22 standpoint, I would like to just reinforce, there's no  
23 reason to establish a subcommittee if half of the whole  
24 committee wants to get into the discussion.

1 MS. DEDERER: Well, half is still half.

2 MS. ALTMAN: Then we should just have that  
3 here. There's no need for a work group.

4 MR. PICK: Right. That's the purpose of  
5 bringing the work product back to the whole group to  
6 review, discuss and then determine what the next steps are.  
7 But there's such a high level of anxiety to be involved in  
8 every -- all the minutia that it just slows the whole  
9 process down again. So that's what I would like to  
10 reinforce, you know, as part of the -- being the  
11 Vice-Chair, that I think we need to maintain the integrity  
12 of what we're trying to accomplish and that the purpose of  
13 having this small work group is just that, have a small  
14 work group, but if the small work group becomes a larger  
15 group again, then all we're doing is perpetuating the same  
16 going-in-circles. Who is on that committee, so it's clear  
17 to the whole group?

18 MS. DEDERER: Can I point something out? Tim  
19 or -- I don't know who did it -- Courtney or somebody had a  
20 very specific agenda for this work group and kept it very  
21 much on task to that agenda, and it was very clearly  
22 outlined, and when other topics were brought up, they were  
23 added in an orderly fashion, and I think that kind of  
24 structure dramatically aided the conversations, and that's

1 been something we've been difficult to achieve in the  
2 larger group, although I think that the same thing would be  
3 useful. But I think to again characterize the fact that  
4 people want to be involved in minutia probably is just a  
5 difference of what's important to different people, and  
6 some of us think things are really important and others of  
7 us don't think they're important.

8 CHAIRMAN WAXMAN: I'd also like to point out,  
9 though, once the report from the work group comes back,  
10 it's still available for everyone to have input. So, no  
11 one is being excluded. The concept is to get some work  
12 done outside of this meeting and move forward at a little  
13 faster pace with reports from various work groups. It  
14 still is open to discussion at the big meeting.

15 MR. PICK: So can we clarify who is on this  
16 work group?

17 MR. PHILLIPPE: Good.

18 CHAIRMAN WAXMAN: I'm not sure I have that  
19 information.

20 MS. ALTMAN: I think we do.

21 CHAIRMAN WAXMAN: Is that accurate? Okay.  
22 At the top of Tim's minutes -- and, again, Tim was  
23 responsible for the structured agenda, so give him credit  
24 for that. The people who are listed at the top of his

1 report are the committee, are members of the committee.

2 So --

3 MR. PICK: Well, then we've got a problem,  
4 because you've got seven members of the committee. That's  
5 Dave, myself, Pat, Phyllis, Stephanie, Teri, and Tim are  
6 all members of the big group, which is -- if we're over  
7 six -- is that correct? So, I think perhaps we've got some  
8 structural issues.

9 MS. ALTMAN: I don't think we were having a  
10 problem with avoiding Open Meetings Act. We don't have to  
11 avoid Open Meetings Act to be a work group. So, for  
12 instance, like Older Adult Services Advisory Committee, we  
13 have work groups that are a manageable size, six or seven  
14 people. We abide by the Open Meetings Act so that  
15 anyone -- we post notice of our meetings, our minutes and  
16 anyone can be there. We do usually do something like what  
17 is suggested here, where the members of the work group  
18 discuss what they want to discuss, and if someone wants to  
19 make comment respectfully afterwards, they can make a  
20 comment. But we try to encourage it basically be the work  
21 group itself that is making it.

22 As far as having the Court Reporter and the  
23 recording, I brought that up before, and you guys here want  
24 to do that and have a transcript. No other group that I'm

1 on, no other steering committee or advisory committee with  
2 the State does that, but that's your choice, and if that's  
3 what they want to do for the Open Meetings Act, then I  
4 guess.

5 MS. AVERY: It's not a choice. We have to.

6 MS. ALTMAN: For every work group --

7 MS. AVERY: We're such a board with such a  
8 history and bad background, they want to know -- and this  
9 is Senator Garrett's project, that she wanted to establish  
10 this with feedback from the community. So this is how we  
11 capture things accurately.

12 MS. ALTMAN: That's up to this committee. I  
13 just brought that up as something that is an encumbrance in  
14 the meetings and a cost. That's the only court-reported,  
15 transcribed -- I can see why that's true for the Mother  
16 Board. I didn't know why that needed to be true for this.

17 CHAIRMAN WAXMAN: Tim, based on a long,  
18 extensive conversation I just had with counsel, will you  
19 make sure that they're aware of your meeting dates so we  
20 can abide by the Open Meeting Act?

21 MR. PHILLIPPE: Yes.

22 CHAIRMAN WAXMAN: So they can arrange for a  
23 stenographer and Staff to be there.

24 MR. PHILLIPPE: Yes.

1 CHAIRMAN WAXMAN: I don't think we can get  
2 around it any other way.

3 MR. PHILLIPPE: Claire has been very helpful,  
4 once that was pointed out to us, because we had more people  
5 at the first meeting than we expected. I think we can  
6 follow through on that, as long as she continues to help me  
7 with that.

8 MS. ALTMAN: The problem is that it's so  
9 inhibiting on a phone call. You had a stenographer last  
10 time asking, "Who is talking now? Who is speaking now?" et  
11 cetera. It's bad enough at a --

12 MR. URSO: But phone calls on their own being  
13 are difficult to conduct.

14 MS. ALTMAN: True, but it made it so much  
15 worse having a stenographer.

16 MR. PICK: Can I ask, if we're over six, is  
17 that the issue, once we're over six?

18 MR. URSO: The majority of the quorum.

19 MR. PICK: So five and under is fine?

20 MS. ALTMAN: Let's limit it down to five. I'm  
21 willing to not be on it. I think I'm knowledgeable on the  
22 subject.

23 MS. AVERY: I don't think anybody needs to  
24 step off. Maybe you need to step off the work group,

1 maybe.

2 MS. HANDLER: It sounds like the meeting has  
3 to be transcribed no matter what.

4 MR. PICK: No, five or under, there is no need  
5 to, is that correct?

6 MS. AVERY: All of our work.

7 MR. PICK: It doesn't matter how many?

8 MS. AVERY: We can clarify it from the Board  
9 and probably Senator Garrett's office. Do you think,  
10 Frank? We can clarify and find out.

11 MS. ALTMAN: It's Illinois law what's Open  
12 Meetings Act.

13 MR. PICK: Also, we want to be sensitive to  
14 resources. So, having Staff and a stenographer at each one  
15 of these meetings, it's consuming resources.

16 MR. URSO: Let me ask this question. Tim, if  
17 you didn't have a transcript, would you have been able to  
18 put this report together?

19 MR. PHILLIPPE: Yes.

20 MS. AVERY: Are people feeling like they can't  
21 verbalize and then with us having say who is speaking -- I  
22 just want to make sure I understand --

23 MS. ALTMAN: Mine are somewhat two-fold, and  
24 maybe it's just because -- I mean, I've done this for 22

1 years but not on this committee. I think I've been on at  
2 least ten either official or non-official advisory groups,  
3 Human Services Commission of Illinois, et cetera.  
4 Absolutely never had a court reporter and transcript, ever.  
5 There's always note takers, there's always meeting minutes,  
6 there's Open Meeting Acts, there's always posting. You can  
7 look at every single State agency website and see how many  
8 committees are we on.

9 I think it inhibits two ways. It's not  
10 impossible to go forward, obviously, but the last phone  
11 call we had extra people on. We had stopping conversation  
12 several times for the Court Reporter to stop us because  
13 people were talking over -- or what she perceived of  
14 talking over us each other, but it was actually a pretty  
15 quick give and take and she stopped us several times to ask  
16 who was speaking, even more so than we do in person. I  
17 mean, people are nodding their head who were on the phone,  
18 Eli, Claire and Phyllis, so I assume I'm not the only one.  
19 It's inhibiting. It's a difficult conversation. A  
20 conference call is somewhat difficult anyway, but sometimes  
21 you do it for expediency. We did really well on our first  
22 one without a Court Reporter. However, the one with the  
23 Court Reporter was much more difficult. So, that's my  
24 opinion.

1 MS. AVERY: We'll check in to it and make  
2 sure.

3 MR. PICK: If I may, I think the only thing it  
4 does is it makes it a much more formal exchange as opposed  
5 to a casual conversation about different issues. So I  
6 don't think it's a matter of secrecy or anything like that.

7 MS. AVERY: It's not secrecy, but I just want  
8 to make sure that people feel they can have a voice and  
9 speak, so we will check in to it.

10 MS. MITZEN: The purpose of these, I think,  
11 both is a sharing of information, and we're all learning  
12 from each other during this process, and I think it's kind  
13 of -- you want an easy flow of conversation so that we can  
14 build on that and then come up with a consensus.

15 MS. ALTMAN: And we had a set agenda and set  
16 amount of time, I think sixty minutes on the first one and  
17 on the second one, so we were kind of under pressure to not  
18 talk too long.

19 MR. URSO: I can say that the Mother Board  
20 errs on the side of transparency for everything it does.

21 MS. MITZEN: We support that. I think  
22 transparency is really important.

23 MS. ALTMAN: There is obviously a history with  
24 the Health Facilities Planning Board that is leading in to

1 all of this.

2 MR. PICK: It's an issue.

3 MS. ALTMAN: It's an issue. I find it  
4 difficult to participate.

5 MS. AVERY: I think we can look into that and  
6 look at how we can still be transparent by whatever means,  
7 the outcome, the report or the minutes or whatever, post  
8 that on the website.

9 CHAIRMAN WAXMAN: Okay.

10 (Discussion held off the record.)

11 CHAIRMAN WAXMAN: Okay. So, I'd like to move  
12 on.

13 Phyllis, you felt like there was some other  
14 pieces you wanted to put on the table. Now is your time.

15 MS. MITZEN: It really was a question, of  
16 what other pieces then go into the Certificate of Need  
17 determination. It was great to parse that out, that the --  
18 that this licensing versus occupancy is one piece of it.  
19 We have suggested that, as I think Stephanie just talked  
20 about what's available in the community, what other  
21 licensed or certified beds are available to people should  
22 be another factor that needs --

23 MS. ALTMAN: I think what Claire pointed out  
24 in all of the comparisons she did and all the work she did

1 for us of other states, I think the three that were most  
2 important to me or that flowed to the top for me were, one,  
3 the other licensed beds in the other facilities, types of  
4 facilities; two -- which is a little easier to get at than  
5 number two, which is what other services are in that area  
6 to support people being at home or in the community, such  
7 as emergency home response, medication management, respite  
8 care, food delivery, et cetera, et cetera, and some of the  
9 things we pointed out, some of the things that were  
10 actually included in other states' requirements, that there  
11 has to be a showing; and, the third was the Medicaid  
12 availability issue, which is the third one that was most  
13 important to me, which was that many people had brought  
14 out, including me based on my representation of clients,  
15 that even though there are beds available, there's often  
16 difficulty with Medicaid as a payor source in Illinois.

17 MR. PICK: Even more so now. The other thing,  
18 as part of the work group I had requested data from a  
19 variety of agencies, including DHS, and Teri was very  
20 helpful in getting that information. But I requested data  
21 from the Illinois Department of Public Health, and  
22 Healthcare and Family Services, and the Healthcare and  
23 Family Services as it relates to -- and the Department of  
24 Aging, and the Department of Aging data I found is most

1 intriguing; first, that the numbers were significant, more  
2 significant than I had appreciated prior. And, in fact, I  
3 got -- so, at the time of the committee, it was around  
4 70,000 individuals receiving Medicaid-funded services, and  
5 I received the subsequent report -- because that was as of  
6 June -- and as of September 30, it's now 74,000. So,  
7 the -- but there were some other interesting aspects about  
8 this that I thought was relevant, and that was that Elton  
9 Arrindell, who was sort of the provider of the data,  
10 indicated that people come on and off, which is much  
11 different than in a nursing home, that when clients are  
12 funded by Medicaid in a nursing home, once they're on,  
13 they're on.

14           So, I think that one of the things that we do  
15 need to be cautious about is that while the service might  
16 be exactly the same or portions equivalent, the dynamics  
17 are different, and that needs to be appreciated in our  
18 process, that what seems to be happening in the  
19 community-based services is folks will get benefits for a  
20 period of time and then go off for a period and they may go  
21 back on, depending on circumstances, where in an  
22 institutional setting or an inpatient setting, that once  
23 they're on and they're in that setting, they're on the  
24 entire time they're in that setting.

1 MS. ALTMAN: And the reason for that is that  
2 most people who are over age 65 obviously have Medicare.  
3 In order to get dual eligibility or Medicaid, they have to  
4 be under about \$900 a month, or they have to spend down  
5 their income and assets to do that. When they're in a  
6 facility, that cost of the facility meets their spend-down.  
7 That's why. It consistently meets it. When they're in the  
8 community, their ability to meet that spend-down goes up  
9 and down, depending on what their health expenditures are.  
10 That's why you see people cycling on and off.

11 MS. DEDERER: Actually, home services counts  
12 towards spend-down.

13 MS. ALTMAN: It does.

14 MS. DEDERER: And Aging was working on doing  
15 the same thing, so that will --

16 MS. ALTMAN: They already have.

17 MS. DEDERER: Okay. So then we do all  
18 contribute. But people do go on and off spend-down.  
19 However, they continue getting services regardless of  
20 whether they're Medicaid or not. So, they're not going on  
21 and off. They're going on and off Medicaid, and I think  
22 that's a very different sort of thing.

23 MS. MITZEN: The Medicaid is more complicated  
24 than --

1 MR. PICK: I'm not bringing this up to  
2 necessarily get some clarity at the moment. I'm merely  
3 raising it as an area that we need to educate ourselves  
4 more, because those of you who are directly involved in  
5 home and community-based services, for you it's second  
6 nature to know all those details. It's not for someone  
7 like me coming out of the nursing home arena. So, I think  
8 the reverse is also true, that there are aspects that we  
9 take as second nature that you may not be as well versed  
10 in. So that's the opportunity for us to collaborate to  
11 better understand and learn the details and the dynamics of  
12 each of our respective arenas that we come from, so that we  
13 can better plan and understand how to meet consumers'  
14 needs, and so I think, much like we started, where we had a  
15 perception of what the bed-need formula was, and as we've  
16 learned and gotten more intimately involved in  
17 understanding the process, we have a different appreciation  
18 for what it is and how it plays as part of the process of  
19 awarding someone a certificate to develop a facility, I  
20 think the same is true for us to learn how different  
21 agencies are providing and funding services and how they  
22 correlate, because ultimately we're coming back to the same  
23 basic question. If a person has a need, how is that need  
24 met, who is funding it, and in what cases are they direct

1 equivalent, so that we can determine those needs are being  
2 met?

3 CHAIRMAN WAXMAN: Are you suggesting that  
4 another work group could be formed to educate this  
5 committee in total on community-based services?

6 MR. PICK: I'm not suggesting that now, but I  
7 think that may be something we will need to consider. I  
8 think we need to be careful, as you've correctly  
9 identified, of not veering off on tangents, that our focus  
10 as the Advisory Committee is revolving around planning, and  
11 I think what I'm learning in the course of this process is  
12 that there is much more detail associated with the  
13 provision of services than I ever understood.

14 MS. ALTMAN: I think that's more appropriate  
15 for a group discussion. I think it is very much to the  
16 point. When you're looking at an area and you're planning  
17 for a need, it is important to get as much information --  
18 that's our opinion that we're trying to put forward. It's  
19 important to get as much information about the home and  
20 community-based services that keep people in the community  
21 as it is about the institutional level of services. The  
22 eligibility for Medicaid is becoming more and more  
23 important, and the State is moving all of their programs to  
24 a Medicaid-only -- and that may be reverse, but to a

1 Medicaid-only requirement. So, it is easier than it has  
2 always been to meet spend-down for higher income  
3 individuals when your cost of services is higher. So,  
4 that's an institutional setting, although, Teri, as you  
5 say, prospective use of the waiver services, like community  
6 care program and home and community-based services through  
7 the waiver programs, can be used as well, and other things  
8 tend to go in and out.

9           So, that's just part of the discussion about  
10 how you access home and community-based services and  
11 whether it's more difficult or not. It's a bias in favor  
12 of, right? In the Federal Medicaid Act, it's a bias in  
13 favor of institutional level of service and has existed  
14 since the beginning. It's also so in Illinois.

15           MS. DEDERER: Something that occurred to me  
16 that I think that nursing home data has always been  
17 expressed or understood, at least periodically, in terms of  
18 the number of people in nursing homes per population, like  
19 how many beds per --

20           MR. PICK: -- thousand.

21           MS. DEDERER: Thank you. We've never done  
22 that -- at least we've never done that with Home Services,  
23 and I don't know that Aging has done it. I think it would  
24 be interesting to take that data and express it in those

1 terms, because there are regional differences in where home  
2 care, community-based care is provided. There's very  
3 definite regional differences and where agencies that  
4 provide all sorts of things, like home-delivered meals and  
5 even emergency home response, aren't available. It was  
6 just a thought as a way to kind of look at the data in the  
7 same sort of way.

8 MS. MITZEN: That's very interesting. It  
9 certainly is not something -- or at least to my  
10 understanding. And most of the planning for services is  
11 done through the Area Agencies on Aging, and I'm not sure  
12 that they're ever looked at it this way. But, actually, we  
13 just met with the new Director, several of us met with the  
14 new Director, and he's very interested in data. So, it may  
15 be a good time to talk about what kind of data he may need  
16 to make the -- to do this kind of planning there's a lot of  
17 data available.

18 MS. ALTMAN: Putting those two things  
19 together, planning, the population and the need, et cetera,  
20 et cetera.

21 MR. SCAVOTTO: Mike, I have a question. At  
22 the risk of sounding like the Christmas Scrooge, I have  
23 to -- I object to the tone that this discussion is taking  
24 and the direction that we're going, so I think that you

1 should straighten me out. I was under the impression that  
2 we were supposed to be looking at revising the Certificate  
3 of Need process as it applied to skilled nursing. That's  
4 not to say that all of the other providers, the older,  
5 aging, home-care based services -- those are all extremely  
6 important, but they're not specifically relating to the  
7 Certificate of Need, and my fear is that we're going to do  
8 a 360. We're going to be spinning our wheels and that you  
9 have a -- to me, you have a specific charge related to  
10 skilled nursing. I don't see us making any progress in  
11 that regard.

12           And just a comment from me, and you can take  
13 it or leave it. I think we're going to continue to have  
14 committee meetings that go nowhere because we're getting  
15 involved in too many tangents. I agree with Eli's comment  
16 that it's a complicated subject. I think the other  
17 providers around the table are -- they impress me with  
18 their intensity and their dedication to what they do, but I  
19 want to just ask everybody the question. Are we focused on  
20 skilled nursing or what?

21           MS. DEDERER: Can I speak to that, please, if  
22 I may? Home care provides skilled nursing. The same DON  
23 that determines whether you can go into a nursing home  
24 determines whether you can go into home care. I will grant

1 you that percentage-wise may be not as much as skilled  
2 nursing, particularly on the aging side, but on the younger  
3 adult side, we provide every bit as much skilled nursing as  
4 they do in nursing homes.

5 MR. SCAVOTTO: That may be the case. You do  
6 not provide it under the Certificate of Need.

7 MS. DEDERER: But can I finish?

8 MR. SCAVOTTO: You may.

9 MS. DEDERER: Over the last thirty years since  
10 home care started -- and home care started because people  
11 looked at the budget and said, "We cannot afford to  
12 continue long-term care for the next thirty years at the  
13 rate we're going." We had about the same number of beds  
14 then as we do now, licensed. That number of occupancy has  
15 gone down as home care has come in, even as the Baby  
16 Boomers are coming in and increasing the population that  
17 needs long-term care. And I think that the people at the  
18 table who do nursing home care want to preserve nursing  
19 home care, which is fine, because I think all of us agree  
20 that there are many people who need to be in nursing  
21 facilities. But not everybody does, and not everybody  
22 wants to, and when you're looking at a community and you  
23 look at long-term care, it's everything. I mean, we said  
24 it -- I don't know if you were at this meeting, but if a

1 person can't buy groceries and they're old, ultimately  
2 they're going to end up in a nursing home or something,  
3 because they'll starve to death otherwise. And so it isn't  
4 necessarily the need for skilled nursing. It is the need  
5 for care that they are no longer able to provide for  
6 themselves.

7 MR. SCAVOTTO: I think everybody around both  
8 tables probably agrees with that statement. It would be  
9 difficult not to agree with it. Okay. So the question I'm  
10 asking is are we focused on skilled nursing under the  
11 Certificate of Need Act, or are we looking at the broader  
12 spectrum of long-term care services, in which case we'll  
13 never adjourn these meetings, we'll never get our job  
14 finished.

15 MS. DEDERER: Why do you think that? It's not  
16 that hard. You just add another component to look at in  
17 your community. Is your community ripe with home care, or  
18 is there practically none? In southern Illinois, home care  
19 is not necessarily as dense as it is other places, because  
20 there aren't people to provide it. There aren't agencies  
21 to serve the low population areas, but we do have nursing  
22 homes down there. So I would expect -- I don't know this.  
23 I would expect that there's a higher number of beds per  
24 thousand people in a county in some of these

1 sparsely-populated counties than there are home care  
2 services being provided per thousand, simply because of  
3 availability of services. So it's something to look at in  
4 the community. Do you really need this much service for  
5 this population? And I would further complicate it by  
6 throwing in the Baby Boomers. But go ahead.

7 MR. FOLEY: I guess --

8 CHAIRMAN WAXMAN: Wait, wait, wait. We have  
9 people over here that have had their hands up quite a  
10 while.

11 Eli?

12 MR. PICK: Mike, if I can respond to your  
13 question, I think -- I agree with you. Our charge is for  
14 reviewing the process that determines how many skilled  
15 nursing beds in nursing homes are needed, and there are  
16 several factors that are focused on the discussion that  
17 we've had. One is the occupancy rate, which I think we all  
18 recognize is significantly lower than the number of beds  
19 and has continued to drop. We've had a whole host of  
20 identified reasons that that's -- that dynamic has been  
21 occurring, not necessarily the home and community-based  
22 services, but if you remember the study that was  
23 distributed that I shared, the primary reason that  
24 occupancy is declining is the level of disability in the

1 population has declined dramatically over the last twenty  
2 years. So, the question that we're being -- having to face  
3 is how to review our existing process that determines how  
4 many nursing home beds are needed in order to satisfy the  
5 consumers' needs when those services arise. Well, that  
6 naturally leads us to, in addition to nursing homes  
7 providing services, what other entities are providing  
8 services to the same population that also impact how much  
9 need is there.

10 I think that that really does keep us focused,  
11 but I do agree with you, that we need to limit these side  
12 bar conversations about all these other things that are  
13 going on. Our focus needs to be on skilled nursing beds.

14 MS. ALTMAN: I just think that when you look  
15 at every other state, including our own -- our own, as  
16 Claire pointed out, actually has some of those  
17 considerations -- in whether you need skilled nursing home  
18 beds in an area, it isn't just what other skilled nursing  
19 beds you have in that area. There are already some factors  
20 in our CON about what else is in the area. We're talking  
21 about adding other factors which relate to the community  
22 that should be looked at. I don't think they are tangents.  
23 When you look at Oregon and some of the other states, when  
24 they look at that, nursing homes have to prove not just

1 that there are a bunch of other nursing homes with beds  
2 available but that there are this kind of service and this  
3 kind of service, et cetera, and they are needed. And so I  
4 don't see it as being any different than let's say you have  
5 to have a license to have a Dominicks in a certain area,  
6 Northfield needs another Dominicks, and Dominicks had to  
7 say, "Well, yeah, there's a Jewell, but it's two miles  
8 away." They also have to say that there's a mini-mart at  
9 the gas station and there's food delivery service from  
10 Peapod and these other services that provide these exact  
11 same services as Dominicks does and is Dominicks needed?  
12 The only consideration is not that there's a Jewell.  
13 There's other services and other kinds of types of a range  
14 of services that provide the same things. It just makes  
15 sense to me.

16 CHAIRMAN WAXMAN: Mike, I tend to agree with  
17 you in concept, and I tried real hard this morning to make  
18 sure we stayed focused and at least complete a segment of  
19 what relates to the CON process in terms of bed count.  
20 But, you know, I also recognize that some of these other  
21 issues that are being discussed -- and I think it's part of  
22 the advantage of having a large group with so many  
23 different kinds of backgrounds. It broadens the  
24 discussion. Now, it also is a disadvantage in that it

1 broadens the discussion and, you know, it takes us in to  
2 some areas that may not seem to fit exactly where some of  
3 us think we should go. So, I think it's just a factor of  
4 everyone's background and the willingness or the  
5 thoughtfulness, if you will, of the Mother Board when they  
6 put together the Committee, consisting of nineteen people  
7 with such a diverse background. But I am trying to limit  
8 the subjects to those that relate directly to our task, and  
9 if I may, our charge -- and if you will bear with me a  
10 minute, I will read it again, just to make sure that  
11 everyone hears once again.

12                   Number 2 under the document that was dated  
13 September 2010, "Develop an open and transparent process  
14 that considers the following: How skilled nursing fits  
15 into the continuum of care with other care providers.  
16 Modernization of nursing homes." That's A and B. "C,  
17 establishment of more private rooms; D, development of  
18 alternative services; and, E, current trends in long-term  
19 care services."

20                   So, I think given that kind of broad  
21 description, we are complying with what our charge is and,  
22 again, I'll refer to Frank to see if you also agree or if  
23 we're misinterpreting.

24                   MR. URSO: No, I think this is all healthy

1 discussion.

2 MR. REPPY: I'm not a member of the Committee.  
3 Reduce the bed supply in nursing homes in Illinois, and the  
4 assisted living and the home care market will grow. We  
5 just -- it was just pointed out here that Oregon is a good  
6 example. Fourteen nursing home beds per 1,000 persons age  
7 65 in Oregon, and they have a vibrant assisted living and  
8 home care industry. Illinois, you use fifty -- actually,  
9 excuse me, that's wrong. Illinois -- Oregon has 24 beds  
10 per thousand; they use 14. Illinois has 64; you use 50.

11 You can't deal with everything here. You  
12 really can't deal with all of these individual pieces, but  
13 if you make a concerted effort to wisely reduce the nursing  
14 home bed supply so that patterns of practice in communities  
15 change and physicians begin to say to families, "Now, I'm  
16 not so sure here. Let's take a look at this, or let's take  
17 a look at that. There's other options for your mom or for  
18 your dad." If you make a concerted effort to reduce the  
19 supply and get the supply in the right places, you're going  
20 to make the assisted living and the lower levels of care --  
21 that whole segment is going to grow, because the money is  
22 going to flow there.

23 And so your effort to deal with the bed-need  
24 formula is the right effort, because you don't have too

1 much assisted living, you don't have too much home  
2 healthcare. You've got too many nursing home beds, and  
3 it's very easy for families in communities to say, "I want  
4 Mom to go here and this is why," and for the physician to  
5 say, "Yes, that's fine with me."

6 CHAIRMAN WAXMAN: Don, would you explain your  
7 role and what you do, because I'm not sure everybody  
8 understands that you're not just Illinois based.

9 MR. REPPY: I'm Director of Health Planning  
10 for HCR ManorCare, and I've been doing health planning for  
11 25 years, and I first appeared before the Board in Illinois  
12 in 1984. So, I do health planning in Michigan, in -- I do  
13 health planning for Illinois, but I also do South Carolina  
14 and Virginia and Washington state, and so there are a lot  
15 of other places that I've worked.

16 I would say if you're interested in the  
17 Medicaid situation, look at Washington. In Washington  
18 state, they evaluate every Medicaid patient in every  
19 nursing home every year and make a decision about whether  
20 that patient is appropriate to be in nursing home care or  
21 not, and they move that patient to --

22 MS. ALTMAN: We tried that three years ago and  
23 it failed.

24 MR. REPPY: In Maryland they have what they

1 call a Memorandum of Understanding. When you get a  
2 Certificate of Need, you also have to sign a document that  
3 says you will serve a certain number of patients as  
4 Medicaid patients.

5 There are all kind of things out there. You  
6 really don't have to reinvent the wheel. You've just got  
7 to go find out what's working somewhere else.

8 MS. ALTMAN: We found these things before and  
9 we brought them forward. But I'm interested in what --  
10 what would you do to the Illinois bed-need formula to  
11 reduce?

12 MR. REPPY: I would adopt a very simple 55  
13 beds per thousand formula, and that's it. You've got --  
14 you're occupied at 50. You're at 64 now. Get yourself  
15 down to 55. Make sure that -- adopt the Ohio system.  
16 That's what I would say. That will make -- and I didn't  
17 want to talk, but if you adopt the Ohio system, I can't  
18 think of anybody that's going -- that loses. Everybody  
19 wins. The Legislature wins, because you have fewer beds  
20 for Medicaid. The consultants win, because they become bed  
21 brokers, buy and sell across the state. The home health  
22 and lower level of care folks win, because the bed supply  
23 is reduced. I mean, I can't think of anybody that loses.

24 CHAIRMAN WAXMAN: Just so you understand,

1 Claire has brought to us resources from all over the  
2 country, so Claire has made us aware of multiple states and  
3 other states. In fact, there is a whole document. I don't  
4 know whether you have it or not.

5 MR. REPPY: I have it.

6 CHAIRMAN WAXMAN: That compares -- Claire's  
7 work that compares all of the states' CON regs.

8 MS. ALTMAN: Some of the states. But you're  
9 honing that down, too. Based an on all of that  
10 information, Ohio is the one that would fit best. It makes  
11 perfect sense.

12 MS. HANDLER: You're bringing your experience  
13 and saying that's a state where it seems to work across the  
14 continuum in the long-term care part of the --

15 MS. ALTMAN: That's the most helpful thing  
16 said today. Thank you.

17 CHAIRMAN WAXMAN: Claire, you did share Ohio.

18 MS. ALTMAN: Yes, but we have the information;  
19 it's his recommendation based on his experience that we're  
20 responding to.

21 MR. REPPY: One other thing. Don't worry  
22 about what's legislatively possible. That's not your job.

23 MS. DEDERER: I have a couple questions on the  
24 55 beds per thousand. Is that all beds or just Medicaid

1 beds?

2 MR. REPPY: All.

3 MS. DEDERER: And does it take into account a  
4 differentiation of short-term beds versus long-term beds?  
5 I mean, there's long-term care provided on a short-term  
6 basis for people recovering from acute episodes in the  
7 hospital, doing rehab, whatever. So does your  
8 recommendation include that kind of differentiation?

9 MR. REPPY: No. It assumes that nursing home  
10 beds are nursing home beds, regardless of where they're  
11 located.

12 MS. DEDERER: But do we have the same system  
13 of hospital reimbursement and low Medicaid payments in Ohio  
14 that we do in Illinois?

15 MR. PHILLIPPE: No.

16 MS. DEDERER: That force people into nursing  
17 homes, because it's really the only option at that moment,  
18 because they're being pushed out of the hospital and they  
19 got to go someplace and so they wind up in nursing homes,  
20 whereas 20 years ago they would have been in the hospital  
21 instead.

22 MS. HANDLER: Medicare is national.

23 MS. DEDERER: Medicare is, but Medicaid is  
24 not. Illinois Medicaid is one of the five most restrictive

1 Medicaid systems in the country.

2 MS. ALTMAN: But most of the coverage in the  
3 hospital is Medicare.

4 MS. DEDERER: I'm not sure that HFS would  
5 agree with that, but okay.

6 MS. HANDLER: Most of long-term care is paid  
7 by Medicare.

8 MS. DEDERER: Medicare only pays for the first  
9 three weeks, then it's Medicaid, right?

10 MR. PHILLIPPE: The average is about 30 days.

11 MS. DEDERER: Okay, whatever. But it's  
12 short-term, it's not the rest of your life.

13 MS. ALTMAN: I've looked at the liability, the  
14 HFS liability on Medicaid for the older population, and  
15 hospital is not the big liability. You're right, there's  
16 some of that, but I don't think that impacts his  
17 recommendation.

18 MR. PICK: Historically, Ohio's Medicaid rate  
19 has been higher than Illinois.

20 MS. DEDERER: Everybody's is.

21 MR. REPPY: But that's not your issue.

22 MR. PHILLIPPE: I operate in Ohio, and you  
23 have to consider the full system. I mean, what you said  
24 about just setting a number makes some logical sense, but

1 it also is very different in Ohio when the Medicaid rate is  
2 about 50 to 70 percent higher. My buildings in Ohio get  
3 about 60 percent or more average daily rate for Medicaid,  
4 and they pay on time. But -- and what that does is it is  
5 also part of the whole Ohio system. I was in Ohio 15 years  
6 ago, and they were talking about what to do about long-term  
7 care expenses then. So they've been working on it a long  
8 time. But what happens, because the rate is higher and the  
9 funding is there for everything, they also use the bed  
10 buying and selling, really. As far as I know, that's the  
11 only way you can expand there. But what that does, because  
12 the funding is better, it allows more innovation. One of  
13 the things that we want to talk about, I think -- a later  
14 issue, though -- is when the funding is very low, and  
15 because the funding is so low, there is very little new  
16 competition in most areas, then there's no innovation.  
17 There's more innovation in Ohio because people can come in  
18 and build across the street and have a successful business  
19 model with a very good program, and successfully. So it  
20 does set up a different dynamic. It's just not the same --  
21 I don't think you can just take the same numbers and say  
22 it's all the same. It's not the same.

23 MS. DEDERER: That's all I was trying to say,  
24 is it really the same?

1 MS. MITZEN: I guess you're absolutely right.  
2 Ohio is not the same as Illinois. Illinois is unique, as  
3 is Ohio, as is Washington state. I think you can take  
4 things from these other states. Ohio -- in terms of my  
5 looking at Ohio for home care services, it's probably the  
6 most like Illinois in the way they're structured and the  
7 way they deliver and the way they provide access to  
8 services. So, there are some similarities. I don't know  
9 that -- we can't lay Ohio on Illinois and say it's going to  
10 work. There are a lot of differences, but are there things  
11 in the Ohio plan that we can use that might be instructive  
12 and helpful, and I think what Don just suggested is  
13 something that we should take very seriously and look at.

14 MS. ALTMAN: I was just wondering, Don, one of  
15 the things you said was Ohio. But before you said look at  
16 Ohio, you said you would set it at 55 beds because that's  
17 what our occupancy rate is right now.

18 MR. REPPY: You have 64 and you're using 50,  
19 so start at 55.

20 MS. ALTMAN: Tim, how does that relate to what  
21 you're saying, not the issue of using Ohio, but why would  
22 doing that, like picking 55, be any different in Illinois  
23 than in any other state? Don based his recommendation on  
24 picking that number on the fact that we're only using 50,

1 not on the amount of money or the flexibility or anything  
2 like that.

3 MR. PHILLIPPE: There's two ways to look at  
4 it. On the one side, it would restrict the growth of new  
5 nursing homes in the state of Illinois. Basically that's  
6 what you're saying. However, if you're going to do that,  
7 it needs to be tied to a bed buying and selling, like they  
8 have in Ohio, because the problem with doing it and setting  
9 that number is you are saying in some markets you have  
10 enough, it doesn't matter what it looks like, it doesn't  
11 matter if they don't serve anybody on Medicaid, it doesn't  
12 matter if nobody wants to go to the buildings in that  
13 community. You're cutting out innovation.

14 MS. ALTMAN: Don did suggest buying and  
15 selling.

16 MR. PHILLIPPE: Right, because that's what  
17 makes it work in Ohio.

18 MR. REPPY: Yes.

19 MS. ALTMAN: So, why wouldn't that work here,  
20 with a 55 number and a buying and selling system?

21 MS. DEDERER: So you think it would work with  
22 buying and selling?

23 MR. PHILLIPPE: I think we should look at it.

24 CHAIRMAN WAXMAN: I agree. We certainly

1 welcome your input and the perspective you put on the  
2 table. However, I don't think we as a committee can simply  
3 say we're going to copy Ohio and be done with the process.  
4 I think it's something we can look at and see what we can  
5 use from Ohio, as well as any other state, and I think we  
6 have to remember that Claire has been feeding us this  
7 information, and whether or not each of us has chosen to  
8 review it carefully is something we have to ask ourselves.  
9 So, Claire, would you make sure that everyone has the Ohio  
10 information one more time?

11 MS. BURMAN: Sure.

12 CHAIRMAN WAXMAN: And at our next committee,  
13 we can make Ohio one of the subjects that we look at and  
14 see what we like and what we don't like, but, again, I  
15 don't think we can simply say we're going to copy anybody  
16 else's --

17 MS. ALTMAN: Could we leave Ohio aside a  
18 second and just discuss a 55-bed system, where you buy and  
19 sell? What would --

20 CHAIRMAN WAXMAN: I saw Mike's hand for a  
21 moment.

22 MR. SCAVOTTO: Mike, could we get the  
23 methodology for Ohio? I just took a quick look at the  
24 materials that we've been given as members of the

1 committee, and there is no mention of 55 beds per thousand.  
2 So, if it's a new item, I'd like to have a look at the  
3 methodology.

4 MS. ALTMAN: 55 isn't in --

5 MS. CREDILLE: In Illinois, our occupied beds  
6 per thousand right now is 50. We have 64 beds per  
7 thousand. So, Don is just suggesting we're over bedded  
8 currently. We only occupy 50, but we have 64. So he  
9 arbitrarily suggested 55, which is -- we could pick 50.  
10 You could pick 45.

11 MS. ALTMAN: And a brokering system. So could  
12 you just discuss that as a concept? I just want to hear is  
13 anyone opposed to change where you would reduce the number  
14 of beds, set a set amount, and have a brokering system?  
15 What is the opposition to that?

16 CHAIRMAN WAXMAN: I think Tim raised several  
17 of them already.

18 MS. DEDERER: I mean, as a vocal home care  
19 advocate, I'm still concerned that we need to look at our  
20 population around the state and make sure that nobody is at  
21 or is over 55 and still needing beds.

22 MS. ALTMAN: You could trade and get more,  
23 Teri. That's the brokering system. If you needed 75, you  
24 could trade with somebody that has it. It's a buy and sell

1 system.

2 MS. CREDILLE: It would tie back to our  
3 original concept of operating beds versus licensed beds.  
4 This ties back in, and part of the reason we're not  
5 operating our licensed is because we're over bedded in some  
6 areas, under bedded in others. So, you would find  
7 anywhere --

8 CHAIRMAN WAXMAN: Well, we can accomplish the  
9 same thing if we incorporate buying and selling beds. It  
10 doesn't need a 55 number. It needs the ability to buy and  
11 sell beds, which is something that when raised, creates a  
12 whole other basket of trouble.

13 MS. ALTMAN: What is that? Someone tell me.  
14 Talk to me about it.

15 CHAIRMAN WAXMAN: First of all, how do you  
16 evaluate the value of a bed? How long can you hold it  
17 without using it? Because you and I both know that there  
18 are people out there that will buy beds and hold them, like  
19 they buy stock, hoping the value goes up, and from an  
20 accounting point of view, how do you evaluate that bed and  
21 how do you continue to report it on your balance sheet? I  
22 don't mean to address it to you, but I'm giving you some of  
23 the aspects, something a CPA would look at. It's a simple,  
24 logical solution to needs being met, not being met, but it

1 raises all kinds of accounting and legal issues that we  
2 haven't even talked about or looked at. So, we would have  
3 to address those issues.

4 MR. REPPY: What were your questions again?  
5 The market evaluates the beds. We've done this in New  
6 Jersey and Ohio and some places we've paid as low as 4,000  
7 a bed and some places we've paid as much as 10,000 a bed.

8 CHAIRMAN WAXMAN: How long can you hold them?

9 MR. REPPY: In Ohio you have to use the beds.  
10 When you relocate your bed, you have to get a Certificate  
11 of Need. You get your Certificate of Need to relocate your  
12 beds, and then it's just like a regular Certificate of  
13 Need. You got to move forward with time lines established  
14 in the CON process.

15 MS. HANDLER: But Illinois doesn't have any  
16 look-back to confirm that those beds are actually being  
17 used. We don't have a look-back on our CON process.

18 MR. REPPY: Yes, you do. I have to submit  
19 progress reports to Mike.

20 MS. HANDLER: Only that the project is done  
21 according to the CON, but beyond that, there's not a  
22 look-back, there's not a look-back one year later or two  
23 years later or five years later.

24 MR. REPPY: True.

1 MS. ALTMAN: But you could add that. We've  
2 talked about adding that, right? So it's market value, a  
3 look-back, and you have to use your beds.

4 CHAIRMAN WAXMAN: How do you show it on your  
5 balance sheet.

6 MR. REPPY: That I don't -- that's not my area  
7 of expertise.

8 CHAIRMAN WAXMAN: But again, as soon as you  
9 start talking about it, it's going to be asked. It's going  
10 to be a question that's going to be generated by homeowners  
11 as well as accountants that have to comply with all of the  
12 new regs.

13 MS. ALTMAN: But that's doable.

14 CHAIRMAN WAXMAN: Everything we talk about is  
15 doable.

16 MR. PICK: The question I would ask is with  
17 regard to the mortgage financing. How have you guys dealt  
18 with it in other states where you have FHA mortgages that  
19 are linked to the number of beds and you're buying and  
20 selling beds?

21 MR. REPPY: I guess the one thing is that the  
22 mortgage holder -- you have a tremendous -- everybody is  
23 out there looking for an asset to sell or buy in the United  
24 States. We name football stadiums now. You have how many

1 thousand unused beds here, how many thousand? You have  
2 20,000 unused beds. If you're a mortgage holder -- you  
3 tell the mortgage holder that "I can sell these 20 beds and  
4 I can make \$300,000 and I can pay down my mortgage with the  
5 \$300,000 that I make in selling the beds." What mortgage  
6 holder -- or "I can pay down the mortgage with 200,000 and  
7 I can use the other hundred for whatever."

8 MR. PICK: In theory that all sounds great.  
9 The reality is if you're leveraged at 25,000 per bed and  
10 all you can get is 4, it's a upside-down formula that's not  
11 going to work, and the owners are not going to go for that,  
12 because you're going to force people into bankruptcy that  
13 are running businesses that are generating profits.

14 MR. REPPY: But it's a willing selling and a  
15 willing buyer.

16 MS. CREDILLE: You don't have to sell.

17 MR. PICK: I understand. The issue is there's  
18 aspects that we also need to think about, and one of them  
19 is the financing and that you don't have to sell anything,  
20 but once the market starts rolling and you're now -- it's  
21 just like we went through in the real estate market in  
22 2008. Once you're under water, it's too late, you can't go  
23 back. But now they're reappraising. We created a problem  
24 that we didn't have before. So, we have to be very careful

1 about unintended consequences. So, that's one of the  
2 things we need to look at when we're evaluating. Ohio is  
3 clearly doing it. How did they address this issue?

4 MS. ALTMAN: Let's say you're extremely over  
5 bedded at 20,000. So, therefore, the market won't bear  
6 anything close to what -- that means not only over bedded,  
7 but our facilities are funded beyond and under water, and  
8 maybe the market should correct itself.

9 MR. PICK: Well, the market is correcting  
10 itself in those instances because you've got facilities  
11 that are going under because they're not making their  
12 payments.

13 MS. ALTMAN: And they would make it go under  
14 faster.

15 MR. PICK: It's not that it's going to make it  
16 go faster. It can cause profitable operations that are  
17 currently meeting their obligations to then be reappraised  
18 and a new fair market value that will force them into  
19 bankruptcy when they're perfectly functional, which is  
20 exactly what happened in the real estate market. So,  
21 that's not the kind of dynamic that we want to trigger,  
22 because if they're operational, meeting a need and they're  
23 delivering a good product, we don't want to force them into  
24 a negative financial position because of a theoretical

1 formula that we apply. So, I think that's one of the  
2 things we have to think about.

3 CHAIRMAN WAXMAN: If you force a home into  
4 bankruptcy, where are you going to put the people who are  
5 currently in that home, which is also a problem.

6 MS. ALTMAN: And the other facilities have no  
7 beds.

8 CHAIRMAN WAXMAN: How are you going to  
9 move -- are you going to move someone from Springfield to  
10 Chicago just because there are no beds in Springfield?

11 MR. REPPY: You're not moving people, you're  
12 just moving beds.

13 CHAIRMAN WAXMAN: If you create an economical  
14 situation where you put a home in foreclosure and therefore  
15 the home closes, where do those people go? All I think  
16 we're saying is we can't jump to the conclusion that we can  
17 copy some other state without thoroughly investigating it.

18 MS. MITZEN: Absolutely.

19 MR. CONSTANTINO: Mike, can we take a break?  
20 The Court Reporter is getting tired.

21 MR. PICK: Can I make one more comment before  
22 we break, and that is we seem to have a pension for  
23 becoming defensive. When someone suggests something, it's  
24 not a personal diatribe. This is merely a contribution to

1 discussion. But the dynamic that seems to recur in this  
2 venue is that when someone suggests something, then the  
3 response is almost like they have a personal agenda to make  
4 that successful.

5 CHAIRMAN WAXMAN: I think Teri said it  
6 earlier. She said we're passionate.

7 MR. PICK: I think we need to be careful that  
8 it's not personal. People are suggesting strategies and  
9 approaches, and we should be taking it as such and not that  
10 they have a vested interest in their own suggestion.

11 CHAIRMAN WAXMAN: I agree. I am suggesting  
12 we break for like -- is a half hour long enough to feed  
13 ourselves, or do you want 45 minutes?

14 MR. DART: 12:30 maybe.

15 (Discussion held off the record.)

16 CHAIRMAN WAXMAN: So we're reconvene at  
17 12:30.

18 (Lunch recess)

19 CHAIRMAN WAXMAN: I'd like to reconvene so we  
20 can stay close to the agenda items. Are you ready to take  
21 notes?

22 Just a couple thoughts and housekeeping. I  
23 notice toward the end, we got a little out of control with  
24 some side bar conversation. So, it's difficult that we're

1 in two different places. So, if we could eliminate those,  
2 it would be greatly appreciated and make it easier for  
3 Karen to take her minutes.

4 Also, I know that during some points, we all  
5 had a lot to say, but if you'd allow me to recognize you,  
6 again it would be easier for all of us to hear and for  
7 Karen to get the minutes straight. I don't want to be  
8 quoted for saying something I didn't say. I say enough as  
9 is. If you can follow that, I would greatly appreciate it.

10 I think we ended on kind of a topic that I  
11 think bears some further discussion, and I don't know if  
12 all heard, but I did ask Claire to make sure that all of us  
13 receive the Ohio information again so we can study it and  
14 put it on this next agenda. We -- before we part company,  
15 we will try to identify the next meeting dates. Our  
16 calendar, I believe, expires as of this meeting. So, we'll  
17 try to identify next meeting for sure and maybe more down  
18 the road so we can plan on how that's going to work out.  
19 So, I would entertain any feedback as to whether you think  
20 this arrangement is more favorable to -- efficient,  
21 productive meeting than meeting in person in one place.  
22 I'm hearing -- already I'm hearing here, it is, but if you  
23 in the Springfield area have some opinions, I'd certainly  
24 want to hear that. Parking here is like a hundred dollars.

1 I think it's free where you are.

2 (Laughter)

3 MR. PICK: I think he just shared his opinion.

4 CHAIRMAN WAXMAN: Going down the agenda, I  
5 think what we've done is we have created additional work  
6 for Tim's committee and, again, thankful to Tim for picking  
7 that up.

8 If we move to Item 6, I think we're going to  
9 come up with another work group. We talked about from the  
10 day we started doing this is that one of the things we want  
11 to look at is the actual application itself, the actual  
12 document, and so Courtney, do you want to talk about it?

13 MS. AVERY: Okay. What we were trying to make  
14 sure that we did -- and you have a draft for the work  
15 group. We haven't distributed it yet, but we want to make  
16 sure that the application would mirror the rulings that we  
17 adopted. So, we did a little bit of a draft for the work  
18 group, and in my discussion with Mr. Waxman, we did not  
19 want to just present it to the whole Board as a product  
20 that came from the Staff. So, we wanted to make sure that  
21 the Committee had some input to it. So, what we did was  
22 just a draft, and I asked Mr. Waxman how he wanted to go  
23 forward, and we decided that we would convene a small  
24 committee, maybe four people, and Carolyn has already said

1 she wants a spot on it, but she had to leave, and I told  
2 her what our next steps were to review that CON application  
3 in order to present it to the Board.

4 CHAIRMAN WAXMAN: I've asked Mr. Scavotto if  
5 he would chair that work group, and yesterday he said he  
6 would agree. Hopefully he hasn't changed his mind today.

7 MR. SCAVOTTO: Fine.

8 CHAIRMAN WAXMAN: Okay. So, again, we're  
9 looking for two more members and --

10 MS. ALTMAN: Sorry. Can you describe this a  
11 little more? This is to review the application?

12 MS. AVERY: One of the things the group asked  
13 for was to have an application that was tailored to  
14 long-term care, because it should look different from the  
15 CON application for hospitals. So, yes, a committee to  
16 look at that application.

17 MS. ALTMAN: But is what would go in this  
18 application everything we've been discussing? What else  
19 would go in? I mean -- I didn't say it correctly. Isn't  
20 what we've been discussing components of what would go into  
21 that application, or is that a totally separate thing?

22 MS. AVERY: It will be a little bit of it, and  
23 some will be different, like the number of proposed beds.  
24 The services and things of that nature will be in it. It

1 won't be too much different.

2 MS. ALTMAN: I did look at it because you guys  
3 gave it to us before. That's not exactly my question.

4 MS. AVERY: You have the application?

5 MS. ALTMAN: Didn't you guys give it to us?

6 MS. AVERY: No, we haven't distributed that.

7 MS. ALTMAN: A year ago in the first things we  
8 got?

9 MR. WILL: It's my understanding that this  
10 would mirror the rules that were adopted, so it doesn't get  
11 to everything we're discussing now.

12 MS. ALTMAN: It's mirroring the rules that  
13 were adopted, so we did get it before when you gave us the  
14 old ones and this is just to conform to the rules that were  
15 adopted.

16 MS. AVERY: Exactly, and whatever other  
17 changes you guys want to recommend.

18 CHAIRMAN WAXMAN: Again, the major  
19 conversation is that it looks like a hospital, and our  
20 charge is to make sure that we're doing a long-term care  
21 application, and that which is not related to long-term  
22 care should be eliminated or reduced or redefined. So  
23 that's the process we're asking this work group to do. So,  
24 if Mike has graciously agreed to chair and Carolyn wants to

1 be a part of it, we need two more members, two more people  
2 to be part of it.

3 (Pause)

4 CHAIRMAN WAXMAN: What scared you guys?

5 MS. AVERY: It won't be a lot of work,  
6 hopefully.

7 CHAIRMAN WAXMAN: Think about it and I will  
8 exercise chair's right and appoint, if I need to, but,  
9 again, if there are some people who have interest in it,  
10 please feel free to join in.

11 MR. PICK: Maybe we should send out an e-mail,  
12 too, because there are several members who are not present.

13 MS. DEDERER: Yeah, like Bibo might want to be  
14 on it.

15 CHAIRMAN WAXMAN: Cece is replacing Mike.

16 MS. AVERY: We need some clarification on that  
17 also. His letter of resignation seemed like it was  
18 contingent upon Cece being appointed, but the Chairperson  
19 hasn't taken up the issue with the vacancy yet. So, my  
20 point is that Mike can't dictate who will replace him. He  
21 either resigns and the Chairperson takes that  
22 recommendation into consideration and -- the Chairperson of  
23 the Board, or he appoints someone else, or he leaves it  
24 vacant. So, officially, Mike is still on, because his

1 letter of resignation reads that he's resigning contingent  
2 upon Cece being appointed. So I need to get in touch with  
3 him.

4 CHAIRMAN WAXMAN: Didn't we pass this letter  
5 on to Dale?

6 MS. AVERY: We did, and when we read it, it  
7 was basically saying until Cece is appointed.

8 CHAIRMAN WAXMAN: Okay. As far as I'm  
9 concerned, that's a good replacement.

10 MS. AVERY: It is, but he just hasn't taken up  
11 the consideration of appointment for the person for the  
12 vacancy. I'll talk to him again. He's recommending Cece  
13 as his replacement.

14 CHAIRMAN WAXMAN: And then we also have an  
15 open position from a union member who has resigned.

16 MS. AVERY: Jo Patton, who we haven't filled.

17 CHAIRMAN WAXMAN: I don't know that Mike  
18 formally can do that. I think he has to resign and assume  
19 we'll --

20 MS. AVERY: We'll take that recommendation  
21 into consideration, but everything has been passed on.

22 CHAIRMAN WAXMAN: Okay. So we'll work out  
23 that one. We'll work out -- I had a brief conversation  
24 with the Chair of the Mother Board as to whether or not the

1 other replacement has to be a union person or whether we'll  
2 leave it open or --

3 MS. AVERY: I don't think it does, because one  
4 of the things that the Board expressed, which we  
5 communicated to him, is that you all would like someone  
6 with an academic background, and there's a person that  
7 we're waiting for her information to be forwarded to him.

8 CHAIRMAN WAXMAN: So we'll -- eighteen is  
9 good enough. Nineteen is better. Eighteen is good enough,  
10 so we'll move on.

11 MR. PICK: Bless you.

12 CHAIRMAN WAXMAN: So, hopefully two will step  
13 up and join Mike and Carolyn in their task.

14 We have, give or take, about an hour left. So  
15 I would entertain your issue again, if there is something  
16 else in the definition of bed need that you want to put on  
17 the table. For example, if you want to start talking about  
18 variances, that would be a subject. I don't mean to point  
19 to you, Phyllis, but if you want -- if we want to start  
20 looking at the subject of variances as another method of  
21 adjusting the application process, I'm willing to go there.  
22 If someone else at the table has another subject that they  
23 want to throw out as a point of discussion relative to  
24 adjustments to the formula or to the acceptance of an

1 application, I'm willing to do that also.

2 MS. MITZEN: I guess a more overarching  
3 question, and that is, it starts with -- Certificates of  
4 Need for long-term care are being approved now? It's a  
5 question.

6 CHAIRMAN WAXMAN: Yes.

7 MS. MITZEN: Okay. So at what point --  
8 what's our time frame for making the recommendations and  
9 getting them accepted, to use a different strategy for  
10 approving?

11 CHAIRMAN WAXMAN: It's my understanding --  
12 and, again, Courtney and Frank can jump in. It's my  
13 understanding that there is no time frame, that the  
14 Committee does not have an ending to it. We had a time  
15 commitment in the beginning to get changes to them, which  
16 we met, and at this point, the Committee is an ongoing  
17 committee, because one of the things it covers is to make  
18 sure that we are complying with current practices.  
19 Therefore, it kind of leaves it open-ended, that we as a  
20 committee -- or this committee -- will always be around to  
21 make sure that we are in compliance with common practices  
22 of the industry in making sure that we are in the continuum  
23 of care. Therefore, we aren't under any other time  
24 deadlines at this time to present to the Mother Board. So,

1 as we formulate either recommendations for change or areas  
2 that we want them to look at because it's a little bit out  
3 of your purview, such as that broad question as to whether  
4 or not assisted living should fall under our committee,  
5 we're open to that.

6 MS. MITZEN: So, we could have these  
7 conversations -- we're meeting what, every other month,  
8 every third month? We could have these conversations for  
9 the next few years and meanwhile we could keep on  
10 increasing the number of beds because --

11 CHAIRMAN WAXMAN: Not necessarily.

12 MS. MITZEN: This concerns me.

13 MS. ALTMAN: We were talking after the break  
14 about we didn't quite understand -- I guess there have been  
15 nursing homes that have already been approved in the last  
16 month, two or three, for increasing services in perhaps  
17 areas where it's already over bedded. Where are we going?

18 CHAIRMAN WAXMAN: Mike, there should be no  
19 application approved in an over-bedded area, right?

20 MR. CONSTANTINO: The Board has wide  
21 discretion of what they want to approve.

22 MS. DEDERER: And they can be specialty  
23 things, right?

24 MR. CONSTANTINO: I said the Board has wide

1 discretion in what they want to approve.

2 MR. URSO: And also there are variances.

3 MS. MITZEN: So, you're saying "variances".

4 You suggested maybe we should talk about variances, and  
5 maybe we should, because I don't understand variances. But  
6 the other issue is, okay, if we're on here for a life, what  
7 difference are we going to make? What difference are we  
8 going to make? I mean, I'm only here because I care about  
9 the overall long-term care system that's going on in this  
10 state, and I know that there are lots and lots -- and I  
11 know by attrition, things are happening, and I know by  
12 choice some things are happening, but overall, I only  
13 joined this because I felt that this may be one other area  
14 where we can impact some change to reform and balance the  
15 long-term care system, and unless I can get a sense that  
16 there is a time at which we will be able to present to the  
17 Mother Board the recommendations that are solid to get us  
18 moving along that line and then pick up on it and continue  
19 to work on it, I'm not sure what I'm doing here.

20 CHAIRMAN WAXMAN: I think the answer to your  
21 question is I think everyone around the table has the same  
22 feeling that you do. Consequently, the pressure to finish  
23 the project is from within. So, I heard Mike say that  
24 earlier. I heard other people say that pretty frequently,

1 which is why I think the way we're going to accomplish this  
2 is to focus on narrow pieces, get resolution, and move  
3 forward, so that we can present to the Mother Board our  
4 concept of changes. So, I think what we need to do is to  
5 continue dissecting those pieces, coming up with solutions  
6 or possible changes, and feeding them up. I mean --

7 MS. MITZEN: Piecemeal or a package?

8 CHAIRMAN WAXMAN: A package that makes sense.  
9 So when they finish what they're going to do, we will have  
10 a package that talks about bed needs, operational beds  
11 versus licensed beds, refer it up so they can take action  
12 on that change and definition, and get legislation approval  
13 on it. Variance, the same thing; the application, the same  
14 thing. As we get pieces that we all agree to, we then feed  
15 it up to the Mother Board. They have to buy into it,  
16 accept it, and turn it into legislation. Yes, the pressure  
17 is -- all of us don't want to feel like we're spinning our  
18 wheels. We all want to make sure and have a sense of  
19 accomplishment in this process. Otherwise none of us would  
20 be here. I think we all feel the same way. The question  
21 is it's up to us to make sure we accomplish things at each  
22 meeting, and it can continue to progress as fast and as  
23 well as we're doing thorough, completed tasks.

24 MS. ALTMAN: So, I just think if we had a time

1 table -- I mean, in the very beginning when we were  
2 appointed -- and by "we," I mean originally there were no  
3 emphasis, I guess, groups on it, and after that Dave  
4 Carvalho called us all and said, at our first meeting a  
5 year ago, "The Mother Board is going to appoint Phyllis  
6 Mitzen from Health and Medicine Policy Group, Stephanie  
7 Altman from Health and Disabilities Advocates, AARP, and  
8 Jon Lavin from Triple A" -- and who else was added? The  
9 four of us?

10 MS. MITZEN: SEIU.

11 MS. ALTMAN: SEIU was added, too. Okay. So,  
12 five of us were added, and you guys had maybe met once or  
13 twice before that? Never?

14 Okay. So then we were added. We had a long  
15 discussion with the Illinois Department of Public Health  
16 about why we were added. They called each of us. They  
17 gave us a long sort of explanation. "You've never been on  
18 this kind of thing before. Here's why you're added.  
19 You're going to do this. It's going to be a period of  
20 time. You're going to provide a perspective on home and  
21 community based care," like the ones you read there, "and  
22 that's why we added you." And then he promptly left the  
23 next meeting. But he called us individually. I had, I  
24 think, an hour and half discussion about why we were being

1 added.

2           Since that time -- and I know in particular  
3 me, I've been a thorn in everyone's side, but I'm trying to  
4 find -- I mean, we're not-for-profit groups, not funded to  
5 do this, get no payment to do this at all, represent people  
6 on Medicaid, trying to add something to it that makes sense  
7 and have some sort of time table to get something out of  
8 it. One of the things, Don, you brought up is why aren't  
9 there more facilities on the Board or more facility-based  
10 groups which actually are working on this? Why would it be  
11 us or a majority of us or half us or whatever? And so I  
12 think the tension that comes up, it isn't really our area  
13 of expertise, which you guys know that. We are trying to  
14 add something in it that is meaningful, which I think you  
15 know that, and it's a somewhat hard process, and it's a  
16 time-consuming process. I've read every drop of stuff  
17 you've given us, and I think it's really good. We've  
18 learned a lot about the area. We're meeting on a very  
19 frequent basis, which I know your preference is we live in  
20 person, in Joliet, which is difficult. We're having  
21 conference calls and work groups that we work on  
22 separately. But we need to go somewhere, and I think it's  
23 possible -- AARP and Triple A have not shown up in the last  
24 three meetings. So, it's only been Health and Medicine

1 Policy Group and Health and Disability Advocates for the  
2 last three meetings. AARP has pretty much dropped out  
3 completely from what I understand, and Triple A hasn't been  
4 here at all. It's really -- SEIU, every time. They have  
5 frustration. I've talked to Jon Lavin and to AARP. They  
6 have the same frustration. It's like, "What are we doing  
7 here? What is our purpose? What is our individual  
8 purpose?"

9 So, how do you see our purpose in terms of  
10 expertise we can give, what we can actually do that could  
11 move the process along, other than like conforming the  
12 application to the regulations? Okay. You guys could do  
13 that, and I just don't see -- if we had a time table --  
14 "Okay, stay on for the next twelve months. We're going to  
15 meet every other month. We're going to come up with a new  
16 bed-need formula with a new set whole number" -- I mean,  
17 where are we going?

18 CHAIRMAN WAXMAN: Well, you gave me  
19 information I never knew before.

20 MS. AVERY: Me too.

21 CHAIRMAN WAXMAN: I never knew you were  
22 called individually. I did not know that.

23 MS. ALTMAN: That's how we ended up on this  
24 thing.

1                   CHAIRMAN WAXMAN: I'm hearing it for the  
2 first time, which is fine. It's information I had not  
3 heard before. I think the reason you are here --

4                   MS. ALTMAN: That's part of the confusion.

5                   CHAIRMAN WAXMAN: The reason you are here is  
6 simply to make sure that this isn't so narrowly focused or  
7 narrow in their experience and information that we exclude  
8 the things that you are bringing to the table. I have --  
9 from my perspective -- and I hope -- you know, when I first  
10 started this process, I never would have thought of  
11 community-based things being involved in the CON process.  
12 I spent thirty years in long-term care, and in my mind,  
13 long-term care are people in nursing homes. So, the fact  
14 that you have educated me and brought that information to  
15 the table is very, very valuable.

16                   So, I think you are doing exactly what you  
17 were put on or asked to join the Committee to do, which is  
18 to make sure that all of us have the perspective of what  
19 really determines services to the elderly in the state and  
20 what are all of the services, you know. So I think that's  
21 my answer to your question. I don't know if that's what  
22 you were looking for, but I do think you provide very  
23 valuable services. You who are not part of long-term  
24 basis -- not Stephanie specifically, but all of you who are

1 in the community side and the other advocacy side are  
2 bringing information that has value at least to me, because  
3 it's changed my perspective on this.

4 Now, I have no problem if we as a group want  
5 to say we want something done by the end of the year or six  
6 months or eight months. I have no problem with someone  
7 bringing that to the table and saying let's get a time  
8 table on the table. I'm fine with that.

9 MS. ALTMAN: Okay.

10 MS. MITZEN: Let's do it. I think we've laid  
11 out a lot of the issues. I think we can probably formalize  
12 that, and perhaps by the end of the hour, or less than an  
13 hour that we have now, perhaps say okay, by next June let's  
14 have these things done with our two work groups. I don't  
15 know if you have the capacity to have too many more work  
16 groups, but either serial or parallel, working on these  
17 things.

18 MS. ALTMAN: And make recommendations maybe by  
19 June 30th.

20 MS. MITZEN: It really worries me in terms  
21 of -- and, quite frankly, Don suggested the 55, which we  
22 may want to explore that and we may want to then say let's  
23 do that. I would love to see something like that in  
24 conjunction with a package saying let's recommend that for

1 a two-year trial and then evaluate it and look at it again,  
2 because the numbers should go down, and money follows the  
3 person, and it is commanding that our ratio go down.

4 MS. DEDERER: But it isn't.

5 MS. MITZEN: We know that.

6 MS. DEDERER: There's nothing to prevent  
7 filling the nursing home beds once people move out, not a  
8 thing.

9 CHAIRMAN WAXMAN: You're absolutely right,  
10 Teri. Any comments from the other group?

11 MR. PICK: Teri is the other group.

12 (Laughter)

13 MS. DEDERER: You forgot us. We got invited  
14 last, too.

15 (Discussion held off the record.)

16 CHAIRMAN WAXMAN: Tim?

17 MR. PHILLIPPE: I think we would all agree  
18 that it's good to have a focus and feel like we're  
19 accomplishing something. So, I think we all agree on that,  
20 and I think what I've heard from people who have not come,  
21 they are concerned it wasn't going anywhere, so it wasn't a  
22 good use of their time. So, the more we focus it, people  
23 feel like their time is well used, that's good. I do see a  
24 need longer term for some type of long-term care

1 subcommittee, because on the provider side, what I've heard  
2 from other groups, for-profit and not-for-profit, is that  
3 there is a sense that the process is set up for hospitals,  
4 and sometimes -- some of that was improved in the past  
5 year. The provider side thought it would be useful to have  
6 some structure for input from the long-term care side,  
7 because we are so small.

8 CHAIRMAN WAXMAN: And the law is written that  
9 way. The statute is written that way. So you may have a  
10 time frame to complete a project by June, but the Committee  
11 will continue beyond that. I just want to make sure you  
12 understand that.

13 MS. MITZEN: And I think that's fine. I  
14 guess I just want to be sure that if we're on the  
15 committee -- we've been on too many committees where it can  
16 go on forever and ever, and that's all very, very nice, and  
17 people from the outside say, "Yes, they've got this  
18 long-term care committee." Well, to what end? And I only  
19 want this to be purposeful. We've got to achieve something  
20 and then move on to the next achievement.

21 CHAIRMAN WAXMAN: I totally agree with you.  
22 I really agree with you. I, sitting in this chair, want to  
23 accomplish probably more than you do, but trying to keep  
24 focused, to use Tim's word -- and, again, the advantage of

1 this committee is its diversification, but it also then  
2 creates a lot of input with a lot of different suggestions  
3 that have to -- you have to allow that to happen, and to  
4 find that narrow, that fine line between when does it go  
5 too far and when does it not go far enough is a task we all  
6 have to kind of agree with.

7 I'm not sure that June is enough time. I  
8 mean, I'm thinking maybe a September date might be --  
9 because the only reason I say that, if we're meeting every  
10 other month, then that gives us three more meetings to get  
11 to that completed date, and I'm not sure whether three more  
12 meetings, with everything we need to look at, is feasible.

13 MR. PHILLIPPE: I wanted to recognize the  
14 Chair for trying to lead a very diverse group. Okay. And  
15 the part -- there's a couple points to make. One is,  
16 people come to this with very different agendas. It  
17 doesn't mean it's a bad thing. It's that we all have  
18 different perspectives and concerns, and it's frustrating  
19 because it takes longer, but that's part of the process  
20 when you have such diverse interests.

21 CHAIRMAN WAXMAN: Agreed.

22 MR. PHILLIPPE: And the second piece is we  
23 have to be careful about pushing some change that's going  
24 to dramatically change the world in our state without

1 realizing the full implications. The cost to State  
2 Government, if there are a lot of new rules and reports and  
3 all of that, to State employees, but also how it would  
4 affect the whole industry. So, we have to be careful with  
5 dramatic change that we study them wisely first.

6 CHAIRMAN WAXMAN: I totally agree with you,  
7 and I think you raised something really important earlier  
8 on, which is you were referring to changes you tried to  
9 create and couldn't get it past the political side.

10 MS. ALTMAN: That's really our biggest  
11 concern. We spent seven years on a long-term care  
12 rebalancing, and each time there has been complete  
13 agreement with one dissension which, frankly, one long-term  
14 care association, and then the legislation has been killed  
15 every single time.

16 CHAIRMAN WAXMAN: So I'm suggesting, as Tim  
17 is, that we make sure that we word things carefully and  
18 send things up well documented with a lot of support from  
19 this group so that we can get the support we need from the  
20 Mother Board, who then can turn it into legislation.

21 MS. MITZEN: It gets passed.

22 CHAIRMAN WAXMAN: So it gets passed,  
23 absolutely. So, again, I understand your desire to say we  
24 finally accomplished something, but, also, I want to make

1 sure that what we accomplish is of value and it can turn  
2 into legislation. So that's -- I appreciate your thinking,  
3 but I think we may have to go a little bit longer to put it  
4 all together.

5 MS. AVERY: Can I make a suggestion, that  
6 maybe you and Staff and Eli can sit down and come up with  
7 some concrete issues and tasks and time lines to present to  
8 the Committee, and we'll go from there, from this time to  
9 this time.

10 MS. ALTMAN: That would be good.

11 MS. AVERY: The CON application will be a  
12 shorter process because we already have a draft. So, I'm  
13 thinking one, maybe two meetings for that. We can have  
14 that done and to the Board by the April meeting. I don't  
15 think we can do it by February. We can shoot for the April  
16 meeting for the Board, and then we can come up with some  
17 tasks and some concrete time lines.

18 CHAIRMAN WAXMAN: Fine with me.

19 MS. DEDERER: But isn't what we're talking  
20 about, what Stephanie is talking about, what Phyllis is  
21 talking about, part of the CON process? How can we be  
22 ready in February or April when you're saying we can't even  
23 consider that stuff until September?

24 MR. PICK: Who said that?

1 MR. PHILLIPPE: Can I ask --

2 MS. ALTMAN: They're talking about the  
3 application, conforming the application to the rules now,  
4 two different things.

5 MS. DEDERER: Sorry.

6 MR. PHILLIPPE: Mike, I do think the  
7 application is good, because what we have to focus on to  
8 feel like we've accomplished something is things that are  
9 concrete in steps, not to spend months or years and try to  
10 come up with a big formula, but let's eat this elephant one  
11 thing at a time. I think that's what you're trying to do,  
12 and that's wise.

13 CHAIRMAN WAXMAN: I'm trying but the elephant  
14 keeps moving on me.

15 MS. ALTMAN: So back to one thing, the  
16 application, and that makes perfect sense, and I love that  
17 idea. I think the next thing would be perhaps working  
18 backwards, what was the number that -- work back from that  
19 and figure out, it's not 69, it's 68, 67, to work on that  
20 number.

21 MS. AVERY: What I'm thinking is that we can  
22 take what we were charged with in this document, break it  
23 out.

24 CHAIRMAN WAXMAN: Would you make sure

1 everyone gets that document?

2 MS. AVERY: Okay. Break it out and figure it  
3 out.

4 CHAIRMAN WAXMAN: And would you share with us  
5 the document you've been kind of passing back and forth  
6 among you so that everyone on the Committee has it, please?  
7 Is there just one document?

8 MR. REPPY: Two.

9 CHAIRMAN WAXMAN: Give me one of each and  
10 Courtney will get it sent to the Committee, please.

11 MS. AVERY: So we will base those on this  
12 scenario and figure out the best way to do it, but in my  
13 opinion, I think the Committee has done a lot of work, and  
14 people were surprised that we got those rules together in  
15 such a short amount of time. But that also attributes to  
16 you all and the work you had done prior to that for all of  
17 those years.

18 CHAIRMAN WAXMAN: Just to make sure that  
19 you're clear, what Courtney now has are the documents that  
20 Don brought to the meeting. So, we all will see them, and  
21 it speaks to the number of beds, the Medicaid rates to  
22 long-term care in all 50 states.

23 MR. REPPY: No, just a group.

24 CHAIRMAN WAXMAN: Selected states. So you'll

1 all get those documents also, so we'll have that for our  
2 next discussion. Phyllis --

3 MS. DEDERER: Michael, you still haven't  
4 called on me.

5 CHAIRMAN WAXMAN: Teri, go ahead.

6 MS. DEDERER: Thank you. I hear us talking  
7 about concrete things that we can carve out. What I don't  
8 hear us saying is that we're all headed to the same purpose  
9 or that we have the same mission. And you talk about  
10 agenda, and we shouldn't have individual agendas. We  
11 should either be on the same road or split up. I'm sorry  
12 to say that, but I think that the other people who are on  
13 the home and community based side are kind of feeling "what  
14 are we doing here," because every time we bring up home and  
15 community-based care, it's a tangent, it's going beyond  
16 what we're supposed to talk about, it's not staying on a  
17 nice, narrow road, and I think what those of us on the  
18 community side have been hearing for ten years, would you  
19 say, is long-term care rebalancing. We're 48th or 49th, or  
20 50th in the nation in terms of the bias to nursing facility  
21 occupancy. We have some fine nursing homes. We need  
22 nursing homes for some things, but there is a definite bias  
23 to nursing facilities, and it is the nursing facility  
24 associations that have appealed anything that talks about

1 home and community-based care and rebalancing, and I think  
2 if we're going to represent this Board that does the  
3 Certificate of Need process, we should be looking at what  
4 we knew as long-term care, which is nursing homes and the  
5 home side.

6 MR. PHILLIPPE: I think that it's not that  
7 simple, because I do think some of us are wanting to focus  
8 on the simple things we can change, to feel progress. I at  
9 least can speak for one association in the state who is  
10 very interested in home and community-based services, even  
11 to the extent that some of the skilled nursing providers at  
12 times would say, "they don't think about us anymore," and  
13 it's because the association has -- I mean clearly has a  
14 focus on what is good for the elderly, where is the field  
15 going, what we should be providing. So, I don't think it's  
16 true that nobody cares about that.

17 MS. DEDERER: But this committee is only  
18 focused on looking at it in isolation. You're looking  
19 only -- you only want to look at nursing facilities in  
20 isolation and --

21 MS. MITZEN: Teri, I'm wondering, though --  
22 what I'm hearing in the group, and particularly from Mike  
23 now, is that we're -- that our presence here is beginning  
24 to change the culture of what has been specifically about

1 it looking only at nursing homes and hopefully now will  
2 take a broader view of what long-term care has always meant  
3 to us, and that is nursing home as a part of services that  
4 is available to people who need it. If that's the case and  
5 if we can all agree that that's where we either are or  
6 where we're going with this, then I think I'm much more  
7 comfortable sitting here than I was an hour ago.

8 MS. ALTMAN: One other thing, Teri. I think  
9 all agreeing on including home-based services in the  
10 discussion, I think, is one thing that -- I think the other  
11 thing is agreeing on the fact that our goal is to change  
12 the current situation, which is an over-bedded situation.  
13 Is everyone going in that direction?

14 MS. DEDERER: I don't think so.

15 MS. AVERY: I think to sum it up, some of the  
16 things that you're discussing, Teri, and putting on the  
17 table are not under the jurisdiction of the Board, and we  
18 have a clear-cut charge from the Legislature as to what  
19 we're supposed to do as a subcommittee. So, some of those  
20 things we don't have the authority to do.

21 MS. DEDERER: You have the authority to  
22 consider what other services are in the community.

23 MS. AVERY: That's part of the variances, but  
24 we don't have --

1 MS. DEDERER: No, it's not. A variance is  
2 providing a different service. We want the availability of  
3 other services in the community to be part of bed need.  
4 Now maybe not part of the formula, but to count as what is  
5 the need out there for service.

6 MR. SCAVOTTO: I really disagree with what  
7 you're saying, and here's why: Those of us who work on the  
8 provider side know that there's two aspects of the  
9 healthcare delivery system. One is finance, the other one  
10 is delivery. Most of us work on delivery. You work on  
11 delivery, I work on delivery. I think this Health  
12 Facilities Planning Board is restricted by finance. So,  
13 who is going to make use of home care and community-based  
14 services? The payors. The providers aren't going to drive  
15 that. They might as a business opportunity, but they're  
16 going to need a payor. Medicaid, HFS in Illinois, will  
17 move blocks of business away from nursing homes to home  
18 care and community-based services. That's going to happen  
19 as a function of cost in the marketplace.

20 MS. DEDERER: But it's not.

21 MR. SCAVOTTO: It's going to happen. More and  
22 more people are going away from the highest cost in the  
23 long-term care continuum, which is a skilled bed. They're  
24 going to supported living, they're going to go to the home,

1 they're going to go to other settings. We have no control  
2 over that with a Certificate of Need process. That's  
3 completely finance. To me that's a very different issue,  
4 and what we've been talking about dealing with here, what  
5 Courtney was getting at, is we've got a certain structure  
6 to deal with. That's what Tim is getting at, and he's  
7 right. We've got a certain structure that we can  
8 influence, and as providers, yeah, it would be great if we  
9 could say we can be all things to all people. But we  
10 can't. The fact of the matter is that Illinois is ranked  
11 50th in Medicaid. The reimbursement octane isn't there to  
12 do much of anything else except keep your head above water.  
13 If someone -- if the State wants to move blocks of business  
14 to other settings, like supported living, it's going to do  
15 that, and it's completely outside the Certificate of Need  
16 process.

17 MS. DEDERER: But can I point out that if you  
18 look at the data, the data does not reflect the number of  
19 beds added in assisted living or added in SLF's or added in  
20 home care over the last -- I don't know, I'm going to pick  
21 10 years.

22 MR. SCAVOTTO: The data doesn't track that  
23 necessarily.

24 MS. DEDERER: But it does with occupancy.

1 MR. SCAVOTTO: You can do a forward-looking  
2 market study. All of this stuff about the bed-need formula  
3 is backward looking. The latest you're going to have is  
4 data a year old. If you're going to look and examine the  
5 market and what's going on, you need to be looking forward  
6 with population projections and other providers in the  
7 community. None of us are going to go ahead with a project  
8 that doesn't address that. So, it's not like we want to  
9 ignore long-term community-based services as happening.  
10 It's happening. It's happening right in the marketplace.  
11 Tim was speaking to that just a minute ago. But what can  
12 we do to impact the Certificate of Need process? You're  
13 not part of the Certificate of Need process. Frankly, I'd  
14 count my blessings if I were you. It's a highly-regulated  
15 activity.

16 MS. DEDERER: That's because we kind of are  
17 the government. That would be why.

18 CHAIRMAN WAXMAN: All right. I think every  
19 meeting has to have this discussion, and I think somehow or  
20 another we manage to get it in to every meeting we have,  
21 but at least in this arena, I'm hearing that we have not  
22 recognized community base as a very valuable part and  
23 something that needs to be part of the process of  
24 determining CON process, and I think we've all learned from

1 that, and we're happy to have you on the committee, and if  
2 you have contact with the people who you think have dropped  
3 out because of their feeling that they're not appreciated  
4 or not -- the value of their input is not being taken  
5 seriously, please share with them that that's totally  
6 untrue and that we would like for them to participate,  
7 since they were appointed for a reason of what information  
8 and experience they have. You know, again, as I read to  
9 you earlier, our charge is how skilled nursing fits in the  
10 continuum of care with other care providers. So, our  
11 charge is to look at all of that stuff, and I think at this  
12 point we all agree that community-based services are part  
13 of the continuum. So, I'm hopeful that this discussion  
14 doesn't have to come up again. I think what we -- we also  
15 have Courtney's suggestion that Staff and Eli and I will  
16 determine some hard objectives -- I don't mean hard  
17 objectives. Some hard dates to complete some objectives,  
18 that we can move forward with a time frame that all of you  
19 agree with and, again, I'd like to point out that the last  
20 charge that we do have is to make sure that the current  
21 trends in long-term care services are being looked at,  
22 which means that statement keeps this committee as an  
23 ongoing committee. Now, on a personal level, all of us --  
24 you know, we are free to come and go to this committee,

1 resign and somebody else will be appointed, if you think  
2 you've served long enough or -- there are no terms defined  
3 in the legislation as to how long we're on, but the  
4 Committee itself is a long-term committee to function for a  
5 while. So, as we complete objectives, there will be more  
6 for us to do. So, I hope all of you will stick around and  
7 see it through to wherever we go.

8           But I also understand the need for target  
9 dates and some completed projects, so I understand all of  
10 that, and I totally agree with it. So, I think we have a  
11 plan for that. We do have two work committees that are on.  
12 The goal, I hope, is two more people will step up. We'll  
13 e-mail, so that Mike and Carolyn are not alone on their  
14 telephone call. But just think about how easy it will be  
15 to understand each other without more than two of you on  
16 the phone call. So, that's maybe a good thing.

17           MS. AVERY: We will have Mike and myself  
18 there.

19           MS. CREDILLE: I can't do anything?

20           CHAIRMAN WAXMAN: You can certainly be a part  
21 of the phone call.

22           MS. AVERY: You can still give feedback.

23           MS. CREDILLE: We need to resolve if I'm on  
24 the committee first.

1 CHAIRMAN WAXMAN: You are a designee. You  
2 are welcome to be on the phone call. I think your  
3 background would fit very nicely. So we need one more.

4 MR. REPPY: Clarification. The committee  
5 is -- the sub-committee is designed to change the existing  
6 application to make it consistent with the changes that  
7 you've already -- that have already been adopted in the  
8 rules; is that correct?

9 CHAIRMAN WAXMAN: We are following through on  
10 that process, yes.

11 MR. REPPY: But it is not designed to change  
12 the application for any future changes that you might make  
13 in the rules?

14 CHAIRMAN WAXMAN: If any future changes  
15 create the need to change the application, we will go back  
16 and do that. So, this is not the last application in the  
17 world. If we need to change the application because we've  
18 come up with some new ideas, it will be changed. That's  
19 the cool thing about computers, that you get the form in  
20 there and you can make changes.

21 MS. ALTMAN: So do we need a work group for  
22 that? Can't the Staff rewrite the application to conform  
23 to the rules and then send it to us all and we decide if we  
24 have a problem with it?

1 MS. AVERY: Conforming to the rules is just  
2 one step. There are going to be other things in there that  
3 are applicable and that you all want to see in a long-term  
4 care CON application. We can do that, but we've gotten  
5 such backlash in the past, like "Staff, Staff, Staff is  
6 dictating" that we can't do that.

7 CHAIRMAN WAXMAN: I also think that someone  
8 like Mike, who has filled out CONs forever, would have  
9 valuable information as to what changes and what fits a  
10 long-term care facility as opposed to a hospital and what  
11 should be there. So I definitely think --

12 MS. AVERY: We have a draft ready to go but  
13 some feedback from other committee members has been that  
14 Staff is kind of dictating, and we didn't want that.

15 MS. ALTMAN: Right. It's just that saying we  
16 are saying two different things --

17 MS. AVERY: I didn't finish what I was saying.  
18 I wanted the Committee to have ownership of that and not  
19 just something that Staff is saying, "Here it is, take  
20 this, and this is it." We wanted a two-step process, and  
21 Mr. Waxman, who is the Chair of this committee, wanted it  
22 to be done that way.

23 MR. WILL: Again, just real quickly -- and  
24 this may be moot at this point. I think that my impression

1 from when this topic was first introduced was, the thing  
2 that will look and feel different about the application --  
3 the changes will be this is the first time there's one for  
4 long-term care facilities that is different from the one  
5 that were primarily hospital-driven, and so that may not  
6 affect huge amounts of content, but it will affect how it's  
7 presented, how it looks, and then there's the stuff from  
8 the adopted rules, which as people will remember is not  
9 huge.

10 MS. AVERY: And some of the feedback, if I  
11 remember correctly, to the Task Force that created the  
12 sub-committee was that they wanted this committee to  
13 dictate how long-term care should be treated, for lack of a  
14 better word, under the CON process. So, I don't want the  
15 phone calls coming from the Legislators saying, "We charged  
16 you to do this and we're hearing that Staff has taken over  
17 this process and doing things." So that's the purpose of  
18 why we tried to have the smaller work groups to come up  
19 with the tasks and do all the things as a work committee so  
20 it wouldn't have the appearance that Staff is dictating  
21 what should be done in the long-term care community.

22 CHAIRMAN WAXMAN: And, again, I think that --  
23 I'm sure Chuck will share his feedback with Mike, if not  
24 already, before this committee meets, because I know that

1 Chuck fills out a few of these a week, and we would greatly  
2 want his input into it. So it has to be our committee work  
3 on the application, because, again, as I've heard from the  
4 moment this committee met is that its current application  
5 is hospital-driven, and that's not right, it's not  
6 appropriate. So we will fix that, and it has to be this  
7 committee's whole acceptance of the suggestions.

8 Teri?

9 MS. DEDERER: I think it's wonderful that  
10 Staff is doing this kind of stuff. I don't see it as Staff  
11 dictating anything and, very honestly, I mean at least with  
12 my participation here and Chuck's participation here, it  
13 would be really hard for Staff to shove something down the  
14 throat of this committee. You bring something to this  
15 table and everybody might say they love it, and it means  
16 they really love it, because if they didn't, you would be  
17 hearing it at this table, and it's just so helpful for  
18 people who aren't working on this stuff full time. To take  
19 everything you've been hearing and put it together in a  
20 small committee isn't a bad thing. I would think some  
21 nursing home people would want to be on this group to make  
22 sure that it does what it needs to do for the people who  
23 have to fill it out, but I don't think you have to worry  
24 about it looking like Staff are dictating anything. I just

1 have to say that. I appreciate it.

2 MS. ALTMAN: I appreciate that, too, and I  
3 agree with Teri that anything you give us is just for us to  
4 look at and for our recommendations. I think it moves the  
5 process forward. But my bigger concern is I remember  
6 looking at the old application. I don't remember what  
7 would be contemplated and all of the changes, but is there  
8 anything in changing that actual application process that  
9 is going to move forward this issue of being over bedded?  
10 Is there anything -- no, there's nothing in that  
11 application that would move that forward?

12 MS. MITZEN: It seems to me -- and I loved  
13 your comment. It seems to me that that would be the first  
14 salvo of saying that something is changing, and at the same  
15 time -- and we should probably be able to do that fairly  
16 quickly. We probably could be approving that today, quite  
17 frankly. That seems to be like a no brainer. Write it and  
18 look at it -- I mean, if that's the case, I'll be glad to  
19 do that and let's bring it up and vote on it in the next  
20 meeting, and let's get it done.

21 MS. ALTMAN: Agree.

22 MS. DEDERER: Agree.

23 MR. URSO: My understanding from past meetings  
24 is this has been requested, that the application needs to

1 change, it needs to be modified. That's why it's being  
2 done. That's exactly why it's being done, because it's  
3 being asked for.

4 MS. MITZEN: So let's do it.

5 MS. ALTMAN: I get it now. This is a pro  
6 forma kind of thing. You guys are going to give us  
7 hopefully a draft, the work group will do it, by next time  
8 we'll vote, and there will be a separate CON application.  
9 Okay. Now move forward. Where are we going forward?

10 MS. MITZEN: The forward are the committees  
11 we're working on. Let's not elaborate on this. Let's be  
12 done with it and --

13 CHAIRMAN WAXMAN: Again, part of that forward  
14 is --

15 MS. AVERY: -- what I said twenty minutes ago.  
16 I will pass that out so everybody is on the same page, and  
17 if there are changes that need to be made to our charge, we  
18 can take that back to Senator Garrett and say, "Look, this  
19 subcommittee feels this needs to be the focus or the  
20 priorities" or whatever. We went through that process of  
21 establishing priorities about four or five meetings ago.  
22 That was thrown out. And so it's like we do something and  
23 then the next meeting things get thrown out, and it seems  
24 like we are in this vicious circle.

1 MS. ALTMAN: You know Senator Garrett has  
2 three more weeks, right?

3 MS. AVERY: Three weeks means a lot. She's  
4 already done a lot of stuff. Just because she's leaving  
5 doesn't mean it's not being passed to somebody else.

6 MR. PICK: Do we know who her successor is?

7 MS. AVERY: No, we don't, but she is dedicated  
8 to making sure there are changes and that that is adhered  
9 to for this process, and it wasn't just her on the Task  
10 Force that came up with this. It was a full Task Force  
11 that did it.

12 MR. PICK: The legislation that was passed  
13 that called for establishing this committee, we don't --  
14 Frank, do you know when that was -- if my memory serves  
15 me --

16 MR. URSO: July of '09.

17 MR. PICK: And it was supposed -- wasn't there  
18 a time by which we were supposed to produce the work  
19 product?

20 MR. URSO: That was the rules. Originally, I  
21 think, it was September of '10, and we got it done by  
22 September of '11.

23 MS. ALTMAN: But that was all we were being  
24 charged with. That was, again, a very small step. We did

1 it, we finished it, and now we will change the application.

2 But then what? I think that's where we are.

3 MS. AVERY: We still have the bed-need  
4 formula. You still need to study that sheet. We have a  
5 lot of stuff that we need to do. I don't know why people  
6 aren't realizing what that charge says on that sheet.

7 MS. ALTMAN: I think I understand what the  
8 charge says, but that's a big charge and a big political  
9 charge.

10 MS. AVERY: That's why we're ongoing. That's  
11 why we're trying to work with the Legislature. When you  
12 all make recommendations, we take them to the Board, and we  
13 say, "Look, this is what is needed; this is what we're  
14 asking for." We go through the process that's required of  
15 State Government and try to get what the Long-Term Care  
16 Committee wants out there. And then I go back to your  
17 discussion as to why we are here. When we looked at the  
18 composition -- when I looked at it, when I looked at the  
19 composition of this committee, first thing I thought was  
20 nineteen people was too large, and how does this group fit  
21 into what's on that paper? Some people are excellent at  
22 the table, and some people are like -- and not people per  
23 se, individually, but the organizations that's represented,  
24 what does that have to do with what's on that paper? How

1 does it relate back? I would have probably composed the  
2 Committee totally different than --

3 MS. ALTMAN: Tell me --

4 MS. AVERY: I would have looked for some more  
5 advocates. I would have made sure we have owners at the  
6 table and probably a little bit of a connection but not  
7 representation at the table from organizations and  
8 industries like AARP but not to be at the table, because  
9 they're not here because they don't see where they fit in.

10 MS. MITZEN: When you say "advocates," who do  
11 you mean?

12 MS. AVERY: Advocates in long-term care. We  
13 have Neyna. She's an ombudsman. I would have just looked  
14 at it a little differently. I can understand you all's  
15 frustration of why you we are here. I would have had a  
16 person who uses the service, a resident. I would have had  
17 that kind of composition and --

18 MS. ALTMAN: The reason we always reference  
19 the Governor's Task Force on Aging is because we are all on  
20 it, AARP, Triple A, us, Health and Medicine, SEIU, and the  
21 nursing home -- all of the nursing home industry, you're on  
22 it, Eli, et cetera. And so we all sat on a table very,  
23 very similar to this, or we still sit on that table. So,  
24 that's why it was always kind of confusing to us just, so

1 you understand. It's an Older Adults Services Advisory  
2 Committee, otherwise known as the Governor's Task Force on  
3 Aging. We were all appointed, all that we've mentioned.  
4 It was supposed to be pretty much all the long-term care  
5 advocates. We have also representation from people over  
6 age 65 as consumers of services, and we have -- so we have  
7 all these people. I think that's what's been kind of  
8 confusing to us, because when we were appointed to this, it  
9 was similar but sort of -- it's like we're having the same  
10 discussion that we have all the time on that group and  
11 advise the Governor and the Legislature on that and propose  
12 legislation, except we have this really specific context,  
13 this really specific context, which is, "You're going to  
14 discuss what you do on long-term care every day all the  
15 time for seven years, make these recommendations to the  
16 Governor and the Legislature on rebalancing and bed need."  
17 We've had entire committees, as you know, on reduction and  
18 buying beds, on grants to produce beds, conversions. Every  
19 single State agency sits on it, the Department of Public  
20 Health, et cetera, et cetera. And so we've been in that  
21 context, and then we were sort of appointed to this really  
22 narrow context of looking at what you guys did with the  
23 Health Facilities Board, which we had no experience  
24 whatsoever on, and a new subcommittee on long-term care to

1 figure out the Certificate of Need.

2           So, maybe you can understand our frustration  
3 is like we sort of participate -- we already advise the  
4 Governor and Legislature, for what that's worth, as a  
5 whole, and we kind of fight out these issues with all three  
6 associations that are on it. Nursing home associations are  
7 on it as well as every long-term care advocate group I can  
8 think of. So, I can't think of anyone who is not, and we  
9 kind of discuss these rebalancing issues and push forward  
10 legislation that sometimes passes and sometimes doesn't for  
11 seven years. It's not that you guys are frustrating us or  
12 anything. It's like what we are doing here is like this  
13 weird off-shoot of that, and we can't put it all together.  
14 I don't know --

15           MS. MITZEN: I guess from my --

16           MS. ALTMAN: It's artificial.

17           MS. MITZEN: It's a narrow piece, but when I  
18 said in the very beginning -- when I first raised this, I  
19 saw this as an opportunity to have an influence in a very  
20 important part of what we've been trying to accomplish on  
21 OASAC, and that is, if we're really going to change things,  
22 we really need to have -- we have to reduce the number of  
23 beds in this state, and I saw this as an opportunity to at  
24 least have some influence on that.

1 MS. ALTMAN: And maybe that's why we have this  
2 discussion every time.

3 MS. MITZEN: I thought we could bring that  
4 expertise to this table.

5 MS. ALTMAN: I don't want to have this  
6 fish-out-of-water discussion every time. I know it's  
7 annoying to people, and I basically was going to resign the  
8 end of 2011, and maybe that's kind of what you guys want me  
9 to do. But, Eli, maybe because you sit on both of these  
10 things and from the provider angle, you really understand  
11 all of this, but from our angle, you really understand what  
12 we've been doing over there. Where does it all fit  
13 together?

14 MR. PICK: May I, Mr. Chair?

15 CHAIRMAN WAXMAN: Sure.

16 MR. PICK: I think Mike Scavotto hit it right  
17 on the head. This is a finance application. Then unlike  
18 the policy piece that talks about designing a service  
19 continuum, the role of the Planning Board is to look at how  
20 development of facilities are financed. So that's the  
21 difference. So, again, as I mentioned to Mike when we were  
22 at lunch, I think one of the things -- we battle it out in  
23 the OASAC kind of environment because you have all of these  
24 competing interests that are coming together to influence

1 policy, and then at the legislative level, depending on who  
2 has the level of -- what's the word -- the ability to  
3 affect the change more determines what actually ends up  
4 happening. So in this case, it's really looking at the  
5 finance piece. But if we're not sensitive to what can  
6 really be legislated, then you end up in the same place.

7 MS. ALTMAN: Right.

8 MR. PICK: So, I think let's learn the lesson  
9 that it's not -- the job is not done when we walk out of  
10 the room saying, "Yeah, we got everybody convinced this is  
11 the right thing to do," if it doesn't get implemented. So  
12 I think this is the venue that we have an opportunity to  
13 apply that lesson, that we want to change -- you know, the  
14 opportunity to make changes. The long-term care  
15 industry -- again, going back to why we're here -- was  
16 frustrated over the fact that the Planning Board was very  
17 much an acute model. The application was designed around  
18 hospital needs, and the nursing home kind of just slipped  
19 in as part of -- well, you know, we really have this  
20 structured system; this is another element of healthcare  
21 that needs to be put in, so the nursing home application  
22 just is essentially a hospital application that the  
23 consultants have learned how to adapt because they have to.  
24 So, part of what was advocated in the legislation was that

1 a nursing home is not a mini hospital. It is unique. It  
2 needs a unique application process. It needs a unique set  
3 of standards and elements that are reviewed to determine  
4 whether there's a need or continuing need to expand growth,  
5 et cetera. So that was really the motivation on the part  
6 of the associations, and we want to change the way the  
7 planning process views nursing home services, and from that  
8 was also expanded -- I think, much of the work at OASAC --  
9 by Senator Garrett and the other legislators that were  
10 involved to say, "We want to also include all of the  
11 services that are needed in the community, which includes  
12 things like home and community-based services." So, then  
13 other elements got added in to it, like private rooms,  
14 because the planning process limited nursing homes' ability  
15 to provide enough square footage. So a whole host of  
16 things -- one aspect affected the next, and they all  
17 started to mushroom into what we have as a final document.

18 So, I can guarantee you, no one is totally  
19 satisfied with the way it came out, but many groups got  
20 many of the things that they were asking for. So I think,  
21 you know, to a great extent I feel like we're trying to put  
22 a round peg in a square hole but the edges -- the corners  
23 of that square are rounded, so it's not a totally round  
24 hole but you know it's moving there.

1 CHAIRMAN WAXMAN: I guess what I've heard  
2 from you -- and I really appreciate you sharing your  
3 thoughts and your feelings, because now what I'm sensing --  
4 and, again, it may be inappropriate -- is your seven years  
5 of frustration are coming to this committee.

6 MS. MITZEN: No, we keep it in that  
7 committee.

8 (Laughter)

9 CHAIRMAN WAXMAN: If that is true -- and I'm  
10 hearing you say it's not -- I would hope that you would  
11 give this committee a chance to make the changes that you  
12 are looking for, because we have a whole different avenue  
13 of how we can move our material along. I mean, they go to  
14 the Mother Board and then it goes to legislation. So it's  
15 a different way of enacting change, and I want to believe  
16 that we can be effective in that process. So, I mean, you  
17 have shared things that I now have a better understanding  
18 of where some of the discussions in the past have come from  
19 and what originated it, and I appreciate that, and I think  
20 some other members of the committee probably are  
21 understanding some of the issues that you raise and  
22 continue to raise, and I understand why, but I would hope  
23 that you would feel that this committee, because it's  
24 structured differently in how it reports and how it moves,

1 you know, should accomplish some of the things you haven't  
2 been able to accomplish in your other activities, I hope.

3 MS. MITZEN: I see this as only a piece of  
4 the other work I'm doing. I don't see this as a way to do  
5 something that I can't do there at all. That's totally --  
6 it's totally separate. This is a piece of a larger thing.  
7 A piece of what I'm doing is there, a piece of what I'm  
8 doing is here, and then there's a whole other aspect of  
9 what I'm doing around long-term care that has nothing to do  
10 with these committees at all. But this is a piece of what  
11 I'm trying to accomplish.

12 MS. ALTMAN: Like we represent in long-term  
13 care situations, we represent people trying to get home and  
14 community-based care. We may try to run legislation that  
15 increases community care -- we do tons of other stuff.  
16 It's just that this is a very narrow focus. I understand  
17 better, too, what you're saying and how it might work to  
18 accomplish some goals, but I think we were fit in in a --  
19 the first six months -- I mean, even until now, I think  
20 still many of us who were appointed that way were sort of  
21 saying why did -- we were still, "What is this even about?  
22 Why are we even here?" It didn't fit into anything else  
23 we've worked on at all. Maybe you guys understand why  
24 we're saying, "What heck is going on," because it just

1 didn't make sense.

2 MS. AVERY: You answered a lot of questions.

3 MS. ALTMAN: We did, of why we look so  
4 strange?

5 MS. AVERY: I think once we get to the point  
6 where we can agree on the tasks and break them out and tap  
7 into it, even if we got to a bed-need formula, there's  
8 nothing to say that we can't invite other people in to give  
9 us feedback with will this work, what doesn't work, do we  
10 need to go back to the drawing board? So, maybe our  
11 meetings will be one agenda item every time to focus on  
12 those things and feel more productive.

13 MS. ALTMAN: Have you ever had a consultant  
14 work like -- not Don, but somebody like him, that would be  
15 a consultant to the committee to actually devise a new bed  
16 formula that everyone would then look at and discuss?

17 MS. AVERY: Claire is really our consultant,  
18 Staff consultant. So, in the short answer, no, but that  
19 was recommended once. It wasn't done, but someone on your  
20 level we thought would be great -- Lanahan or someone?  
21 But, yes, we did think of that.

22 MS. ALTMAN: I think that would be a good  
23 recommendation.

24 MS. BURMAN: He would be very helpful. It's a

1 -- Patrick Lanahan. It's a matter of pinning him down.

2 MS. AVERY: Once we get to those tasks and say  
3 this is what we want to do and get feedback, we are able to  
4 come to you all and say, "Who is a good person?" Now we  
5 have Don, and we have a face.

6 CHAIRMAN WAXMAN: Again, I appreciate you  
7 being here, but I think the fact that you are associated  
8 with an ownership in this state kind of precludes you from  
9 being a consultant.

10 MS. ALTMAN: Who is Patrick?

11 CHAIRMAN WAXMAN: I just want to make sure  
12 that everyone understands I do appreciate you being here,  
13 the same I appreciate Chuck coming, even though he can't be  
14 an official member of the committee, and Terry, when he  
15 comes here. I do appreciate your input as being extremely  
16 valuable, but I can't stand here and say that you can be a  
17 consultant.

18 MR. REPPY: No, I don't want to be. What I  
19 would like to offer is -- I have staffed one of these  
20 committees before, several years ago, and one of the things  
21 that I learned from that experience is that with a  
22 committee this large, you are not going to be successful  
23 unless you have strong Staff support, a consultant who can  
24 help you, so that the Staff brings to you suggestions of

1 "You can go this way, you can go that way, or you can go  
2 that way. These are three opportunities. Let's talk about  
3 which ones of those options you want to do." But I hear in  
4 this committee a reticence on the part of the Staff,  
5 because their concern is that if they take that leadership  
6 role and bring you options, that that will be perceived as  
7 the Staff telling you what to do, and that is -- given that  
8 environment where we have members of the committee who are  
9 frustrated and we have a Staff that's reticent to say,  
10 "This is really what you ought to do, folks," it's going to  
11 be very difficult for you to mix it. If I was serving on  
12 this committee -- which I don't want to serve on this  
13 committee, but if I was serving on this committee, I would  
14 be looking at the Staff, saying, "Bring me a  
15 recommendation."

16 MS. DEDERER: Yes, or a couple  
17 recommendations.

18 MR. REPPY: "Bring me a recommendation" every  
19 time for everything.

20 MS. ALTMAN: That's what I want to hear.

21 MS. BURMAN: I think the way we've tried to  
22 approach data and, hopefully, helpful information is to  
23 organize it so you're not puzzled over what the heck anyone  
24 is saying or trying to look for any kind of special

1 dictionary, by taking a common sense approach. We can look  
2 at this, we can look at this, we can look at this and take  
3 it from there.

4 MS. ALTMAN: More opinion -- not opinions.  
5 More recommendations.

6 MS. BURMAN: But we generally try to avoid  
7 doing that, because that is for this subcommittee to  
8 handle.

9 MS. DEDERER: How about options?

10 MS. AVERY: It was at the -- and not  
11 disclosing, but it was at the feedback from some other  
12 members, and this is the first time this has come up. But  
13 I'm glad to hear that there is not a consensus with that,  
14 and if that's what you all want, that's what we can do.

15 MS. ALTMAN: I think I would like to bring a  
16 motion, actually, to have Staff revise a bed-need formula  
17 that they present to us, or two or three options based on  
18 the research you've done with the states, based on what  
19 you've heard in the work groups, and based on the  
20 conversations that we've had, I think, for eight or nine  
21 months, and give us a recommendation or two or three  
22 recommendations or have a consultant do that. I think that  
23 makes sense. Otherwise we do go in circles. And we don't  
24 have the expertise.

1 MS. AVERY: It is our expertise. I mean,  
2 Claire can probably whip that out right now.

3 CHAIRMAN WAXMAN: I need a second for the  
4 motion.

5 MS. MITZEN: I'll second.

6 MS. AVERY: Okay.

7 MR. URSO: We need to vote.

8 CHAIRMAN WAXMAN: We still have ten. Frank  
9 is suggesting a roll call vote on it. So --

10 MR. PICK: I don't think we've completed the  
11 discussion. I think that the subject of determining what  
12 the prevalence per thousand population should be as far as  
13 a bed-need formula is also dependent on us determining --  
14 you know, resolving the question of how many operational  
15 beds are actually there. So, until we complete that  
16 process, it would seem to me it's going to be hard to do  
17 and say this is how we should modify it. How great that we  
18 may have a statistic that may indicate how many beds per  
19 thousand are actually being used. I haven't seen that  
20 data. I don't know where it came from.

21 MS. CREDILLE: This is from the U.S. Census  
22 Bureau.

23 MR. PICK: Okay. I think we need some time to  
24 look at this information before --

1 CHAIRMAN WAXMAN: Would you amend your motion  
2 to simply say after the committee makes its report on  
3 operational bed count, that you -- the work group --

4 MS. ALTMAN: They have to do that survey and  
5 get a response from the survey?

6 MS. MITZEN: No, no, no, how to determine.

7 MS. ALTMAN: How to determine operational  
8 beds?

9 MS. DEDERER: Can I offer a suggestion? HFS  
10 should have data based on MDS for at least patient days at  
11 any point in time or patient days for the year, which  
12 should give you an actual count for occupancy based on MDS,  
13 right?

14 MR. PICK: HFS can only provide information on  
15 Medicaid.

16 MS. DEDERER: No, they get MDS on everybody, I  
17 thought.

18 MR. PICK: No, CMS gets it on everybody, but  
19 Public Health should have it.

20 MS. DEDERER: Mike thinks they've got it. We  
21 can at least look into that. It would sure be a lot easier  
22 to have a computer spit it out.

23 MR. DART: I think they would have it. I  
24 think there's a few places we can look at the patient days

1 to try to back it up to per thousand type of calculation.

2 MS. DEDERER: They should be able to do point  
3 in time, averages, whatever.

4 MS. DEDERER: But that isn't why I had my hand  
5 up.

6 CHAIRMAN WAXMAN: Again, would you amend your  
7 motion to let the work group make its report first and then  
8 have Staff do a recommendation?

9 MS. ALTMAN: Fine.

10 CHAIRMAN WAXMAN: So the motion is now --  
11 will you second that motion?

12 MR. PICK: Yes.

13 CHAIRMAN WAXMAN: The motion is now that  
14 after the report from Tim's committee on operational bed  
15 count, the motion is still that Staff provide one or more  
16 methods of revisions to the bed count formula for us to  
17 look at. Eli made -- Stephanie made the motion and Eli  
18 seconded it. Roll call vote? So, I don't -- do you have a  
19 roll call, or should we just go around the table and  
20 identify ourselves?

21 MS. ALTMAN: Stephanie Altman; I vote yes.

22 MS. MITZEN: Phyllis Mitzen; I vote yes.

23 MR. WAXMAN: Mike Waxman, yes.

24 MR. PICK: Eli Pick, yes.

1 MS. JOHNSON: Neyna Johnson, yes.

2 MS. DEDERER: Teri Dederer, yes.

3 MR. SCAVOTTO: Mike Scavotto, yes.

4 MR. PHILLIPPE: Tim Phillippe, yes.

5 MR. DEES: Rick Dees, yes.

6 CHAIRMAN WAXMAN: Is that enough? Did  
7 somebody leave from your group?

8 MR. PHILLIPPE: No.

9 (Discussion held off the record.)

10 MS. AVERY: We'll table the motion and still  
11 work on it.

12 MS. DEDERER: Can I make a request?

13 CHAIRMAN WAXMAN: I have to table the motion  
14 until our next meeting.

15 MS. AVERY: Which will be when?

16 MS. DEDERER: You talked about -- you know,  
17 Mike was starting to talk about this is a finance approach.  
18 At the next meeting, could somebody spend ten minutes and  
19 explain to those of us who don't understand the finance  
20 part of it, just briefly, because like he's talking about  
21 it's market driven. On the other hand, if it were all  
22 market driven, you wouldn't need the Board at all. So,  
23 there's some other things in here, and it would be helpful,  
24 I think -- I don't know. Phyllis, do you understand the

1 finance part?

2 MS. MITZEN: I would appreciate a discussion  
3 of that, too.

4 MS. DEDERER: Just brief. We would appreciate  
5 it.

6 CHAIRMAN WAXMAN: Thank you, Teri. We will  
7 put it on the agenda.

8 MR. PICK: If I may, I think a Staff  
9 presentation on how the financing of the facilities -- why  
10 the Planning -- what's the Planning Board's role as it  
11 relates to capital required for financing for the  
12 development of facilities in the state.

13 MS. AVERY: This is why a transcript helps us,  
14 because we can go back to exactly what you said and get it  
15 right to the point. So we will do that.

16 MS. MITZEN: I think it's going to take more  
17 than ten minutes, and I would also suggest that we add to  
18 that -- or maybe it's a separate conversation -- that whole  
19 issue of then buying beds across --

20 MR. PICK: Well, it's another discussion.

21 MS. MITZEN: Maybe, but I'd like to hear more  
22 about that also, because in terms of looking at the Ohio  
23 model, we're going to need to know more about that, too.

24 MS. DEDERER: And specifically when you talk

1 about how this is a finance thing, could you kind of help  
2 those of us who know that HFS is paying for -- I don't  
3 know -- eighty percent of nursing home costs, or whatever  
4 it is right now, and Medicare is paying a hunk, how  
5 whatever this Board is doing is finance, how it fits in?  
6 Because the ongoing costs are either private pay or  
7 government, and then I just get kind of lost in finance and  
8 market, and as you might imagine, I didn't pass economics.

9 CHAIRMAN WAXMAN: We're building an agenda  
10 for the next meeting, which is going to be a two-day --

11 (Laughter)

12 MS. MITZEN: This is not ten minutes.

13 MS. DEDERER: Finance for dummies.

14 MS. AVERY: Third Tuesday in January, or do  
15 you want to go to February?

16 CHAIRMAN WAXMAN: Do people want to meet in  
17 January?

18 (Discussion held off the record.)

19 CHAIRMAN WAXMAN: 31st of January.

20 MS. AVERY: Video conference?

21 CHAIRMAN WAXMAN: Okay. We will pick the next  
22 meeting date so people can get it in their calendar and  
23 then we can send it out after that.

24 MR. PICK: So that would be March? The third

1 Tuesday is the 20th.

2 MS. AVERY: March 20th.

3 CHAIRMAN WAXMAN: Next meeting then after the  
4 31st of January would be March 20th.

5 MS. DEDERER: Are we still planning two  
6 locations?

7 MS. AVERY: We will.

8 MS. DEDERER: Okay. Cool.

9 CHAIRMAN WAXMAN: Is anyone aware of someone  
10 not attending because of the fact that the two choices were  
11 only Chicago and Springfield?

12 (Pause)

13 CHAIRMAN WAXMAN: Okay.

14 MS. AVERY: I didn't receive any feedback.

15 CHAIRMAN WAXMAN: In that case, I thank  
16 everybody for their participation. I think it was a good  
17 meeting. I think we heard some things today that we  
18 haven't heard previously, and I appreciate people being  
19 forthright and sharing feelings and background with us, and  
20 I think that's very helpful. So, again, thank you all. I  
21 will take a motion to adjourn.

22 (Discussion held off the record.)

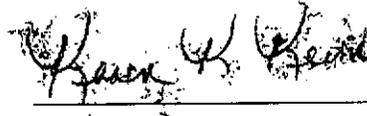
23 CHAIRMAN WAXMAN: We are in recess.

24 END TIME: 2:09 p.m.

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## CERTIFICATE OF REPORTER

I, KAREN K. KEIM, CRR, RPR, a Certified Court Reporter in the State of Illinois and the State of Missouri, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken, and further that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.



KAREN K. KEIM

CRR, RPR, CSR-IL, CCR-MO

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