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

LONG-TERM CARE ADVISORY SUBCOMMITTEE

MEETING

AUGUST 14, 2012

NATIONWIDE SCHEDULING

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

LONG-TERM CARE ADVISORY SUBCOMMITTEE
MEETING

The meeting of the State of Illinois Health Facilities and Services Review Board, Long-Term Care Advisory Subcommittee, was held on August 14, 2012, scheduled to begin at the hour of 10:00 a.m. at the Bolingbrook Golf Club, 2001 Rodeo Drive, Bolingbrook, Illinois.

1 MEMBERS PRESENT AT CHICAGO LOCATION:

Michael Waxman - Chairman

2 Eli Pick - Vice-Chair

David Raikes

3 Mike Scavotto

Tim Phillippe

4 Neyna Johnson

Cece Credille

5 Carolyn Handler

Greg Will (for Dave Lowitzki)

6 Phyllis Mitzen

7 ALSO PRESENT:

8 Dale Galassie - HFSRB Chairman

9 Frank Urso - HFSRB Legal Counsel

10 Juan Morado - HFSRB Staff

11 Alexis Kendrick -HFSRB Staff

12 Courtney Avery - HFSRB Administrator

13 Cathy Clarke - HFSRB Staff

14 Claire Burman - HFSRB Staff

15 Michael Constantino - HFSRB Staff

16 Charles Foley

17 Terry Sullivan

18

19 Reported by:

20 Karen K. Keim

21 CRR, RPR, CSR-IL, CRR-MO

22 Midwest Litigation Services

23 401 N. Michigan Avenue

24 Chicago, IL 60611

1 START TIME: 10:00 A.M.

2

3 CHAIRMAN WAXMAN: Why don't we do this: We
4 have a new Board member, who we would like to welcome.
5 Would you be kind enough to introduce yourself and share
6 your background a little bit?

7 And then when we do roll call, if you would
8 take a few minutes to identify yourself and what you do,
9 for the benefit of our new joinee, that would be greatly
10 appreciated.

11 So, we'll start with you, if don't mind.

12 MR. RAIKES: My name is David Raikes.
13 R-a-i-k-e-s is the spelling of my last name. I just
14 recently retired as Business Manager of Laborers Local
15 Union 393 in Marseilles, which is about 49 miles west of
16 here, off of Interstate 80. Worked as a union rep with the
17 laborers in the construction industry for 40 years. So,
18 I'm looking forward to learning and being a part of your
19 group here.

20 CHAIRMAN WAXMAN: Thank you for being part of
21 the Committee. If you have any questions, ask. You're
22 sitting between two very, very bright young men. I'm sure
23 they will help you.

24 What I'd like to do is do roll call with the

1 members first, and then we'll come back and get our invited
2 guests.

3 So, Mike, if you want to be next.

4 MR. SCAVOTTO: Mike Scavotto, Management
5 Performance Associates, St. Louis.

6 CHAIRMAN WAXMAN: Young lady?

7 MS. JOHNSON: Nanya Johnson, Department on
8 Aging.

9 MR. PICK: Eli Pick, semi-retired, Post Accute
10 Innovations.

11 CHAIRMAN WAXMAN: I'm Mike Waxman. Eli is
12 Vice-Chair. I am Chair of this committee. I work for a
13 company called PRS Dialysis.

14 We'll come back and pick these people up.
15 Tim, I think you're next.

16 MR. PHILLIPPE: Tim Phillippe with Christian
17 Homes. We're a not-for-profit.

18 MS. CREDILLE: Cece Credille, and I represent
19 Illinois Healthcare Association.

20 CHAIRMAN WAXMAN: Okay. We're -- we need ten
21 to make quorum. We're at seven at this moment. We did
22 have quorum by phone count last night, so, hopefully, a few
23 more people will show. If we don't get quorum, we'll do
24 what we did last time, which is go through the agenda,

1 cannot vote, and then schedule a conference call, and just
2 make it for voting purposes only, a unique concept.

3 Chuck, would you be kind enough to introduce
4 yourself?

5 MR. FOLEY: Yes. Charles Foley, healthcare
6 consultant from Springfield.

7 CHAIRMAN WAXMAN: You're no longer Chuck?
8 You're Charles?

9 MR. SULLIVAN: Terry Sullivan, working with
10 the Illinois Council on Long-Term Care for the past 30
11 years.

12 CHAIRMAN WAXMAN: I was excited until he said
13 40.

14 MR. SULLIVAN: And I've been working in the
15 long-term care field for 40 years.

16 CHAIRMAN WAXMAN: All right. I think the rest
17 are staff. So, Frank?

18 MR. URSO: Frank Urso, General Counsel to the
19 Health Facilities and Services Review Board.

20 MS. BURMAN: Claire Burman. I'm the
21 Coordinator of Rules and Legislation for the Board.

22 CHAIRMAN WAXMAN: We'll save Dale for last.

23 MS. AVERY: Courtney Avery, the Administrator
24 for the Board.

1 MR. CONSTANTINO: Mike Constantino, Board
2 Staff.

3 MS. KENDRICK: Alexis Kendrick, Board Staff.

4 MR. MORADO: Juan Morado, Board Staff.

5 CHAIRMAN WAXMAN: Dale, do you know the rule
6 for Juan? He only gets to speak 50 words.

7 MR. GALASSIE: But I'm sure he does it very
8 eloquently.

9 CHAIRMAN WAXMAN: This gentleman, for those
10 who don't know, is Dale Galassie, who is Chair of what we
11 refer to as the Mother Board.

12 Dale, do you want to say anything more?

13 MR. GALASSIE: Good morning. Thank you for
14 allowing me to be here. In theory, I'm representing
15 Dr. Burden, who I was just reading -- you have two
16 absences, you can be dismissed. I assure you his intention
17 is good, but, fortunately for him, his semi-retirement has
18 allowed more travel with his lovely wife.

19 I want to thank all of you for your 30 and 40
20 years -- no, but for all of your efforts here. It is
21 helpful. It's a long, arduous process. No question about
22 it.

23 I'm, honestly, here today to learn. One of
24 the primary issues on your agenda is the bed transfer and

1 selling issue, and I don't pretend to be a proponent or
2 opponent. Big believer in listening, after 30 years in the
3 public sector, CEO of Lake County Health Department. I'd
4 like to be better educated on that subject, and I sit on
5 two other boards besides the Health Facilities Review
6 Board, and I find, as perhaps many of you do, that I tend
7 to learn more than I contribute. I'd like to think that
8 makes me a better member ultimately. But that's really my
9 intention today, is try and learn a little bit more about
10 that aspect of this agenda, and I don't have a long-term
11 care background of significance, anywhere near what folks
12 around this table do.

13 I have known Michael for more years than he
14 would want to admit, and when I was told part of my mission
15 was to appoint this board, I can assure you, he was the
16 first person who came to mind for me, because he's been my
17 go-to person on long-term care for a long time.

18 That having been said, again, good morning.

19 CHAIRMAN WAXMAN: Thank you, Dale. We're glad
20 you made it and look forward to helping you understand a
21 very interesting concept.

22 Phyllis, would you be kind enough to introduce
23 yourself for roll call?

24 MS. MITZEN: Phyllis Mitzen, Health and

1 Medicine Policy Research Group.

2 CHAIRMAN WAXMAN: We have a new board member,
3 David, so we kind of did a little bit longer introduction
4 than normal.

5 And, Carolyn, if you also would introduce
6 yourself.

7 MS. HANDLER: I'm Carolyn Handler. I'm with
8 Rainbow Hospice.

9 CHAIRMAN WAXMAN: So, we're now at nine. We
10 have our plan set out, so we will -- we can't approve the
11 agenda. We can't approve the minutes.

12 Who is covering the bylaw changes?

13 MR. URSO: I am.

14 CHAIRMAN WAXMAN: The floor is all yours, sir.

15 MR. URSO: Thank you.

16 What I want to pass out is what the current
17 bylaws are and then what the amendments to those bylaws
18 are. So, if you would be so kind to pass those down that
19 way, pass those down that way, see if we have enough.

20 (Pause)

21 MS. AVERY: Frank, is it different than what
22 we sent out with the meeting notice?

23 MR. URSO: The second one I'm handing out is
24 what was sent out with the meeting notice.

1 (Pause)

2 MR. URSO: The second set of documents is the
3 amendments. So, basically, the first one is the existing
4 bylaws. The second document that I'm handing out are the
5 amendments to those bylaws that we discussed at the last
6 meeting, and, according to your bylaws, it states that you
7 will receive the amendments at one meeting and then make a
8 decision about them at the next. So, I guess it's
9 fortuitous we can't make a decision at this meeting anyway.
10 So, we will be following the bylaws. Also, according to
11 the bylaws, it says you need two-fifths.

12 MR. SCAVOTTO: Three-fifths.

13 MR. URSO: Three-fifths vote of members to
14 pass the amendments. So, with 19 members, that means we
15 need 12. So, we're a little short of that, too.

16 So, let me -- if you want, Mike, I can go
17 through the amendments, and the first section that is
18 proposed for an amendment is section 1.3, and it says that
19 the absent subcommittee members may be represented by an
20 authorized proxy, who may participate in Subcommittee
21 meetings and are entitled to vote and to receive
22 reimbursement. The reimbursement we're talking about, of
23 course, is the travel reimbursement. And then the entire
24 new language is where -- the process essentially, the

1 procedure in which a proxy could be appointed, and,
2 essentially, it could be made by a written or oral request
3 to the Subcommittee Chairperson, Mr. Waxman, and it should
4 include candidate's resume` or credentials, and then
5 Subcommittee Chair, with the advice of the Subcommittee,
6 will determine if the candidate can be an authorized proxy.
7 And this all needs to be done in open session, on the
8 record.

9 CHAIRMAN WAXMAN: Just as a quick aside, for
10 those of you who weren't here last time, when we talked
11 about these, what we're trying to do is to adjust the
12 bylaws to a more realistic approach, so that we can get
13 quorums at our meetings more easily, because we don't want
14 to be stopped in carrying out our task, in making motions
15 and being able to approve and get votes. So, all the
16 changes that have been suggested -- and, again, everyone
17 who was at the meeting had input. So, this wasn't Staff's
18 bylaws. This is our input into these bylaw changes, and
19 it's all geared to making us a more productive and more
20 efficient subcommittee.

21 Frank, I'm sorry.

22 MR. URSO: The next section that was added is
23 Section 1.4, and that's just to make it entirely clear to
24 all of the Subcommittee members that they're subject to the

1 State Officials and Employees Ethics Act.

2 And then we go on to the amendment proposed
3 for Section 1.5, which Dale mentioned a little bit earlier,
4 about Subcommittee members who are absent from two or more
5 meetings during a calendar year without a valid excuse or
6 requesting an authorized proxy will be considered dismissed
7 from the Subcommittee. And then it goes on to say, "Valid
8 reasons for a Subcommittee member's absence include the
9 following," and you can see what those are.

10 So, there was a lot of discussion about a
11 number of people not being here, so this puts a little
12 substance to that topic.

13 And then I go on to the "Conducting Business"
14 section of the bylaws, where we're contemplating an
15 amendment to Section 5.2, which reduces the quorum for a
16 majority to 30 percent of the Subcommittee membership. So
17 in this case, it's reduced from 10 members to 6 members.
18 So, if these bylaws were in place right now, we'd have a
19 quorum. But they're not.

20 And so then the change to 5.5 is a change from
21 the majority to 30 percent of the membership also to
22 appoint the presiding officer for the Subcommittee meeting,
23 and that same change goes through to Section 5.7, where a
24 motion can be passed with 30 percent versus the majority.

1 Likewise, on page 3 of the amendments, Section 6.1, another
2 reduction from the majority to a 30 percent in terms of the
3 formation of ad hoc or task force committees. And then
4 6.2, once again, is a reduction from the majority,
5 three-fifths majority, to a 30 percent membership, trying
6 to fall in line with the reduction to 30 percent throughout
7 the bylaws.

8 And then we go on to "Remuneration and
9 Reimbursement" on the bottom of page 3, which amends
10 Section 7.1. It now allows the actual necessary travel
11 expenses to be reimbursed not only to the Subcommittee
12 members but also to an authorized proxy.

13 And then 7.2 once again ties in with the
14 travel regulations.

15 And then the last one is an amendment to 7.3.
16 There's no compensation for Subcommittee members nor is
17 there compensation for authorized proxies.

18 So, I believe those were the issues that were
19 raised at the last meeting, and so these are the proposed
20 amendments in that regard.

21 CHAIRMAN WAXMAN: Does anyone have any
22 questions of Frank or any other changes they wish to make
23 at this point.

24 Phyllis?

1 MS. MITZEN: Does this mean that -- what does
2 this do to voting on substantive issues? For example,
3 today's -- we're voting on something today what will -- I
4 mean, how does the 30 percent apply to that? I'm not
5 clear.

6 MR. URSO: It essentially replaces the
7 majority vote on substantive issues.

8 MS. MITZEN: So, 30 percent of the people who
9 are present?

10 MR. URSO: 30 percent of the total membership.

11 MS. HANDLER: Need to be here for a quorum?

12 MR. URSO: No. The quorum will be 6 now, if
13 these are approved, because that's 30 percent of the 19
14 members. So, the quorum will be 6 on substantive issues,
15 rather than majority of the total membership. We were
16 always dealing with -- we were always coming off the 19
17 number, and so it was a majority of the 19, which was 10.
18 So now we're doing a majority of -- excuse me, 30 percent
19 of the majority -- 30 percent of the total membership,
20 which would then be 6.

21 MS. MITZEN: Okay. So in order for something
22 to pass today, for example, it would have to be the total
23 of 6 people voting yes on that issue?

24 MR. URSO: Once the bylaws are approved, then

1 it would be 6.

2 MS. MITZEN: Okay.

3 MR. URSO: If the bylaws were approved.

4 CHAIRMAN WAXMAN: Unfortunately, today the
5 bylaws are the old bylaws.

6 MS. MITZEN: I understand that. I'm making
7 the assumption that this passes, and what I'm trying to
8 figure out is, okay, once it passes --

9 CHAIRMAN WAXMAN: It would be 6.

10 MS. MITZEN: It's still -- to pass anything
11 out of this body, it has to be 30 percent of the total, not
12 30 percent of the quorum present?

13 MR. URSO: Correct.

14 CHAIRMAN WAXMAN: It would be 6, and that
15 number has always been -- I don't think we've ever had a
16 meeting with less than 6. It's been in the 8, 9 range, one
17 or two short of our quorum. So this will allow us to
18 conduct -- the other thing that's difficult is the fact
19 that we are down two spots.

20 MR. URSO: Four spots, I think. I think
21 there's 15 now.

22 CHAIRMAN WAXMAN: We just filled -- David --

23 MS. AVERY: 15.

24 CHAIRMAN WAXMAN: So, even though we're stuck

1 with the original rules, which says 10 of 19, we really
2 only have 15 potential people to be here. So, it's 10 of
3 15. So, this will make it a whole lot easier for us to --

4 MS. MITZEN: I understand that. I just had
5 concern about the way of passing things as we're sitting.

6 CHAIRMAN WAXMAN: Charles?

7 MR. FOLEY: I guess a question. Does a proxy
8 have to represent the person that he is substituting for,
9 that organization, or can it just be anybody?

10 CHAIRMAN WAXMAN: I believe a proxy has to
11 relate to the person that they're representing.

12 MR. FOLEY: Okay.

13 MR. URSO: That's why the proposal is that
14 they submit their resume` and credentials through the
15 Subcommittee member.

16 MR. SULLIVAN: Since we have a little more
17 stringent attendance requirement where, if you don't send a
18 proxy or miss, you're off the board, we may be dealing with
19 vacancy issues on a regular basis. Might I suggest, or at
20 least throw it out, that the bylaws say that the
21 Subcommittee shall consist of no more than 19 members and
22 that a quorum is a -- is 30 percent of the current
23 membership? So, a quorum would be 30 percent of 15, rather
24 than 30 percent of 19, since we may be dealing with

1 vacancies. I'm throwing that out as a suggestion. I don't
2 have a strong feeling about it. It just might make it
3 operationally easier.

4 CHAIRMAN WAXMAN: Again, just based on past
5 experience, we've never had less than 6. So, I think if we
6 get it to 6, we will not have any issues. That being said,
7 it will probably happen at the next meeting and there will
8 be 3. So, I understand what you're trying to do, but I
9 think we're going to be good with the way Frank has drafted
10 these bylaws.

11 MR. PICK: I have a question about the
12 language as drafted. If we had 15 voting members and 6
13 voted for and 9 against, does it still pass?

14 MR. URSO: If you approve these bylaws the way
15 they're written, that is correct, 6 positive votes.

16 MR. PICK: Then I don't think that's the
17 intent. So, I think we need to modify the language that
18 the majority of the members present voting would pass or
19 fail an item, but we only need at least 6 to establish the
20 quorum and successfully pass if that's the majority of the
21 members present voting. Do you follow what I'm saying?
22 Because we don't want to end up where 6 can make an agenda
23 item succeed, even though that's the minority vote.

24 MR. SCAVOTTO: That makes sense. That does

1 make sense. 6 to do business and then the majority to
2 accomplish.

3 MR. PICK: The majority of voting members in
4 order to successfully pass an item. Do I need to make a
5 motion?

6 MR. URSO: No. We're just at discussion right
7 now.

8 MR. PICK: That's right. We haven't passed
9 these anyway.

10 MR. URSO: So, you're saying that you want 30
11 percent or 6 members to open a meeting to institute
12 business, but you want a majority of the voting members
13 present at that meeting to pass any items?

14 MR. PICK: Pass or fail, right.

15 CHAIRMAN WAXMAN: From a legal perspective, is
16 there an issue for you, Frank?

17 MR. URSO: No, as long as we spell it out,
18 because the bylaws are your creation.

19 MS. CREDILLE: So would that mean if you have
20 6 attend, 4 would need to pass?

21 MR. URSO: That's what you're saying.

22 MR. PICK: The majority present.

23 MR. GALASSIE: But if 10 attend, 6.

24 MR. PICK: Or if 15 attend, it has to be at

1 least 8.

2 CHAIRMAN WAXMAN: I don't know what I would do
3 if 15 showed up.

4 MR. PICK: It would be a longer meeting.

5 MS. HANDLER: May I ask an operational
6 question? Is it the intention of every member to actually
7 designate a proxy, so that in advance these folks are
8 approved, so that if somebody did have a sudden illness or
9 a death in the family, that proxy can step in, so, you
10 know, there's essentially a plan for those unplanned
11 absences?

12 CHAIRMAN WAXMAN: I don't think that issue was
13 addressed, but it certainly has some logic behind it.

14 MS. HANDLER: Because if the proxies have to
15 be vetted in this forum, then there has to be an
16 intentional -- you know, an intention to either miss a
17 meeting or plan for it, or we should be expecting to try
18 to --

19 MR. PICK: I remember we discussed this and
20 somebody had an objection to having pre-appointed proxies.
21 I forgot exactly why. There was a rational reason, which I
22 can't recall why they didn't want that to occur, but rather
23 that the voting member needed to appoint somebody in their
24 stead for a specific meeting, rather than an ongoing proxy

1 that could step in every time.

2 CHAIRMAN WAXMAN: Does anyone remember?

3 MS. MITZEN: But then this puts a huge burden
4 on an emergency situation.

5 MS. HANDLER: If you have an emergency --

6 MS. MITZEN: How realistic is it that we'll
7 be able to do this?

8 MR. PICK: Perhaps we should --

9 CHAIRMAN WAXMAN: Frank, do you have a legal
10 opinion on whether you can create proxies for people?

11 MR. URSO: I think it's really at the
12 Subcommittee's discretion. If they want to have, like, a
13 standing order, essentially a standing proxy for them,
14 that's on record that's been approved, I think that's at
15 this Subcommittee's discretion to do that. I don't know
16 who -- I don't remember who that was, Eli.

17 MR. PICK: Somebody objected. The way this is
18 currently drafted, it's really dependent on the Chairperson
19 to accept and appoint a proxy prior to a meeting, based on
20 an oral or written request.

21 MS. HANDLER: Frank said it has to be done in
22 an open meeting forum.

23 MR. URSO: The actual appointment.

24 MR. PICK: That would occur at the meeting

1 itself.

2 MR. URSO: Somebody can, I guess, call the
3 Chair and say, "I have an emergency that came up. I have
4 someone who I want to -- an authorized proxy. I want to
5 e-mail his resume` or credentials, and can you please act
6 on it?" And then at the meeting, you can do that. I mean,
7 that's the way I foresee it occurring. That's why I put in
8 specifically here the language "written or oral," because
9 normally I would put just "written" for everything. But I
10 wanted more flexibility here, I think, because of the
11 circumstances, and I -- that's up to your discretion.

12 MR. PHILLIPPE: It just doesn't seem that hard
13 to me, really. The valid reasons include the emergencies,
14 right? So, we're going to be covering the emergencies,
15 because it's a valid, excused absence. Right? So really,
16 all we're talking about is things that are work-related or
17 vacations or things like that, right? And I don't remember
18 exactly the idea about the pre-approval, but it sort of
19 gives the impression that the Committee is twice as big,
20 because you have these standard people who are coming all
21 the time, the tag team, and that doesn't -- that seems
22 confusing to me. Doesn't it? So, I mean, I think it's
23 fine -- I don't see a problem the way it is, because, like
24 you said, we can call if something comes up a week early or

1 a couple days early. We can call and fax you somebody's
2 resume` and get it done, right?

3 CHAIRMAN WAXMAN: Yeah, I'm fine with that.

4 MR. PICK: That's the way it's handled in all
5 of the other board meetings I go to.

6 CHAIRMAN WAXMAN: So, any other corrections or
7 suggestions to the bylaw changes?

8 MR. URSO: I'll make that correction and then
9 I'll get that to everybody.

10 CHAIRMAN WAXMAN: Okay. Anything else?

11 MR. URSO: We have a new person that came in.

12 CHAIRMAN WAXMAN: Would you be kind enough to
13 introduce yourself?

14 MR. WILL: Greg Will, SEIU Healthcare.

15 MR. PICK: And Greg would qualify as a
16 regularly-attending proxy.

17 CHAIRMAN WAXMAN: If we had the bylaws in
18 place and a document.

19 Then we'll have to have our illustrious
20 conference call.

21 There are no arrangements for lunch, correct?

22 MS. CLARKE: Right.

23 CHAIRMAN WAXMAN: So we'll just have to --

24 MR. PICK: -- be done by then.

1 MS. AVERY: If you choose, you can go down to
2 The Nest on the lower level.

3 CHAIRMAN WAXMAN: Or what I heard in this ear,
4 we just need to be done. We just want to show Dale how
5 efficient we are in our meetings.

6 MR. GALASSIE: Start on time and end early.

7 CHAIRMAN WAXMAN: That's what I teach. I
8 learned that from you.

9 Legislative updates.

10 MS. KENDRICK: I spoke with the Governor's
11 office about Senate Bill 3614, the statute or the bill that
12 would give the Subcommittee authority to evaluate the
13 buying and selling of beds. It's currently not signed by
14 the Governor, and there is no real update on the status of
15 that, but he would let me know when it would move forward.

16 MR. GALASSIE: Why would that be in front of
17 the Governor now, prior to having come before the Board?

18 MS. KENDRICK: 3614? So, it passed the House
19 and the Senate, but we still need the Governor's signature
20 for it.

21 MR. GALASSIE: And clarify for me again what
22 3614 is calling for.

23 MS. KENDRICK: It allows for this Subcommittee
24 to evaluate the topic of the buying and selling of beds and

1 to make recommendations to the Board.

2 MS. AVERY: It wasn't a legislation that was
3 originated by the Board. It was legislation that was
4 originated by the long-term care community, and we came to
5 a compromise; and that was the compromise -- to look at the
6 evaluation, because the original language called for the
7 establishment of a bid exchange program, and in
8 negotiations, the Board and the long-term care communities
9 came up with that compromised language, to evaluate the
10 possibility of.

11 MR. GALASSIE: Interesting. Okay.

12 MS. MITZEN: To evaluate what? I'm missing a
13 bit here.

14 MS. KENDRICK: So, the exact language -- so
15 this is a change to the Health Facilities Planning Act, and
16 it says, "The Subcommittee shall evaluate and make
17 recommendations to the State Board" -- Dale -- "regarding
18 the buying, selling and exchange of beds between long-term
19 care facilities within a specified geographic area or drive
20 time," and the -- when this is signed by the Governor, if
21 it is signed by the Governor, it would take effect in one
22 year.

23 MR. GALASSIE: I'm obviously unclear as to --
24 the original umbrella and mission of this committee

1 interpreted that wasn't within its purview. I don't
2 necessarily know why, and I don't need to know why right
3 now. It also suggests that if the Governor doesn't sign
4 that, what's the point in talking about it? If we're
5 suggesting we need the Governor's authority -- if you need
6 the Governor's authority to make a recommendation to the
7 Board and the Governor doesn't sign it, why do you want to
8 go forward continuing to talk about it and bringing it to
9 the Board?

10 MR. PHILLIPPE: I can mention that, because we
11 talked about that in the past, and that would be, we would
12 hope that if our Subcommittee made a strong recommendation
13 to the Board and the Board was interested in that, thought
14 that was wise, then the long-term care community, along
15 with Staff or the Board, could actually sort of advocate
16 for the change. So it's a slower process, but that was the
17 idea, too.

18 MR. GALASSIE: But isn't that step precipitous
19 to this?

20 MR. PHILLIPPE: It is a great step. If it
21 happens, it would make it easier, much easier.

22 MR. GALASSIE: Thank you.

23 MR. SULLIVAN: I think, Dale, there was some
24 confusion about whether the Act allowed the establishment

1 of bed exchange. So now it's clear. It allows it, if the
2 board so desires.

3 MR. GALASSIE: It allows it if the Governor
4 signs the bill allowing the Board to consider it. Thank
5 you.

6 CHAIRMAN WAXMAN: Any other legislative
7 updates for us?

8 MS. KENDRICK: That's probably the most
9 relevant for the Subcommittee.

10 CHAIRMAN WAXMAN: Okay. That being the case,
11 we're at the point of talking about buying/selling of beds
12 and points of consideration.

13 Claire, are you leading this discussion?

14 MS. BURMAN: Unless someone else wants to.

15 CHAIRMAN WAXMAN: I think everybody in this
16 room would take you up on that offer, but I think we'll
17 start with you.

18 MS. BURMAN: All right. At the last meeting
19 that this Subcommittee held, it was decided that we needed
20 to put together points of consideration, so that we could
21 think about all of the different elements that would go
22 into this kind of activity. This would be a brand new kind
23 of activity in Illinois. Of the 30-odd states that have
24 Certificate of Need, there are about 6, maybe 6 and a half,

1 that allow some form of the sale of beds. Michigan allows
2 the relocation. They have a very interesting set of rules
3 for that. But they do not allow the sale. They consider
4 the sale of those beds to be illegal.

5 MR. GALASSIE: But they can transfer?

6 MS. BURMAN: They can transfer to help with
7 the redistribution for the beds where they're needed, but
8 they don't go for the sale part of it.

9 By contrast, if you look at Washington state,
10 this went to some level of court in the state, and it was
11 decided that the operating rights belonged to the owners of
12 the long-term care facilities. So, you have those two very
13 different points of view on it, and then everybody else who
14 has this activity is somewhere in between. They allow the
15 sale, but they have different sets of rules for it.

16 So, what I tried to do is I picked up from the
17 transcripts of our meetings and the discussions what the
18 purposes would be if we were to consider this activity here
19 in Illinois, and these would be the ones that I did pick up
20 on. There could be something else.

21 It would allow the redistribution of excess
22 beds to areas with bed need.

23 It would encourage downsizing, maybe.

24 Provides for expansion of individual

1 facilities without increasing beds in the system. And
2 that's a problem that is rampant throughout all the states.
3 Every state I've talked to about it, they have the same
4 problems with the number of beds.

5 And then the last one -- the second to the
6 last -- sorry -- is it will provide access to capital to
7 modernize the older facilities, which would help with that.

8 MR. GALASSIE: By selling the beds?

9 MS. BURMAN: By selling the beds. If you're a
10 seller, you can use the money to help upgrade whatever
11 needs upgrading, and then it would bring your occupancy
12 down and should help reduce your operating costs as well.

13 The fifth purpose would be that it would be
14 helpful in reducing debt. And it was decided that only a
15 portion of the funds received could be used for that
16 purpose, if we were to go forward with this. This is
17 something that we discussed with the two Chairs.

18 Then the other part that is very significant
19 to put into this arena here is the parameters that are
20 within our set system for Certificate of Need, and those
21 would be that it would have to somehow comply with the Bed
22 Need Determination that we have in place. That's
23 important.

24 It would have to be reviewed under the CON

1 auspices. There have to be specific rules for that, to
2 determine if it's compliant with the goals and purposes of
3 the Board.

4 MR. GALASSIE: Can I interrupt you? I
5 apologize. Was it Michigan, Claire, where you said they
6 have a transference of beds, no dollars are exchanged, I
7 assume no tax implications?

8 MS. BURMAN: That's correct.

9 MR. GALASSIE: Is that transfer process in
10 Michigan subject to CON, or exempt?

11 MS. BURMAN: Yes, it is subject. And they
12 have -- I'll send you a copy of the rules, if you wish.

13 MR. GALASSIE: Yes, please do.

14 MS. BURMAN: It's not a big document, so you
15 can scan that and see what you think.

16 Now, if you look at the Act under Section 2,
17 which states the purposes of the Act, it requires the
18 following things: A person establishing, constructing or
19 modifying a healthcare facility, as defined in the Act --
20 and that would include long-term care facilities -- would
21 have to have the qualifications, background, character, and
22 financial resources to adequately provide the proper
23 service for the community, and this ties into the rule we
24 already have in place, which is what we call "Background of

1 the Applicant," plus the rules under the Financial and
2 Economic Feasibility Review. There would be some form of
3 rules to follow suit with that.

4 The second part would be: Projects that
5 promote, through the process of comprehensive healthcare
6 planning, the orderly and economic development of
7 healthcare facilities in the state of Illinois. So that,
8 again, would be a reason to go through a formal process
9 that avoids unnecessary duplication of such services. That
10 would go back to, you know, are these beds going where
11 they're really needed? There would need to be a
12 justification why the facility that is purchasing the beds
13 needs those beds. It wouldn't be the same need calculation
14 necessarily that we have for the normal process, but that's
15 all conjecture.

16 And then the third point would be: Projects
17 that promote planning for and development of healthcare
18 facilities needed for comprehensive healthcare, especially
19 in areas where the health planning process has identified
20 unmet needs. So that again goes back to the bed need
21 determination. We've already looked at that and have that
22 calculated. And then we do also have an Occupancy Standard
23 for long-term care beds and other healthcare activities as
24 well.

1 So, those are the tie-ins. That's the
2 umbrella under which any rules that may be developed would
3 have to fit under.

4 So then going a little bit further, if you
5 talk about the distance, that's this big -- a big part of
6 this. How far away should one be from another, buyer from
7 the seller? And those are things that would have to be
8 decided.

9 There was a very, very good suggestion that
10 the beds can be sold only from existing skilled nursing
11 facilities with an excess of beds to an existing skilled
12 nursing facilities with need of long-term care beds,
13 according to the Bed Need Determination, and that could be
14 statewide or within the same Planning Area or within
15 specified travel time. That can be defined.

16 Another very good suggestion was that if we
17 were to decide to go ahead with this activity in Illinois,
18 it might be a smart idea to start it as a pilot program in
19 a smaller defined area, either a single Planning Area or
20 maybe a group of Planning Areas that have a denser
21 population. So that was a suggestion, too.

22 Then getting to the requirements for the
23 seller and the buyer: For the seller, beds would be sold
24 only from existing facilities with an excess of beds as

1 recognized by our bed inventory. The seller can only sell
2 the number of beds in excess of the Board's 90 percent
3 occupancy standard, or the number necessary to reduce the
4 facility's occupancy to the Board's 90 percent occupancy
5 standard. The seller must provide a detailed explanation
6 of how the money obtained from the sale of the excess beds
7 will be used to improve the seller's facility, and up to
8 two years after the sale of the beds, the seller would
9 submit documentation to verify that the money was used for
10 those stated purposes. And that ties back to the large
11 statement that this is one of the purposes. It's important
12 to tie it back.

13 The seller cannot sell any occupied bed,
14 because I think there's some confusion in maybe some other
15 states. Because of the way the rules are written, that
16 happens. Only the sale of historically-documented,
17 unoccupied, excess beds is allowed, and it was suggested
18 that we use a three-year time frame for going back
19 historically.

20 And then we should also consider the status of
21 the licensed beds. It would go back to the background of
22 the applicant, that kind of thing.

23 And then the other point is that the license
24 in place at the seller's facility does not travel. Once

1 the beds are sold, then the buyer would have to probably --
2 the buyer would have to go ahead and get a license for
3 those beds. But we have not had any input yet from
4 Licensure. We're not sure where all of that plays out and
5 how that would work, if they would accept this as an idea.

6 Now, for the buyer, the beds can be sold only
7 from an existing facility with an excess of long-term care
8 beds as recognized by the inventory.

9 The buyer can purchase only the number of beds
10 needed to accommodate the number of persons on a documented
11 wait list or a service request or inquiry list. We have to
12 have some kind of reason for why the beds are necessary,
13 because that, of course, goes back to the original question
14 of what do we do with all of these excess beds?

15 The buyer can purchase the number of beds
16 estimated by documented historical trends at the buyer's
17 facility. I think that's a long-time honored way of doing
18 that.

19 Beds cannot be used to establish a new
20 service. For instance, if you're a facility that has
21 assisted living, you can't buy these beds and think you're
22 going to have skilled care. You can't be using this bed to
23 open a new facility. That's not the purpose, and you don't
24 want to be expanding a skilled nursing facility beyond the

1 90 percent Occupancy Standard.

2 Then the buyer must document that specified
3 funds are available and committed for operation, and this
4 would include money for staffing and housekeeping and food
5 services and to build space, if that's necessary, and this
6 would be as required by IDPH and an accreditation agency.
7 Those are other considerations.

8 Another point would be, the applicant would
9 document the impact of the project costs and charges on
10 both a per diem and an aggregate basis. This documentation
11 would include portrayal of all costs, including any costs
12 for acquiring of beds, and of how the cost will be
13 recovered and a demonstration the costs are reasonable when
14 compared to the benefits of the relocation.

15 These are, again, suggestions and ideas. Some
16 are borrowed from other states and how they put it
17 together.

18 Now, there are requirements that apply to both
19 the seller and the buyer. One would be, both the seller
20 and the buyer must comply with all of the Background of
21 Applicant requirements, all of them. This is really a
22 privilege. This is not a normal kind of process.

23 And then the price per bed would have to be
24 determined, as well as perhaps a cap on the total amount.

1 These are reasonable things to discuss and decide.

2 Regarding the review process, which would be
3 the next point to consider, it could be a substantive
4 review, with a 120-day review. It could be an expedited
5 review or 60 days. And those are really the only two
6 choices. I'm not sure there is another one that would
7 work.

8 Then there's the question of a moratorium.
9 Some states have a moratorium. They actually -- some of
10 them had that before they even thought of the sale of beds.
11 Some have a partial moratorium with certain conditions in
12 play, and then there is, of course, others, like us, that
13 currently do not have a moratorium in place.

14 Then there is the question, what happens if no
15 beds are available to purchase? Well, you apply for a CON
16 permit, if you can get one, to expand your facility.
17 Another option is -- and this is in the Act -- to add 20
18 beds or 10 percent, whichever is less, every two years.
19 That's statutory, and all that has to be done is the Board
20 gets a notice when that happens. Others would be unknown.
21 Those are the only two that I could think of within the
22 time frame.

23 Then returning back to Licensure and how they
24 fit in, in most states that have this in place, the beds

1 lose their license when they're sold, and they get
2 relicensed, and that's really what we have right now, and
3 we're hoping for some helpful input on that.

4 And another under miscellaneous, it was
5 suggested that perhaps a certain portion of beds that are
6 purchased would need to be Medicaid certified, because that
7 is a big issue, of course, in all the states, very much so
8 in Illinois. So, we'd have to have something in place that
9 would take care of that population.

10 Another point of -- under miscellaneous
11 options is related to access, and that would be the
12 relocation of the existing or approved beds will not impair
13 the access of the population served or proposed to be
14 served by the existing facility or the existing or approved
15 beds to quality long-term care, particularly in the case of
16 medically-underserved populations, including those that are
17 geographically underserved and those, of course, that -- to
18 repeat -- are on Medicaid. So, those are two important
19 considerations as well.

20 So, this is a very big topic. There's a lot
21 of detail attached to it and would have to be worked out.

22 CHAIRMAN WAXMAN: I'm going to give you the
23 big picture. As we sit here, there is over-bed count,
24 over-bedded in Illinois. That's fact number one. However,

1 if you are a person in a certain geographical area looking
2 for a nursing home bed and a bed doesn't exist, you could
3 care less that there is an over-bedded situation. So, what
4 we're trying to deal with is a bed formula that goes back
5 many, many, many years. It may not be logical anymore. It
6 doesn't encompass the fact that when the bed formula was
7 created, there weren't things like assisted living and
8 there weren't as many options in the community as exist
9 today. So, those primarily impact the conditions.

10 More importantly, members of this committee
11 truly believe that the nursing home of today, going into
12 tomorrow, is going to be much different than the ones that
13 existed five years ago and that they will have specialized
14 units and unique programming and almost look hospital-like,
15 and there are some nursing homes in the marketplace today
16 that have those environments, but they're few and far
17 between. And community activists will tell you that one of
18 the issues they deal with all the time is that there aren't
19 enough Medicaid beds, and, you know, again, from an owner's
20 perspective, when Medicare pays \$400 a day and the State of
21 Illinois pays \$150 a day --

22 MR. SULLIVAN: 130.

23 MR. PHILLIPPE: If you're in Chicago.

24 CHAIRMAN WAXMAN: \$130 a day, you can kind of

1 understand why management owners will say, "I don't want
2 any more Medicaid beds in my facility," or, you know, they
3 push for Managed Care and HMO contracts. On the surface,
4 it seems like why are we discussing the issue? But when
5 you get into the details of what people deal with on a
6 day-to-day basis, you begin to realize that there is a need
7 to make beds available. One way, of course, is the process
8 that comes before your group (indicating) to build,
9 construct a new home, but then you have to demonstrate the
10 need for an entire new facility. There is the rule that
11 allows you to add 10 percent or 20 beds, whichever is
12 lesser, over a two-year period, and many homes have availed
13 themselves of that option. It's been around forever. It's
14 a letter-writing process, but then you're still left with,
15 you know, the whole issue of "I want to create a new
16 program. I have a waiting list and, yes, I have a
17 competitor a block away from me who is noted as a bad
18 provider and people don't want to go there." I mean, the
19 marketplace still allows you to choose where you want to
20 go. So, the fact that there are empty beds in your
21 geographical area but they're not exactly favorable or, you
22 know, if we go back to some of the newspaper articles and
23 some of the facts that some homes have allowed mixed
24 populations to occur and may be dangerous.

1 You know, so, there is this very valid reason
2 to talk about the solution of allowing buying and selling
3 of beds. I think what is critical -- one of the critical
4 points that Claire alluded to is the use, from a buyer's --
5 from a seller's perspective, the money cannot go into the
6 pocket of the sellers. It can't be a way for them to
7 profit from it. They have to either reduce their mortgage,
8 which would then improve their operating efficiency, reduce
9 their expenses, and/or improve their facility, so the
10 remaining beds are much more market favorable, if you will.

11 So, I think that's kind of what's driven us to
12 the point where we are now, where we believe that the
13 committee has much discussion, that there is an
14 agreement -- and we'll kind of look for it today -- to move
15 forward with bringing to your (indicating) group then some
16 ideas and some proposed rule changes or set of rules that
17 will allow us to look at buying and selling beds.

18 So, floor is open, if anybody wishes to jump
19 in and share their opinion.

20 MS. BURMAN: Before we get too far into the
21 discussion, there's another document that everyone was
22 sent, and this was a memo that Tim Phillippe had prepared
23 originally for the Work Group that we were both involved
24 in. We really didn't have time to go through it with the

1 Work Group even, because at that point, it was decided that
2 this was really a very huge consideration and it should
3 come back to the Subcommittee. So, I think perhaps we
4 might want Tim to go through this memo, because these are
5 things that he remembered as being involved in all the
6 discussions early on. I don't know for how many years, but
7 these are points that he thought were important to discuss.

8 MR. PHILLIPPE: I think you actually covered
9 most of them. I don't agree with everything you proposed.
10 Everybody has something we can propose a tweak to, but I
11 think you did a good job of really putting it all together.
12 That was very useful.

13 The -- probably the things I would point out
14 that maybe are some of the things you have in there. The
15 things I had that were different, maybe, is, just what do
16 we do with innovation? I've been mentioning that, and it
17 does, I guess, fit into the whole idea. Do we still use
18 the bed-need formula, or how do we allow for innovative
19 programs, even if there is not a bed need in the community,
20 like you mentioned, but there is a need for innovation in
21 the community?

22 And then I would want to point out, Illinois
23 is unique, and we are unique, and it's partly the rate
24 issue. The disparity between Medicare and even private

1 pay, I guess, and Medicaid is so skewed, it skews all of
2 our decisions in this market. For example, I have -- and
3 others know this. I have a campus, a place in a small town
4 in southern Indiana that would not be unlike places in
5 Illinois, and I can operate that building with Medicaid
6 residents and be considered a good -- great provider in the
7 community, really, with high five-star ratings, high
8 surveys. The reputation is good, and it's because the rate
9 is about 40 percent higher than I'm going to get in the
10 same community in Illinois. So, that does skew our
11 decisions here, because even though we try to build in the
12 Medicaid access, one of the issues in Illinois is that
13 having a certified Medicaid bed does not mean anybody ever
14 gets into that bed in the state of Illinois. Right?

15 MR. SCAVOTTO: That's right.

16 MR. PHILLIPPE: Providers know we can pick and
17 choose who we take, and I know providers who have a
18 strategy of "We only have this many Medicaid people in our
19 building," and even if that census is 60, 70 percent, they
20 hold to that rule, and they just leave those beds unfilled.
21 So, just saying we are going to have more certified beds
22 doesn't really improve access. It's better than not having
23 the bed available at all.

24 MR. SCAVOTTO: Just to clarify, Tim.

1 MR. PHILLIPPE: Is that right?

2 MR. SCAVOTTO: It is right, but just to
3 clarify, you could have been 75 percent occupied but 100
4 percent of your Medicaid beds would be full with private
5 pay, for example.

6 MR. PHILLIPPE: Right. Or you could be 70
7 percent full, have a 100-bed facility, and you have 30 beds
8 that are empty right now. They're certified for Medicaid,
9 and you just don't choose to take anybody for those beds,
10 and people do that every day.

11 MR. PICK: Let me challenge that.

12 MR. PHILLIPPE: I know people who do that.

13 MR. PICK: Practice and the rule. So,
14 enforcement may be the issue. If there is an available
15 Medicaid certified bed in the building and a resident
16 presents themselves as wanting services in that bed, the
17 operator is legally obligated to provide services to that
18 resident in that bed. If that bed is already occupied by a
19 Medicaid resident -- not a private, by a Medicaid
20 resident -- then they can say, "My Medicaid beds are full;
21 I have no Medicaid beds available." If there are Medicaid
22 beds available, they're obligated to provide services.

23 MR. PHILLIPPE: Practically speaking, they do
24 not. You're right.

1 MR. PICK: Again, enforcement may be the
2 issue. They may tell the resident, "I have no beds
3 available," and the resident or family or advocate does not
4 investigate further or merely accepts on the surface that
5 that's true and chooses to go somewhere else. That may be
6 practically what happens. But I think it's important to
7 differentiate what is the obligation versus the practice.

8 MR. PHILLIPPE: That's fair.

9 MS. CREDILLE: Illinois also has Distinct
10 Part, which is different than other states.

11 MR. PICK: And that's fine. That is the law.

12 MS. CREDILLE: Right, but instead of
13 certifying a whole facility, you can certify 20 beds and
14 then that --

15 MR. PICK: That's okay.

16 MS. CREDILLE: That to the public looks like
17 I'm not allowing Medicaid patients, when you only have 20
18 out of your 100, and that's the law in Illinois.

19 MR. PHILLIPPE: True.

20 MR. PICK: And that's okay. But the important
21 distinction I wanted to make --

22 MR. PHILLIPPE: That's a fair distinction.
23 That's accurate.

24 MR. PICK: If there is an available bed and

1 you say, "I don't have a bed available," then you're
2 breaking the law. Nobody may challenge it, but you're
3 breaking the law.

4 MR. PHILLIPPE: Personally, I just think it's
5 inefficient.

6 MR. GALASSIE: But there isn't a Hill-Burton
7 that makes you post your occupancy?

8 MR. PICK: Not anymore.

9 MR. SULLIVAN: Two procedural comments.
10 First, the one that is obvious, that Claire, as always, has
11 done an outstanding job. Her research of other states was
12 one of the more impressive pieces of research and
13 scholarship I've seen in a while. And you have synthesized
14 all of that rather well in key points.

15 But then, Michael, my second suggestion is
16 that you take control of this discussion and that we go
17 almost line by line, because I think if you open it up too
18 much, we'll be all over the place, because I think a lot of
19 people have comments. I almost think the Committee needs
20 to see things line by line and come to an agreement.

21 CHAIRMAN WAXMAN: I appreciate that comment,
22 Terry.

23 MR. PHILLIPPE: Can I just make one overall?
24 As a practical issue on the Medicaid side, because of the

1 rate disparity, it is different in Illinois. Financially,
2 really, nobody can afford to pay -- well, I would say I
3 couldn't. People I know couldn't. Maybe some people
4 could. But practically speaking, in Illinois you cannot
5 afford to buy beds, build the building, and operate it and
6 give a -- and show a budget that would not lose money
7 through mostly Medicaid. Right?

8 MR. SCAVOTTO: I agree. Some can do it, but
9 most can't.

10 MR. SULLIVAN: I'm not sure I agree with that.

11 MR. PHILLIPPE: So, we're primarily -- if
12 we're talking about expansion here, we're primarily talking
13 expansion for Medicare or private pay, correct?

14 CHAIRMAN WAXMAN: Charles, do you wish to
15 address that issue, since you do an awful lot of
16 applications?

17 MR. FOLEY: Well, this board -- Planning Board
18 just recently approved a project that encourages all
19 Medicaid, and that's building a new facility. But, I
20 guess, the real question is going to be, to align with what
21 you're trying to say, Tim, is that reality will face that
22 facility one of these days as to whether or not he can
23 afford to build it in the first place. The projection
24 shows, with the Medicaid rate as it is today, that they

1 could survive, but what you have to look at, I think, is
2 important in this facility is the kind of facility that
3 they built and that they did, in fact, build a Medicaid
4 facility, all double rooms. Even the Planning Act says
5 that you should provide more private rooms than you're
6 currently providing, if it's an existing facility. This
7 facility did not even do that. So, it is building, in
8 essence, a 1960 nursing home. So one is going to have to
9 question whether or not they can even build that tomorrow,
10 or keep it built tomorrow, because the competition out
11 there, obviously, is going to come in with more private
12 rooms. That's what the people want. They want more
13 private rooms.

14 CHAIRMAN WAXMAN: Where is the building?
15 Geographically, where is this proposed building?

16 MR. FOLEY: Pontiac, Illinois.

17 CHAIRMAN WAXMAN: Any other overall comments?
18 And then I do accept Terry's suggestion.

19 MR. PICK: I would just make one comment. I
20 think from a planning standpoint, as a policy body -- not
21 to dispute what you're saying, Tim. I think we responsibly
22 have to incorporate Medicaid beds as part of the
23 initiative, and I think the notion of having a pilot is for
24 that exact purpose, is to see how it would work and learn

1 from, you know, doing it in a smaller, defined area, rather
2 than, you know, just going statewide with this kind of a
3 concept. But I think for us not to include Medicaid beds
4 as part of this initiative, as a new approach to looking
5 for ways to reclaim some efficiencies in our bed
6 availability, is just not appropriate.

7 MR. PHILLIPPE: I agree, actually. I don't
8 disagree. I'm not one -- I am actually one that thinks
9 that the bed -- the facility operates best when it's
10 efficient, and so -- even with Medicaid people, and it's a
11 good service to provide. More than half of our people are
12 funded through Medicaid. So I agree with that.

13 CHAIRMAN WAXMAN: Mike, do you want to talk
14 about anything in terms of the bed need, bed formula,
15 before we go through this document?

16 MR. CONSTANTINO: No. It's the same formula,
17 like you said, the same formula we've been using for years.
18 I do think it takes into consideration other services by
19 the utilization that we collect every year. If that
20 utilization decreases, those residents have gone somewhere
21 else, either assisted living, supported living, or
22 something like that. I do think that formula takes that
23 into consideration.

24 CHAIRMAN WAXMAN: Okay. Charles, you had

1 something else?

2 MR. FOLEY: No. I agree with Mike a hundred
3 percent. The bed need methodology was not meant to be a
4 perfect tool. It was just meant to be an indicator, based
5 on population projection and utilization, whether or not
6 there is a bed need. I agree with Mike that it does, in
7 fact, take into account that patients are going somewhere;
8 i.e., supported living or assisted living.

9 MR. SULLIVAN: Or in the community.

10 MR. FOLEY: Or in the community itself.

11 MR. CONSTANTINO: Home health.

12 MR. PHILLIPPE: Can I -- I guess I was trying
13 to get to a policy issue -- very poorly -- and Eli helped,
14 actually, with it in that because Illinois is different,
15 what could happen in Illinois is that the operations that
16 are the most financially viable and can afford to provide
17 better services, like the private rooms, maybe are the
18 operations that would tend, all things being equal, to have
19 more people in their facility who are funded through
20 Medicare or private pay. And so if we make changes that
21 actually allow fewer buildings to actually have more of
22 that part of the population being served and reduce that
23 funding in most of the buildings, so that more of the
24 people with money, who are funded better, go into a smaller

1 group of buildings, and the rest of the State has less
2 funding, what it causes is poor services. It's an access
3 issue for the Medicaid person, and that's what I'm
4 concerned about in Illinois. I don't have an answer. I am
5 concerned that we make changes carefully, because we don't
6 really want to have a two-tiered system, where 30 percent
7 of the people are in nice buildings with good programs,
8 private beds, private rooms, all of that stuff, and then
9 you have a large number actually funded through Medicaid
10 that are in very old buildings that don't have the
11 resources to provide good care. I think we all agree with
12 that.

13 MR. SCAVOTTO: I have a comment. I'm kind of
14 agnostic on this whole issue, and I don't care if you buy
15 beds or not, and to me, I don't think it's going to make a
16 lot of difference. We're not going to get away from
17 Medicaid. We're not going to get away from the rate issue,
18 but I do think in the next couple years we're not going to
19 recognize what happened with Medicaid. HFS is rolling out
20 the Managed Medicaid project very quickly, and it's very
21 possible that within three years, we're going to see
22 intermediate care disappear from our facilities. They're
23 going to get pushed downstream. I don't think we know. As
24 a policy standpoint I don't think we know what's going to

1 be out there, and that's one of the things that puts me on
2 the occupancy side rather than the bed need, the bed-need
3 formula, and I think it's all going to be driven by
4 occupancy, and the rate is going to -- the rate will take
5 care of itself as an issue. It may still not be enough.
6 The people in the metropolitan areas will get paid from a
7 plan rather than the State. People downstate in the small
8 areas will probably get paid from HFS.

9 So, we don't know how this is going to roll
10 out, and I think this is going to change our entire
11 approach to this policy. I agree with you, Tim, that this
12 is a big policy overview that we ought to have when we
13 bring it to the table, but I think fundamentally, it's
14 going to be influenced by HFS, and, try as we might here to
15 be responsible with this, the health plan is going to
16 dictate the day.

17 Back to you.

18 CHAIRMAN WAXMAN: Thank you, Mike.

19 Okay. I guess maybe at this point, I want to
20 make sure that there is a consensus among this group that
21 everyone -- or the consensus is that we do want to look at
22 the whole concept of buying and selling beds, as a group.
23 Is there anyone who is not in that ballpark?

24 (Pause)

1 CHAIRMAN WAXMAN: Hearing that -- then we
2 can't make a motion as a group to do that, so we'll have to
3 abide by the fact that it's in our transcripts that the
4 group has initiated a consensus of the group to move
5 forward with the discussion of buying and selling beds.

6 Frank, good?

7 MR. URSO: Um-hum.

8 CHAIRMAN WAXMAN: Thank you.

9 I do appreciate Terry's suggestion that, as a
10 means of organizing the discussion, we take the points as
11 Claire has pointed out. I'm not sure we can do all four
12 pages today, but we have a program and a methodology.

13 Thank you, Claire, once again. Incredible
14 amount of time is spent on doing a good job.

15 So, if we take these in the order that Claire
16 has put them in front of us -- "Distance". And she has
17 designated that they can be bought and sold statewide
18 within the same Planning Area or within specified travel
19 distance.

20 For those of you like me, who don't remember
21 things like this -- Michael, how many Planning Areas are
22 there in the state of Illinois?

23 MR. CONSTANTINO: I had told you 102 last
24 week. It's 95. I apologize. 11 Service Areas, 95

1 Planning Areas.

2 MR. SULLIVAN: Mr. Chairman, I'm back on page
3 1, "Purposes", A, and we have parameters, all of which are
4 relevant discussion.

5 CHAIRMAN WAXMAN: You're not accepting those?

6 MR. SULLIVAN: I do have several questions.

7 CHAIRMAN WAXMAN: I thought you were giving us
8 that.

9 MR. SULLIVAN: And I guess this is more of a
10 question. "Allows redistribution of excess beds to areas
11 with bed need," and it is throughout this document. I
12 guess I see this whole issue similar to replacement
13 facilities, that if I have an old facility and I'm going to
14 build a new facility down the block, it's a transfer type
15 of approach. I see -- and, in fact, several states treat
16 it exactly that way. It's replacement facilities, or
17 buying and selling of beds. What if I'm in an overbedded
18 area and I have a waiting list? I want to expand, there --
19 it's what we talked about, the facility down the street
20 that has the empty beds. Are we saying that within an
21 overbedded area, you can't transfer the beds from one place
22 to another?

23 CHAIRMAN WAXMAN: Can?

24 MR. SULLIVAN: Can't. When it says you have

1 to go to an area with bed need, there's only a few areas in
2 the state with a bed need, which kind of just shuts down
3 this program. I got to think that we can move beds around
4 without increasing beds, but I don't think we should shut
5 down the over-bedded areas as --

6 CHAIRMAN WAXMAN: I totally agree with you,
7 because I agree that beds should be able to be moved where
8 there is a need that is not currently being met, example
9 being that a neighborhood may be over-bedded, but they're
10 the kind of homes where the market is choosing not to use
11 them, for a variety of reasons, or there is a need for a
12 specialized program. I believe that's what you're going
13 for. I agree with you, and I think we should be able to do
14 that.

15 MR. SCAVOTTO: Isn't that what this says?

16 CHAIRMAN WAXMAN: I guess I assume that, but
17 maybe the language needs to be cleaned up, but I'm not a
18 language person. That's Claire's fault. I'm kidding.

19 MR. FOLEY: I agree with Terry. I think what
20 we're doing is penalizing a lot of good providers who are
21 out there who are full, maintain a 90 percent occupancy
22 rate in an area where there are excess beds, and cannot
23 expand. That person is being penalized. So, I think we
24 really need to take a look at that. Look at a Planning

1 Area. Give you an example. Let me think of one. 6A. 6A
2 is grossly over-bedded --

3 CHAIRMAN WAXMAN: Charles, none of us know
4 where 6A is.

5 MR. PHILLIPPE: Rogers Park.

6 MR. FOLEY: North side of Chicago. It's got
7 1900 excess beds in probably the oldest facilities in the
8 state of Illinois, dilapidated -- I'm sure there are
9 facilities that provide excellent, quality care, but some
10 of the facilities are --

11 MR. SULLIVAN: Older.

12 MR. FOLEY: So, we have to allow for them to
13 be able to replace beds, if needed, in an area where there
14 is excess beds.

15 CHAIRMAN WAXMAN: If they're as bad as you're
16 saying, we have an enforcement issue, as Eli alluded to
17 earlier. I believed that what we just talked about was
18 really incorporated in this process, that even though it
19 could be over-bedded, that there was going to be a method
20 to add beds where there was a waiting list or program
21 needed. So, if you think the language needs to be changed,
22 then --

23 MS. BURMAN: If you look further into the
24 points, it's really from a facility with too many beds to a

1 facility that needs beds, and the distance is something
2 that has to be decided.

3 MR. PICK: Can you edify me, for an existing
4 facility that wants to build a replacement facility? I'm
5 not familiar with what the current Board rules are. If the
6 building is less than 90 percent occupied, does the
7 replacement facility number change as a result of the fact
8 that the facility is not meeting the 90 percent threshold?

9 MR. CONSTANTINO: No. The Board recently
10 approved one in Pontiac, essentially a replacement facility
11 there, and their occupancy level was in the mid 50's. In
12 that instance, the facility was in very poor shape, and the
13 Board approved that project.

14 MR. PICK: So, I'm not understanding the issue
15 on replacement facilities then, Terry. I'm losing it.

16 MR. SULLIVAN: My concern was, in an
17 overbedded area, you would be prohibited from exchanging
18 beds, with this wording. Like for "A," I would probably
19 say, "Allows redistribution of unused beds without
20 increasing beds in the system," would probably be our --
21 the purpose of that, rather than get into excess beds in
22 areas with bed need.

23 MR. PHILLIPPE: I think we're all saying the
24 same thing here, to save a lot of time, right? Because I

1 think that's what Claire meant. I think what we're doing
2 is confusing the bed-need formula with a perceived need of
3 a bed in a facility somewhere. Right?

4 MR. PICK: No, no, no, no, because when Claire
5 went through the document, you're not eligible for
6 additional beds unless you meet the 90 percent threshold,
7 and that's what you're getting to. You may have a building
8 that's below the 90 percent threshold that wants to buy
9 more beds. They wouldn't be eligible, based on the way
10 this is currently crafted, and both you and Chuck are
11 saying that's an issue?

12 MR. SULLIVAN: My issue was, I know some
13 states say you can only exchange beds from -- according to
14 the bed-need formula, from an over-bedded area to an
15 under-bedded area, and I think we don't want to go there.

16 CHAIRMAN WAXMAN: Correct.

17 MR. PICK: Right, and I don't think that's
18 where we're headed, but what I'm hearing is something
19 different. If there is a facility that is less than 90
20 percent occupied but they want to add beds because they
21 want to introduce some kind of specialty program, this
22 current form precludes them from being able to do that.

23 MR. SULLIVAN: Let's talk about it when we get
24 there.

1 MR. PHILLIPPE: True. That's what I thought.

2 MR. PICK: Okay.

3 MR. FOLEY: So, are we going to change A then?

4 MR. PICK: We're not in a position to
5 really -- we haven't adopted this, nor can we adopt
6 changes. I think this is just discussion for us to take
7 into consideration when we have a voting body. So, it's
8 all comments.

9 MR. GALASSIE: But you seem to have a
10 consensus on that issue here now. So, you'd want to reword
11 this based on that consensus put forth.

12 CHAIRMAN WAXMAN: I think Claire's point is,
13 if you read the details, the details cover your concern.

14 MS. CREDILLE: I respectfully disagree. I'm
15 where Terry is. I think that it needs to be very clear in
16 the purpose, and exactly what you said, which I have to go
17 back to your transcription of what needs to be said here.
18 Or we're going to get stuck in the same place.

19 MS. HANDLER: I think when people hear the
20 word "area," they're thinking specifically a Planning Area,
21 right? They're translating that word into a defined
22 language in legislation or regulation. So maybe that's
23 where we open it up a little bit and maybe not use those
24 same words interchangeably.

1 CHAIRMAN WAXMAN: Okay. Claire, will you --

2 MS. BURMAN: Just change "areas" to
3 "facilities".

4 MR. PICK: That works.

5 CHAIRMAN WAXMAN: All right. So now, going
6 back to -- are you okay with B? Everyone okay with B?

7 (Pause)

8 CHAIRMAN WAXMAN: Everyone okay with Section
9 C?

10 (Pause)

11 CHAIRMAN WAXMAN: All right. I think we
12 should adjourn, since we're on a roll here. "Distance".
13 Okay. So, now what we have indicated --

14 MR. SULLIVAN: "Parameters" and "D".

15 CHAIRMAN WAXMAN: We're changing "A". We
16 agree on "B". We agree on "C". What am I missing?

17 MR. SULLIVAN: "D" and "E".

18 CHAIRMAN WAXMAN: I don't have a "D" and "E".

19 MR. URSO: What's the date on your document?

20 CHAIRMAN WAXMAN: I'm using the one from our
21 telephone discussion. I gave Dale the other one.

22 MR. URSO: What's the date on it? It's
23 written diagonally on it.

24 MR. PICK: 8/7. This is 8/8.

1 CHAIRMAN WAXMAN: I gave Mr. Galassie my copy
2 of 8/8.

3 (Pause)

4 CHAIRMAN WAXMAN: All right. What is it on
5 "D" and "E" that anyone wants to speak to?

6 MS. HANDLER: Maybe just to address Tim's
7 point about there's nothing that talks about innovation.
8 Maybe we should add something under "Purpose" that would,
9 you know, promote innovation or some kind of a --

10 MR. PHILLIPPE: I agree with that.

11 MR. SULLIVAN: Downsizing, modernization, and
12 innovation.

13 MS. CREDILLE: That's right in our bylaws,
14 that this is the whole purpose of the Committee.

15 CHAIRMAN WAXMAN: Our bylaws that haven't been
16 approved, those bylaws?

17 MS. CREDILLE: The one section we didn't
18 touch.

19 MR. PICK: So, do we have consensus then that
20 we expand it to include modernization and expansion?

21 CHAIRMAN WAXMAN: Okay. How about "HFSRB
22 Parameters"? Any issues there?

23 MR. SULLIVAN: "A," and, again, this is
24 possibly my misunderstanding. Must comply with the most

1 recent bed need determination for long-term care as stated
2 in the only bed inventory? What does that mean?

3 CHAIRMAN WAXMAN: Claire?

4 MS. BURMAN: There's a bed inventory. You're
5 familiar with that?

6 MR. SULLIVAN: Yes. What are we saying here?

7 MS. BURMAN: It's updated, I believe, monthly.

8 MR. PICK: I think the question is, what do
9 you mean by "bed need determination"?

10 MR. SULLIVAN: Right now, without the buying
11 and selling of beds, if I'm in an overbedded area, I can't
12 go to the Board and say, "I want 40 new beds," because I'm
13 in an overbedded area. With the buying and exchanging, if
14 I'm in an overbedded area and I buy 40 beds from somebody
15 who is not using their beds, I can expand. Except this
16 says you must comply with the bed-need formula.

17 MS. BURMAN: Understand what the parameters
18 are. These are things that are in place. We're not
19 changing any of those.

20 MR. SULLIVAN: Right, and we're not increasing
21 the beds in the area.

22 MS. BURMAN: We're not changing any of those.
23 Now, the part you're getting at -- this is the old. Is it
24 facility to facility or is it Planning Area to Planning

1 Area or what? That has all got to be hashed out, but what
2 we have in place is what's under "Parameters".

3 MR. SULLIVAN: Okay. And I read this that, as
4 with the current rule, you couldn't expand in an overbedded
5 area by buying beds, and I just want the make sure that
6 that's --

7 MS. BURMAN: These are all points to consider
8 and discuss. This is not the rules as we go forth.

9 CHAIRMAN WAXMAN: I think there is agreement,
10 Terry, that we can expand in an overbedded area, but for
11 the right reasons.

12 MS. MITZEN: But an overbedded area -- at
13 least maybe I'm looking at it in a very elementary way, but
14 if Nursing Home X in Rogers Park decides to sell 20 beds to
15 Nursing Home Y in Rogers Park because Y wants to bring in a
16 new program or a new -- doesn't it reduce the amount of
17 beds by 20 from one facility?

18 MR. SCAVOTTO: No, it stays the same.

19 MS. MITZEN: So, it stays the same. So, we're
20 not increasing the number of beds, we're just
21 redistributing the beds in that area so they can serve a
22 better --

23 MR. SCAVOTTO: You're right.

24 MR. SULLIVAN: Right. That's the purpose. If

1 you're saying "A" doesn't mean you have to meet the
2 bed-need formula, then I'm content.

3 MR. PHILLIPPE: I want to make sure that we
4 don't put Claire on the spot. Okay? Because she was asked
5 to try to take the discussion and the input from the Work
6 Group and what she has heard and try to illuminate the
7 issue and make proposals. I don't think this is Claire's
8 plan.

9 MR. SCAVOTTO: I would agree with that.

10 MR. PHILLIPPE: It's just that we're trying to
11 take the information she got from other states and what we
12 said and try to lay something out that we can start with.

13 MS. BURMAN: This is for discussion by this
14 Subcommittee and for you to draw conclusions and --

15 CHAIRMAN WAXMAN: And I hope we all appreciate
16 that.

17 Dale?

18 MR. GALASSIE: This is a very rudimentary
19 question, so bear with me. But I think I -- and I also
20 would like to caveat that by saying, I hope I spent my
21 career trying to get an organization to think out of the
22 box. So, I commend you for this dialogue. I get why
23 Organization A in Rogers Park, who is underutilized, wants
24 to sell, and I think there's been some good reasons

1 articulated for the system to support that. What I don't
2 get is why does Organization B in Rogers Park care about
3 buying them from A? Why doesn't Organization B just do a
4 CON and ask for whatever they want?

5 MR. SULLIVAN: Because if it's an overbedded
6 area, you can't.

7 MR. GALASSIE: Because the rules restrict you
8 from coming in --

9 MR. PICK: Your only option is 20 beds/10
10 percent every two years, and it often doesn't satisfy the
11 need for being able to develop a new program with --

12 MR. CONSTANTINO: Now, your rules allow for
13 what we call "variance to calculated bed need," which is
14 the CCRC variance, and then the defined population
15 variance. So, if there is a bed -- if there is an excess
16 of beds in a Planning Area and you want to establish a
17 facility, you could come in under one of those variances.

18 MS. BURMAN: If I may, one of the things this
19 group is going to be looking at, when we start looking at
20 amendments to the rules, is to prepare a variance, perhaps,
21 for innovative systems within your facility. So, that
22 could address that, if that was needed.

23 CHAIRMAN WAXMAN: Charles?

24 MR. FOLEY: I think we also want to address

1 just the opposite, and that is, if there is a need for beds
2 in a Planning Area, you should still be able to buy beds
3 from another existing facility, which, obviously, would add
4 to -- wouldn't add to the overall bed calculation. But I
5 think we need to encourage that as well, to get rid of some
6 of those bad beds.

7 MR. PICK: Excess beds.

8 MR. FOLEY: Or excess beds.

9 MR. GALASSIE: But isn't that the no brainer?

10 The issue here isn't for anybody that is in need. The
11 issue --

12 MR. SCAVOTTO: I don't think it's a no
13 brainer. That's the logic we're having trouble with, and
14 if the State is over-bedded, what difference does it make
15 where you move them to?

16 MR. GALASSIE: Because some aspects of the
17 State aren't over-bedded.

18 MR. SCAVOTTO: Right. And what I hear them
19 saying -- and I think they're right -- is what are those
20 areas? Do those areas really matter? And that's why
21 they're saying define them. You can take the broad
22 position. The State is over-bedded here; have 50 beds;
23 move them over there. You've still got the same number of
24 beds. It goes right at the appropriateness of that move.

1 MR. PICK: And if I may add, I think the other
2 piece of this is, while there may be mechanisms in place
3 for the existing formula or structure to get variances, the
4 issue is, the State is occupied at about 82 percent. Am I
5 right? Or less than eighty percent?

6 MR. FOLEY: 82 now. It went from 79 up to 82.

7 MR. PICK: So, the reality, when you step away
8 from, you know, the mechanics, is that the system has a
9 significant number of beds that are not being utilized, and
10 rebalancing where those beds are before we start adding
11 beds by virtue of variances and other mechanisms that allow
12 the -- that the system allows to add beds, even though the
13 formula doesn't show a need, just is a more prudent way to
14 do it, because if the system just continues the way it's
15 going, we're going to continue to have excess beds.

16 MR. SULLIVAN: Dale, before this Committee was
17 even established, a number of the associations had phone
18 calls with other states, including Missouri. Tim was on
19 that phone call; Eli was, too; and we talked to the head of
20 the Planning Board in Missouri, and they have a statewide
21 redistribution. You can move beds anywhere in the state,
22 and he said when it first started, he wasn't terribly sure
23 that that was a good idea. He wanted to control where it
24 went, and he said, pretty much the market has created -- in

1 fact, beds do move from over-bedded areas to under-bedded
2 areas, because that's where the market calls for. I don't
3 think we need to put in a lot of rules about where you can
4 move beds.

5 MR. GALASSIE: Thank you.

6 CHAIRMAN WAXMAN: So, under -- we're okay with
7 the parameters, right? We've gone through each of those
8 statements and we're cool.

9 So, "Points of Consideration".

10 MR. SULLIVAN: One, the pilot program.
11 Doesn't that put one area of the state at an advantage over
12 another area of the state? I know that's going to come up,
13 and I talked to various people who are very interested in
14 this program all over the state. Do we cause problems by
15 doing a pilot, and even have challenges because of it? Why
16 are you doing it for this area? And, Eli, I know this was
17 your idea.

18 MR. PICK: Yep. Actually, it was Terry
19 Dederer's idea, and I've been advocating.

20 MR. SULLIVAN: I'm throwing it open for
21 discussion and am willing to listen.

22 MR. PICK: Again, I think rather than the
23 whole state be the pilot -- because I think that's the
24 other option. The other option, if it's going to be -- we

1 still have to pilot this, no matter what, because, as a new
2 program, it's prudent for us to have some defined period to
3 do it for a while, see what happens, learn from that, and
4 make adjustments. So, whether the pilot is statewide or
5 smaller area -- again, it seems to me to be more prudent to
6 do it in a smaller geographic area to test it out and learn
7 some stuff. It doesn't have to be for a year or two, but
8 for some period of time, for at least the first
9 applications or projects that get reviewed, approved, that
10 it actually occurs, you see how it goes, and make some
11 adjustments.

12 MR. SCAVOTTO: I think you got an obligation
13 to pilot, and I -- to me, it makes good sense, and let's
14 see what works, set up a laboratory, and I would be in
15 favor of it, and I think the more control of the
16 environment, the better. I wouldn't have a pilot that goes
17 on three years, but let's narrow it down so we can get out
18 of the block on it.

19 MS. CREDILLE: The State -- I don't know if
20 other states do this. I can only speak to the state of
21 Ohio, and they artificially create a time period. I say
22 "artificially," but they have a time period within every
23 two years of when you can buy and sell. So, instead of
24 creating a pilot, their program only occurs at X amount of

1 time. So, it's controlled that way and sort of, to me, is
2 a simpler kind of thought process. If piloting -- which
3 seems to me to be difficult. I don't know how you choose a
4 certain area. It would impact access. I think there would
5 be issues like Terry is referring to. If you limited a
6 time period, you could buy and sell, then you're
7 controlling it.

8 MR. URSO: That's the next point.

9 MS. CREDILLE: In the document.

10 MR. PHILLIPPE: I approve the idea of pilot.
11 I just think if we're going to do it, we should do it in an
12 urban area, a couple of areas that are different, downstate
13 plus up here, something like that, so we get a -- kind of a
14 picture of how it works in two different worlds. That's
15 all.

16 MR. PICK: The notion of a pilot in my mind is
17 not that it's restricted to a specific area. We have to
18 define what the pilot is. It could be statewide for a
19 defined period of time or it can be, I think, as you just
20 suggested, maybe one urban and one rural area. I think
21 that's very much a Staff kind of question, of how much can
22 they handle and --

23 MR. PHILLIPPE: That's right.

24 MR. PICK: -- how do we begin to draft it out,

1 and we may -- and, Cece, I think it's also an excellent
2 suggestion. Maybe we do it for one period of time, close
3 the door and see how it went, but at the end, I think it's
4 also a function -- if we end up with a hundred
5 applications, for example, is that -- and I don't know
6 theoretically. We have no idea what it's going to be. How
7 do we handle that and how much do we learn? Do we need to
8 say statewide be limited to the first 10 or 20? Let's see
9 how we do that and review it again. So, again, I think
10 this is just points for consideration and discussion. We
11 need to be thoughtful about what volume and period and
12 geography we want to use to test this out.

13 CHAIRMAN WAXMAN: And I think Claire or
14 someone -- point number 2 on the next page covers your time
15 period.

16 MR. JOHNSON: If Illinois is over-bedded, will
17 the free lawsuits -- and, in particular, Colbert versus
18 Quinn and -- money follows the person. Is that going to
19 have an impact on the formula here and what you're doing,
20 because there is going to be a -- soon to be a mass exodus
21 of residents leaving long-term care beds, going into the
22 community.

23 MR. SCAVOTTO: Which means the formula is
24 ridiculous now. It's nice to have, but --

1 MR. PICK: If I may, in theory what it's going
2 to force operators to do is change what services they're
3 providing, because as the population shifts back to a
4 community-based service model, the options are either the
5 beds are empty and buildings close, or they reorient who
6 they're serving, because the people they used to serve are
7 no longer going to be there. So.

8 MR. SCAVOTTO: Which means the Planning Board,
9 us, needs to relook at that bed-need formula. Probably
10 it's going to be obsolete.

11 MR. PICK: I don't know. I think your earlier
12 comment, Mike, is where it's headed, that it might be or it
13 might not be.

14 MR. SCAVOTTO: It's possible we'll get a lot
15 of help from the hospitals. It's possible.

16 MR. SULLIVAN: And that's the other trend that
17 is going on on the other side, is the whole emphasis from
18 Managed Care to reduce hospitalizations, with long-term
19 care probably serving a significant need there. So it is a
20 population shift but, you know, it is hard to predict where
21 we're going to be in five years. It is going to be
22 different.

23 MS. MITZEN: I sit here and I listen to this,
24 and it's like every other committee I'm on. Nobody quite

1 knows where this is going, but I think that our
2 responsibility is to anticipate exactly what you're talking
3 about. You're talking about 300 people in the first year
4 out of Cook County nursing facilities. Those are mostly
5 Medicaid folks. So, they are going to be moving out in the
6 community. 1,400 after two years, three years, something
7 like that, 1,400 after -- so what is going to happen with
8 those beds? Are they going to be filled with other people?
9 Who are those people who are going to fill those beds, or
10 not? So, out of X number of beds in the Cook County area,
11 we're talking about --

12 MR. PICK: The counter argument to that,
13 Phyllis, is, it may not occur in the time frame that's laid
14 out, because why? Because the services are not currently
15 available in the community and have to be developed.

16 MS. MITZEN: Yeah.

17 MR. PICK: So, there is no question that the
18 movement is going to go in that direction. What the volume
19 will be, we have to wait and see.

20 MS. MITZEN: Right, we have to wait and see,
21 but I guess I'm going back to some of the comments that
22 have been made in terms of this process, anticipating what
23 is actually happening with HFS and where the dollars are
24 going to be going.

1 MR. PICK: If I may, I'd like to share -- just
2 a little bit of digression -- a visit I just had in a
3 facility in the market area I used to populate in, a very
4 good facility with an excellent reputation with a 50
5 percent occupancy. All right? Almost all of them private
6 pay, very little Medicaid in that building, and the
7 discussion I had with the owner -- and this is a for-profit
8 facility -- was, you know, "What are you doing to attract
9 other kinds of business?" His response was, "I'm not
10 comfortable managing complex medical patients." He said,
11 "That's not my background." He's been in the business for
12 over 30 years, and his focus has been custodial care. His
13 population has become more frail, but he's not managing
14 complex medical patients.

15 So, the reality is, this is a very good
16 facility, has an excellent reputation in the community, but
17 he's offering a service that's no longer in demand and so,
18 his reality is, he's still selling buggy whips. Right? So
19 the market is passing him by. So, while we talked about
20 the scenario of over-bedded area in the context of a bad
21 provider, this is an overbedded area in the context of a
22 good provider, because he's unable to adapt to the new
23 environment, and money follows the person, and he realizes
24 this, and development of community-based services is only

1 accelerating the rate at which his occupancy is going to
2 continue to decline, and his competitors are rapidly
3 initiating new programs for complex medical patients,
4 because there's an ACO being developed in that area. It's
5 a pilot for a very large acute system, and they're
6 enlisting providers to participate in their program,
7 because that's the direction things are moving.

8 So, again, I think it's not necessarily in the
9 context of bad versus good providers. It's the market.
10 Market forces are rapidly changing what the role of skilled
11 nursing facilities are in the market, and the free market
12 is adapt or die, and he's dying, because he's not adapting
13 while other providers in the area are adapting. Not
14 everybody and not everybody at the same rate. You know,
15 some facilities are still doing orthopedic rehab. That's
16 their definition of complex medical. Others in the market
17 are doing ventilator dependent patients. So, it's all
18 based on the eyes of the beholder.

19 But the reality is that -- and I think that's
20 where I wanted to bring this back. It's not a good/bad.
21 It's -- and it's not community versus institutional. It's
22 from the notion of funding, that the resources available
23 are diminishing for custodial, residential care, and it's
24 moving away from an institutional-based model, and has been

1 for 20 years and the reality of -- what is the role of the
2 buildings that we've heavily invested in developing? You
3 know, there's been a tremendous amount of public support
4 and funding for developing all these facilities. What are
5 they going to do? We don't know the answer to that yet,
6 and I think that speaks from a planning standpoint. How do
7 you plan? Well, I think this discussion is the most
8 prudent.

9 Rather than adding more beds to a system, when
10 we don't know exactly what their needs are going to be or
11 how they're going to be used, it's much more prudent to
12 take existing assets and redeploy them before adding more
13 to a system where we don't know where it's going.

14 MR. SULLIVAN: Amen.

15 CHAIRMAN WAXMAN: I've been requested to ask
16 the group to hold for a ten-minute break, because the Court
17 Reporter is in desperation. Meeting will reconvene at
18 12:15, 12:20.

19 (Lunch recess)

20 CHAIRMAN WAXMAN: I think we're ready to go.
21 First of all, let me again thank everyone for coming and
22 participating. I think we had a great first half, and just
23 sort of a plan, because I know some of you traveled far to
24 get here -- and I really do appreciate that -- our meeting

1 is scheduled until 2:00, so hopefully by 6:00, we'll be
2 done.

3 We'll try to get to 2:00 as close as possible
4 and reconvene. We also have a meeting set for October.
5 That date is?

6 MS. AVERY: October 9th.

7 CHAIRMAN WAXMAN: October 9th will be our next
8 meeting. Can we assume it is going to be here?

9 MS. AVERY: If you would like.

10 CHAIRMAN WAXMAN: Yeah, are you guys okay with
11 October 9th here?

12 MS. AVERY: I'll send her an e-mail and see if
13 it's okay.

14 CHAIRMAN WAXMAN: I think, with the amount of
15 work we have to do face-to-face, it's going to be
16 important, because I'm sure we're not going to get through
17 this whole list today. So, October 9th is definitely the
18 date. We'll wait to make sure we can have this space
19 again.

20 MR. PICK: Can I suggest that we order lunch
21 up here?

22 MS. AVERY: The issue is -- and I'll talk to
23 her and tell her it didn't work for us and they'll have to
24 do something else. The issue was that they now created

1 this limited menu for groups under 25, and you can only
2 make two selections. So, I couldn't send out the menu and
3 you all make your choices like we normally do. So, I'm
4 going to tell her that didn't work. They had Nest menu,
5 and you can only choose two sandwiches, two salads off the
6 entire menu.

7 MR. SULLIVAN: Let's save money on the cost of
8 the room and just meet at the bar.

9 MS. AVERY: I will express that that did not
10 work for us.

11 CHAIRMAN WAXMAN: We can't -- and you can't
12 have somebody else deliver food here, I assume. They would
13 take unkindly to that.

14 So, we have gotten through, I think -- we've
15 gotten through page 1.

16 MR. SCAVOTTO: No.

17 CHAIRMAN WAXMAN: You're not going to let me
18 do that, are you?

19 "Implementation". We're having a discussion
20 on the concept of a pilot. That's where we left off. So,
21 the concepts of pilot are either by time or geography, and
22 if we're going to do geography, can we combine A and B
23 together? I mean, can we incorporate that into our
24 discussion? Because you said there are 95 Planning Areas?

1 MR. CONSTANTINO: Yes.

2 CHAIRMAN WAXMAN: Okay. So if you're going to
3 do a pilot, 95 areas says to me that they're a pretty small
4 size.

5 MR. CONSTANTINO: Generally they reflect the
6 counties.

7 CHAIRMAN WAXMAN: So a Planning Area equates
8 to a --

9 MR. CONSTANTINO: County, right. Except Cook
10 is divided, and there are some counties in southern
11 Illinois that are combined.

12 CHAIRMAN WAXMAN: Then you had another term.

13 MR. CONSTANTINO: Health Service Areas, which
14 there are eleven.

15 CHAIRMAN WAXMAN: Okay. I'm wondering if the
16 Service Area might be the geographical size of a place to
17 try a pilot.

18 MR. PICK: Can I ask him a related question?
19 I really believe the challenge is the Staff's ability to
20 process. So, is it based on the size of the area, or is it
21 based on volume? What are going to be the challenges that
22 the Staff would have in order to manage this kind of a
23 program, so that we can craft out a pilot that will allow
24 it to be manageable? So, is it geography? Is it just

1 volume of cases? What's the -- what would be the challenge
2 for you guys?

3 MR. CONSTANTINO: We calculate a bed need
4 every month by Planning Area and by Service Area. So,
5 that's not an issue regarding the planning need for either
6 one. The Service Area, there's eleven of them in the
7 state.

8 MR. PICK: So if it was statewide, it wouldn't
9 be an issue for you guys?

10 MR. CONSTANTINO: No.

11 MR. FOLEY: Even with the volume?

12 MR. CONSTANTINO: The volume?

13 MR. FOLEY: The number of applications. You
14 might get a hundred all at once, Mike.

15 MR. CONSTANTINO: I would think you would
16 want -- this is my opinion. I haven't discussed it with
17 anybody. I would think you would want to do it through an
18 exemption process. And this would all have to play out.
19 It would be just a one or two-page application. You submit
20 it; we review it, make sure everything we requested is
21 there, if we have to do any follow-up. I was talking to
22 Courtney at lunch. I don't know if there is going to have
23 to be public notice that this is occurring. That I don't
24 know, and I don't know if we have to hold a public hearing

1 or not.

2 MR. PICK: Well, is it a rule change? Because
3 if it's a rule change, then you have to give public notice.

4 MR. CONSTANTINO: No, no. I'm talking about
5 bed buying, an entity that comes in and says, "I want to
6 buy this number of beds." I don't know -- I would think we
7 would have to do a public notice in the newspaper.

8 MR. PICK: Like you're doing in any project.

9 MR. CONSTANTINO: Right, and on our web site.
10 Then I don't know if we're going to have to have a public
11 hearing or not. I guess that's something Frank would have
12 to --

13 MR. SULLIVAN: Do you have to have public
14 notice and public hearing on non-substantive?

15 MR. CONSTANTINO: Yes.

16 MR. PICK: I would think you would have. So
17 then, if -- I'm thinking out loud. It would seem to me
18 that the real significant question is how many of these
19 should we have -- should we go through before we kind of
20 step back and say let's take a look at this again? So, it
21 doesn't seem to me it's geographic that is the limitation;
22 it's the volume.

23 MR. CONSTANTINO: The exemptions are easier to
24 process for us time wise. They're not a 700-page

1 application. We used to do them with change of ownerships
2 for long-term care, and we used to turn them around within
3 a week or two.

4 MR. PICK: Those didn't require public --

5 MR. CONSTANTINO: Yeah, we did have to hold a
6 public notice for those.

7 MR. PICK: Then it doesn't sound like it's
8 that difficult.

9 MR. SCAVOTTO: My question -- which you just
10 answered, I think -- was that -- I read -- I see us heading
11 down the road of requiring a full Certificate of Need
12 application, and you're saying you don't need that, and I'm
13 just saying why would you need it?

14 MR. CONSTANTINO: It's an exemption process.
15 Now we allow 10 percent or 20 beds with just a letter to us
16 and approval of Staff.

17 MR. SCAVOTTO: To me it makes sense. A full
18 CON doesn't make sense to me, but the exemption does.

19 MR. CONSTANTINO: It would still have to have
20 Dale's approval. Once it is all received, we would still
21 have to have Dale approve it or take it to the Board, one
22 or another. This is all off the -- this is my personal
23 opinion.

24 MR. PICK: No, it's good.

1 MR. SULLIVAN: I think you're right on.

2 MR. SCAVOTTO: That's another reason to have a
3 pilot program. What sort of documentation are you going to
4 require? To me, little as possible on something like this.
5 You've already got the best.

6 MR. CONSTANTINO: Yeah, we've -- name of the
7 facility, you know, we could -- it would probably just be a
8 two-page application with an attestation and a signature.
9 That's what we're doing with -- that's what we used to do
10 with change of ownerships.

11 MS. MITZEN: A pilot project implies to me
12 that we want to learn some things from it. So, I mean --
13 okay. I can understand a two-page, but it seems to me that
14 this would be different than the way we normally do
15 business. We would want reports back on what were issues.
16 That would be the purpose of a pilot.

17 MR. PICK: If I can respond, I think what we
18 would end up doing is reviewing, as an advisory committee,
19 the applications that the Staff have processed, who is
20 applying, who is selling, who is buying, how many beds, how
21 is it going to be used. So, we're starting to get some
22 data on the activity, to get some feedback to us from a
23 policy question. Is this achieving what we outlined our
24 objective was, which is to redistribute the beds to go

1 where the need is as opposed to just lying fallow where
2 they are, and then monitoring the overall occupancy
3 statewide, so that we start to see utilization going up in
4 conjunction with this initiative?

5 MR. FOLEY: I guess I'm kind of a little bit
6 confused in that the bed buying concept to me is an
7 excellent idea, but if our overall goal is to somehow
8 reduce the number of beds in the state of Illinois --

9 MR. PICK: No, it's to --

10 MR. FOLEY: Then to redistribute the beds.

11 MR. PICK: It's to redistribute the amount of
12 empty beds.

13 MR. FOLEY: Or even to redistribute.

14 MR. PICK: It's not to stop new applications.
15 We still need those.

16 MR. FOLEY: I understand that. I'm not saying
17 that.

18 MR. PICK: Again, the reason is, the State is
19 funding those empty beds. Right? We're paying for that
20 asset to be out there.

21 MR. FOLEY: I guess it will depend also on
22 what kind of documentation that the State is going to
23 require. If it's just going to be a simple notice of
24 application, notification, like you said, Mike, name and

1 address of parties involved -- and I'm sure you're going to
2 have to have some kind of binding contract contingent on
3 Board approval, something of that nature. I guess it would
4 depend on what the occupancy rates are on both facilities.
5 I guess I don't know as I sit here -- background of
6 applicant plays a part in this also. So there's going to
7 be questions there. Then there's the financial criteria.
8 So, I could see a lot maybe, but it just depends on what
9 kind --

10 MR. CONSTANTINO: That's the old change of
11 ownership application that we did for long-term care. I
12 mean, everything you stated there is what was in that
13 application, that exemption application.

14 MR. FOLEY: Okay. Hopefully, there's going to
15 be nothing there that is going to trigger a full review,
16 like we did on some change of ownership applications?

17 MR. CONSTANTINO: Well, if you're doing
18 something that conflicts with our statute or laws, yeah,
19 that -- we're going to question that, yes.

20 MR. FOLEY: I don't mean that.

21 MR. PICK: That's going to trigger something.

22 (Laughter)

23 MR. FOLEY: It's like in change of ownerships.
24 Sometimes there was a requirement there for exemptions

1 where it converted into a full-blown review whether or not
2 the facility had an A bond rating or something like that.
3 If they didn't, they had to go through the full review.

4 MR. CONSTANTINO: Oh, no, no, no, no. I'm
5 talking about the old long-term care --

6 MR. FOLEY: The old, old long-term care.

7 MR. SULLIVAN: Really old.

8 MR. PICK: And you've been around long enough
9 to know what that means.

10 MR. CONSTANTINO: Before that new law came in
11 effect in September of '06. That's what I'm talking about.
12 That's how we used to process those long-term applications
13 for change of ownership.

14 CHAIRMAN WAXMAN: On the bottom of the form
15 it's got "Old, Old, Old"?

16 MR. CONSTANTINO: Yes.

17 CHAIRMAN WAXMAN: As a suggestion, so we can
18 keep moving forward, can we ask Staff to design their
19 concept of a pilot program and bring it back to us at the
20 next meeting?

21 MR. GALASSIE: Can I just comment on that?
22 I'm not sure it's Staff's role to determine if you want
23 this statewide or time limited. As much of a pain that is
24 to still discuss, I think the Board needs to hear from the

1 background of this table as to whether you want to do it
2 statewide, a limited geography or --

3 CHAIRMAN WAXMAN: The only reason I suggested
4 is because there seems to be some suggestion that the
5 criteria is going to be based upon Staff's ability to deal
6 with it. Therefore, I thought maybe they could pose a
7 plan.

8 MR. GALASSIE: I'll comment on that very
9 quickly. I'm the first one to defend Staff, but I don't
10 think you should limit your thought process based upon
11 Staff's ability right now. I think you should move forward
12 and assume -- there's a finite ability that Staff has.
13 There's a finite ability that the CON Board has. If there
14 are a hundred applications that come in, guess what. A
15 hundred -- it might take six months to get through them.

16 MR. PICK: What I'm hearing is, it's not a
17 geographic limitation; you should set a time frame and just
18 let it roll through, see what comes through, and then do a
19 review.

20 MS. MITZEN: Either a time limit or perhaps
21 the first hundred applications.

22 MR. SULLIVAN: Right, first come, first serve.

23 CHAIRMAN WAXMAN: Charles will have the first
24 92. No? Not the first 92?

1 MR. FOLEY: No, I wouldn't do that.

2 CHAIRMAN WAXMAN: Frank?

3 MR. URSO: I just wanted to mention, that
4 pending bill talks about a specified geographical area of
5 drive time. That's what the bill says. It's not been
6 passed.

7 CHAIRMAN WAXMAN: Right.

8 MR. SULLIVAN: Specific geographic area being
9 the state of Illinois, but I think Phyllis is right on. I
10 think if we limit geographically, we're possibly running
11 into issues, and maybe, I think, the pilot should be
12 statewide geographically. We may want to limit that beds
13 cannot move more than 60 miles, whatever. That's a
14 different discussion. But I think Phyllis is right, that
15 maybe it's first come, first serve, first 50 applications,
16 and then we stop and see where we're at. What came with
17 those 50 applications? What were the up sides, down sides,
18 whatever? I think that's a good limit in a period of
19 review.

20 CHAIRMAN WAXMAN: My issue with drive time is
21 that having spent -- in Chicago, I've spent 10 minutes
22 going nowhere, an hour going nowhere, and yet you can get
23 halfway across the country, once you get past Route 80, in
24 a half hour. So, drive time for me is a wrong measurement.

1 MR. PICK: But all Frank is saying is, that's
2 what the language is in the bill.

3 CHAIRMAN WAXMAN: I know. If they had asked
4 me, I wouldn't let them do that. It's there. We've got to
5 deal with it, but I think, being serious, our purpose is to
6 make recommendations back to the Board and they carry it
7 out. So, I think we can still have them make the
8 recommendation for the concept that drive time is not
9 logical, but time length might be more appropriate and get
10 rid of that drive time issue. Can't we?

11 MR. SULLIVAN: I don't know.

12 MR. URSO: All this bill says is evaluate and
13 make recommendations. So, you have the discretion to go
14 anywhere you want with this, up to the Board, and then the
15 Board has to determine what the next move is.

16 MR. SULLIVAN: Not that -- I mean, I could go
17 either way with it. I mean, Missouri has a statewide
18 thing. Ohio has within the county or next county,
19 contiguous counties. Take Cook County. You have several
20 market areas, and do we move something from Willmette down
21 to Palos? Is that -- those are three market -- at least
22 three market areas separate that's all within -- and, you
23 know, drive time made sense, because according to MapQuest,
24 it takes -- you can only go 20 miles in Chicago for -- in

1 30 minutes, whereas downstate, you can go 40 miles. So, it
2 does limit how far you can move beds, and I think that's a
3 legitimate public policy issue. I don't have an opinion
4 either way, but people did say, "Can I buy beds in Cairo
5 and move them up to Evanston? Is that a fair market
6 exchange?" That's a legitimate question.

7 MR. PICK: That may be part of what the pilot
8 ferrets out, the initial period. So, that may be something
9 we let roll through the first group to see what comes up.
10 The other is, we may be expecting, by virtue of our
11 discussion, that everybody in the state is going to want to
12 go for this and, therefore, we're going to get a flood of
13 applications, when, in fact, there may be a small trickle
14 until people get a sense of what it is. If the market rate
15 for a bed is 50 or 60,000 a bed, the rate of applications
16 is going to be a drop. If it's 5,000 a bed, there's going
17 to be, I think, a lot more activity. We don't know. So,
18 I -- that's why I hesitate to say let's pick a number. We
19 may want to do a time frame or after a certain number of
20 applications go through. I don't know, because we don't
21 know how the market is going to react.

22 MS. MITZEN: How quickly do we want to do
23 this? I want to modify what I said before. Maybe it's X
24 number of applications or 6 months, whatever comes first,

1 so that at least we get a sense of what the interest is and
2 where the market is, and then stop ourselves and take a
3 look at it and talk to Staff, also, at the same time.

4 MR. SULLIVAN: That's reasonable.

5 MS. MITZEN: But it seems to me that we
6 don't -- pilots can go on endlessly, and we don't want
7 that. So --

8 MR. SULLIVAN: I think you were a part of the
9 25-year demonstration process, Eli.

10 MR. PICK: And it ended when I sold the
11 building.

12 CHAIRMAN WAXMAN: This discussion has kind of
13 triggered a question that just occurred to me. Tim, if you
14 move beds from one of your buildings south to one of your
15 buildings north, is there a dollar value placed on those
16 beds, because of staying within the same corporate
17 structure?

18 MR. PHILLIPPE: I'd have to check with our
19 attorneys. It is possible that we would actually, within
20 an organization, have to do the finances because we have
21 separate corporations -- we have -- based on financing and
22 corporations and all of that, and to actually show value
23 received. Right, you can't just give it away, but, still,
24 you can do it, and it would be -- of course, it would be --

1 this is something you bring up that's useful to talk about,
2 because we do have organizations that have 80 facilities in
3 the state. It will be a very different situation for
4 someone who has 40, 50, 80 than it does for someone who has
5 two or three or five around the state, because then it --
6 depending on the size of the geographic area we allow it,
7 will allow organizations that are very large to move their
8 beds around where they're most effective, and that could be
9 good or not good. I don't know.

10 MR. PICK: I think that's the purpose of the
11 pilot. But, you know, the other thing I recall when Claire
12 did her research, there was some areas where they set a
13 number of the cost of the bed, and others, they just let
14 the market. Was there anything -- any feedback in regards
15 to good, bad or indifferent?

16 MS. BURMAN: The only one I remember is from
17 the State of Washington agency, and she said some of the
18 prices went sky high. She was amazed at how high some of
19 the beds went for because there was no cap.

20 MR. PICK: That's a CON state?

21 MS. BURMAN: Yes.

22 MR. PICK: So it must have been very hard to
23 get a bed in Washington.

24 MS. MITZEN: Washington is kind of an unusual

1 state in that it is one of the first states to rebalance.
2 So they have a whole range of housing options in terms of
3 they have a fairly modest supply of long-term care and
4 nursing facilities. So, I'm not sure what to make of what
5 you're saying, but those beds must have been extremely
6 valuable, and I can see why.

7 CHAIRMAN WAXMAN: Charles, do you have any
8 idea what the average price of a bed is in the state of
9 Illinois these days?

10 MR. FOLEY: You know, yesteryear we could
11 probably come up with that figure. Today everything is
12 just based on -- it's not a per-bed basis anymore. It's
13 really based on bottom line, looking at your financial
14 statements, because today you have facilities that are 50
15 percent occupied, sitting there with all private paid
16 residents, versus another facility that is 50 percent
17 occupied with all Medicaid residents, and so the value of
18 those two facilities, obviously, is going to vary
19 significantly. So, it's really kind of hard. The only way
20 you can determine that -- which we don't keep track
21 anymore -- is, you know, we used to have that information
22 when they had to file an application to go through a change
23 of ownership. We would get that value, but today that
24 information is not available to the Planning Board. Is

1 that still correct, Michael?

2 MR. CONSTANTINO: Yeah, Licensure doesn't
3 collect that information.

4 MR. FOLEY: So it's not really available
5 anymore. I wish we could get back to that.

6 CHAIRMAN WAXMAN: It's just an interesting
7 question.

8 MR. PICK: We could find out from the realtor,
9 the people who are -- the agents that are representing the
10 owners and get some ranges of what's going on. I can tell
11 you what I've been hearing, and that is for, quote,
12 unquote, traditional long-term care, more of a chronic
13 environment, that value is running about mid 60's, 60 to
14 70,000 a bed. The organizations that have a higher
15 Medicare and higher medically complex populations, we see
16 95,000 a bed. So, that's the range. Anywhere -- 60 is the
17 average. So, I'm sure there are deals that are still being
18 done in the low 50's up to the mid 90's, depending on what
19 kind of organization it is.

20 MR. FOLEY: It's going to be interesting to
21 see what kind of value is going to be placed on facilities
22 now going through the buy/sell concept. Other states I've
23 seen as low as \$5,000 a bed up to, you know, whatever
24 number. It's whatever somebody is willing to pay for it, I

1 guess.

2 MR. PICK: My guess is, when the buy/sell is
3 in place in Illinois and you can buy beds for 5, \$10,000 a
4 bed, that it will reduce the value of the whole facility
5 selling, because if I buy a facility that's 50 percent
6 occupied and I'm taking into account that I may sell off
7 some of the excess beds that I wouldn't be using, I'm not
8 going to be calculating them at 50 or 60,000 a bed, because
9 I'm only going to get 5 or 10,000 a bed for them, but that
10 means that this program is fully mature and implemented and
11 really working. Because right now, those excess beds are
12 just -- they're in Neverland. They're like ghosts.

13 MR. FOLEY: Another thing, too, we need to
14 realize is that next year, July 2013 or August 2013, we do
15 have 200-some-odd facilities in the state that are not
16 fully sprinkled, and so at that point, we're going to find
17 facilities are either going to be closed and they're going
18 to go bankrupt or they're going to try and sell. It's
19 going to be difficult to sell, I would think, because
20 they're mandated by Federal law that, regardless who owns
21 that facility, they still have to be fully sprinkled by
22 that date. So, I see a lot of facilities are going to be
23 going under.

24 MR. PICK: Yep.

1 CHAIRMAN WAXMAN: Wow.

2 MR. FOLEY: Maybe this is premature in that
3 respect. I don't know.

4 MR. PICK: No, no, no. I think you're right on
5 target. The other one is the life safety for shafts and
6 duct work, requiring enclosures, like the sprinklers.
7 Although sprinklers has a drop-dead date, life safety was
8 issuing waivers for facilities that were not built with
9 enclosures, which is most of the buildings in the state of
10 Illinois. But from what I understand, in the last year
11 those waivers are not being issued anymore. So -- and the
12 cost of building enclosures around the vertical shafts and
13 the duct work is even more than the sprinklers.

14 MR. FOLEY: That coupled with the low Medicaid
15 reimbursement rate, and not only that, but the timing in
16 getting a check, you know --

17 MR. SULLIVAN: Why don't we just slit our
18 wrists?

19 (Laughter)

20 MR. PICK: So, going back, I like Phyllis's
21 recommendation of whatever number of applications or 6
22 months, whatever comes first, and then we step back and
23 let's take a look at what happened.

24 MR. FOLEY: I hate to submit an application

1 and then go through the entire process, submit an
2 application and then all of a sudden it's pulled because
3 for whatever reason, run out of time, or we got enough
4 applications already.

5 MR. PICK: I wouldn't say that we should pull
6 it. I think just leave it in the queue and then reevaluate
7 it based on whatever we determine --

8 MR. FOLEY: Whatever we have at that point in
9 time.

10 MR. PICK: Yeah, and keep processing.

11 CHAIRMAN WAXMAN: Mike, when a building closes
12 for whatever reason, do those beds come out of the
13 inventory?

14 MR. CONSTANTINO: They go back into the
15 inventory.

16 MR. PICK: It increases the beds that are
17 available. It increases the need.

18 MR. PHILLIPPE: As long as we're talking about
19 kind of current trends, the other trend that is happening
20 is, hospitals are giving up their beds in their units. The
21 hospitals are going back to the Board and closing their
22 units and putting their beds back in the inventory.

23 MR. GALASSIE: Definitely.

24 MS. MITZEN: If the beds are in the

1 inventory, what does that mean?

2 MR. GALASSIE: More availability.

3 MS. MITZEN: They're available to somebody
4 else to buy them?

5 MR. PHILLIPPE: Not to buy them. Just to go
6 ahead and come to the Board --

7 MS. MITZEN: Build a building because there
8 are beds in the inventory?

9 MR. PICK: Right.

10 MS. MITZEN: So we're saying the bed need
11 is -- that we have too many beds in the state. We're
12 saying that we want to reduce the number of beds. How does
13 throwing those beds back into the inventory reduce the beds
14 in the state?

15 MR. GALASSIE: You're not saying you want to
16 reduce the beds. I've not heard you say you want to reduce
17 the beds.

18 MS. MITZEN: What do we mean by encouraging
19 downsizing?

20 MR. SULLIVAN: Where an individual facility
21 would go from 100 beds to 60 and convert to private rooms.
22 That's downsizing.

23 MS. MITZEN: So we're not talking about a
24 statewide downsizing?

1 MR. PICK: Wait, wait, wait. Let's go back to
2 -- what we're talking about is, there are currently 19 or
3 20 percent of the beds that are unoccupied that, according
4 to the formula, they're being used. They're in the system.
5 They're available for use. So what we're talking about
6 with buy/sell is a redistribution. When buildings close,
7 that's a completely different -- that's a whole new kettle
8 of fish. So, when the building closes and that license is
9 given up, those beds go back in the inventory and the
10 bed-need formula is still the same. The population or a
11 percentage of that population determines how many beds are
12 available, but the application process requires more than
13 just the bed need. It's what services, what other services
14 are available in the market in the Service Area that you're
15 applying for. It's not just if there's beds available in
16 that area based on the formula, a Certificate of Need gets
17 issued. It's the whole process.

18 MR. SCAVOTTO: However, I think Phyllis is
19 doing us a favor, and she's doing us a big favor, and when
20 I read "B" under "Purposes," it says "Encourages
21 downsizing," and I think what Phyllis is saying -- and I
22 agree with her -- is that we should be careful how we write
23 this, because if we move beds within the system, we're not
24 encouraging downsizing. The beds still stay in the system.

1 MR. PICK: The downsizing is within a
2 building.

3 MR. SCAVOTTO: It could be within a building,
4 but what do we mean here? And I think that's what you're
5 getting at. I hope that's what you're getting at.

6 CHAIRMAN WAXMAN: Just say yes, Phyllis.

7 MS. MITZEN: Yes. Brilliant conversation.

8 CHAIRMAN WAXMAN: Right. We're talking
9 about -- it's facility downsize.

10 MR. SCAVOTTO: At what level do you want to
11 downsize?

12 CHAIRMAN WAXMAN: We're not talking about
13 taking beds out of the whole system. We're talking about
14 making better use of the beds that we have, and it means
15 that a facility that has 20 empty beds the last two years
16 gets rid of them.

17 MR. SCAVOTTO: Right. That facility
18 downsizes. The facility that ends up with the 20 beds
19 didn't downsize. So what are we talking about? I think
20 she's got a point.

21 MR. PHILLIPPE: As long as we're on this point
22 and you guys are talking about it, if I look at the trends,
23 what are the trends? We're about 80 percent occupied
24 currently. There are some places where people would like

1 to add beds, I guess, but 80 percent are being used. All
2 the trends are to push occupancy down. Everything being
3 equal, no matter what you said about higher acuity, it's
4 still going -- that's Managed Care. That's their whole
5 purpose, right, is push the occupancy down? So, at the
6 same time then, we keep the same formula, people can still
7 go and add beds in locations that have a need, and then
8 we're going to be doing something to encourage more use in
9 the places that don't have a need, official bed need,
10 because you're going to be adding a new program or swapping
11 it into a new unit or something. It feels like we're kind
12 of working at cross purposes to me.

13 MR. PICK: What's the cross?

14 MR. PHILLIPPE: I mean, some people may say
15 just stop the bed-need formula, freeze the number of beds
16 in the state, and then require people to move them from one
17 place to another. If you're going to do it, if you want to
18 add and grow, move them where they're not being used
19 someplace else, but don't keep growing the number and then
20 trying to find ways for people to use the beds, when they
21 officially don't look like they're going to be needed.
22 Because people are going to do things to try to use more
23 beds, because -- I think you're the one that said it -- the
24 more nursing home beds you have, the more people that will

1 be in nursing homes. That's true of almost everything,
2 really, because if you have a product, you try to sell it.
3 Is that good public policy to be doing things that
4 encourage more use of beds?

5 MR. SCAVOTTO: That's why we're going with
6 Managed Medicaid.

7 MR. PICK: Here's where I'm coming from.
8 There's a fundamental assumption that is not necessarily
9 true. What is true is that for seniors, which this whole
10 system was built around, is that we need beds, because the
11 number of seniors keep increasing. The reality is that the
12 number of seniors in nursing home beds is going down, but
13 we've got another population where it's going up, and
14 that's younger patients who are not permanent residents but
15 who are there on a transitional basis. That's not
16 accounted for at all. So that's my difficulty. If we --
17 what I hear you saying is moratorium, right, we put a
18 moratorium on new beds; let's use the existing beds in the
19 system, let it rebalance and that should be adequate?

20 MR. SCAVOTTO: Why doesn't your occupancy rate
21 account for those people?

22 MR. PICK: Well, it does, and that's where I'm
23 going, but the bed-need formula doesn't. The bed-need
24 formula doesn't. The bed-need formula is based on a

1 population of 65 and older. There's the disconnect. But I
2 think until we've got some methodology to replace what we
3 have now in adequately determining what the real need is,
4 short of a moratorium or replacing the formula completely,
5 an interim step is let's allow beds to move where the need
6 is, but don't stop a new building, because there may also
7 be a need for new properties in certain locations. This
8 does not allow for new buildings, and a moratorium --

9 MR. PHILLIPPE: That's what you have to do,
10 that's right. If you're going to have a moratorium, this
11 has to be expanded from adding onto a building to building
12 a new one, which is what happens in some areas.

13 MR. GALASSIE: It does with hospitals.

14 MR. PHILLIPPE: So, in other states, they
15 would say you buy the beds, if you think they're needed.
16 Buy them downstate or three counties away and build your
17 building where you want. The advantage of that, by the
18 way, is that we are an under-funded system and want to
19 provide good care for the consumers we have. If there's
20 really a need and you let the market decide the value of
21 the bed, then it moves money to places where they don't
22 have money right now, because they have low census, to use
23 to improve the product and the services for the consumers
24 in that market. So, it shifts money from maybe a growing

1 area where there's a better demand to a place where it's
2 not as good financially and help the consumer help the
3 people who live there.

4 MR. PICK: I think that's where the argument
5 is being made for why you need a pilot. And putting in a
6 moratorium is dramatic.

7 MR. PHILLIPPE: That would be extreme, right.

8 MR. PICK: So, I think it's a subject for us
9 to continue to ponder, but I don't believe it's something
10 that should be done at this point in time. That's why,
11 again, I think the pilot makes perfect sense. Let's see
12 what this does, because if it's not moving the -- if it's
13 not moving all of the key measurements in the direction
14 that we want, which is increase utilization, by decreasing
15 the availability in areas that are not being used and
16 moving them to areas where they are, then the impact should
17 be that, overall, we should start to see the occupancy
18 levels increasing, because we're making the services
19 available where they're needed, and it should affect the
20 need for new projects. Theoretically the need for new
21 projects should go down, if beds are being moved to areas
22 where they're needed, because right now, that's the only
23 option. The only option is either you're building a new
24 building or you're replacing the one you have now, because

1 very few people are taking beds off line.

2 Dale's comment is right on target.

3 Resurrection bought my building. They had a nursing home
4 two blocks from mine, and, instead of selling it, they
5 discontinued it and returned the beds back to the
6 inventory, which I didn't understand at all. But that's a
7 hospital mindset.

8 MR. URSO: And you're happy.

9 MR. PICK: I didn't care. They're using the
10 building now as an office building.

11 MR. FOLEY: So it goes back to the issue of
12 distance. I think we need to be careful, because if we
13 keep it within a Planning Area or within the contiguous
14 Planning Areas, depending on how big those areas are within
15 itself, at least what I've been told is that facilities
16 could be reluctant to sell their beds to somebody, because
17 it could, in fact, affect your occupancy even further.

18 MR. PICK: Be their competitor.

19 MR. FOLEY: That's right. So you have to have
20 a much wider geographic area in which to draw from.

21 CHAIRMAN WAXMAN: What I'm hearing, if I can
22 draw some conclusions, is it should be statewide, it should
23 be both time limited, and quantity limited. I think --

24 MR. PICK: And/or.

1 CHAIRMAN WAXMAN: The pilot. The pilot should
2 be statewide and time or quantity limited, like the first
3 100 within 6 months. Do we agree? Is there a consensus
4 that those three things are what's being talked about? So
5 then can we then go back and ask Staff to put together a
6 plan based on.

7 MR. WILL: I have a question. It's about the
8 geographic piece, and through this conversation we've been
9 talking about geographic scope for a pilot. We've also
10 been talking about the geographic scope or distance that
11 you can move beds. When you say, "Do we have consensus
12 that it is statewide," do you mean the pilot would be
13 statewide, or you mean that you could move beds from Cairo
14 to Evanston?

15 CHAIRMAN WAXMAN: Both, that the pilot would
16 be statewide and the beds could be moved statewide.

17 MR. WILL: I believe they are separate issues.
18 I wanted to flag that. I was unclear about it.

19 CHAIRMAN WAXMAN: Okay. I will take it apart.
20 Is there agreement that the pilot should be statewide?

21 MR. PICK: Yes.

22 MR. PHILLIPPE: I agree with that.

23 CHAIRMAN WAXMAN: Okay. So we have consensus
24 that the pilot should be statewide. Do we have consensus

1 that the beds could move statewide?

2 MR. PHILLIPPE: I would like to talk about
3 that for a while.

4 MR. WILL: I would as well.

5 MR. PHILLIPPE: One thing is, they have that
6 in Missouri, but Missouri is a very different state than
7 Illinois. Something that makes Illinois a unique state --
8 from a person who lives downstate -- the Chicago metro area
9 is so different from the downstate area, and my guess is,
10 some markets in the growing suburbs must be the places
11 where people want to add beds, because downstate they're
12 mostly trying to figure out -- they either want a new
13 building in a market because they have the advantage of a
14 new building, or they're just downsizing their building to
15 private rooms, because there's not too many people -- I
16 have some buildings, but there's not too many people
17 downstate that have issues with their building being full.
18 So, I think it's going to change the dynamic, really,
19 because you're talking about moving beds mainly from north
20 Chicago -- it sound like an issue too, but you could be --
21 I mean, it changes them. It brings the price down. The
22 advantage of having statewide move is the price of the bed
23 drops. The bigger the area, the more supply is out there,
24 the more the price will drop, and especially if you're

1 making a deal with moving beds from Sangamon County to
2 Chicago. Like, "I don't care; I'll sell them; take them to
3 Chicago." I mean, really, people will think that way. So
4 the question is, is that what we want? Do we want a bigger
5 area like Ohio, a big area but not the whole state? That's
6 all.

7 MR. PICK: I can tell you that there are
8 excess beds in the Chicago area as well. So, I don't think
9 it's limited to the rural versus the urban. Again, I'm
10 advocating for that's why it's a pilot. Let's see what
11 happens.

12 MS. MITZEN: We can stop that.

13 MR. PICK: Right. We can adjust that, after
14 we see if indeed it has unanticipated -- unintended
15 consequences that -- we're pre-determining that we want to
16 limit how many we're going to allow to happen, so we can
17 watch for that and make the adjustments, and I don't
18 disagree that it may be prudent for us to look at north of
19 I-80 or south of I-80 as just two gross areas or something
20 more finite than that, but it would seem to me, again, it's
21 premature at this point to pre-determine whether those
22 dynamics are there or whether we just perceive them to be.

23 MR. GALASSIE: You'll get a lot of comment
24 from Public Health on this issue, a lot of comment. This

1 will be one of their key issues that they'll hone in on,
2 being concerned about a two-tier system, being concerned
3 about the beds being sold from rural coming up to urban.

4 The other issue -- so I can give you a bit of
5 reality check -- for the 6 months/100, the CON Board meets
6 every other month, and we have about 20 on the agenda. So
7 why don't you just say 25, instead of scaring everybody
8 away with 100.

9 MR. PHILLIPPE: Good advice.

10 MR. GALASSIE: Just practical.

11 MR. CONSTANTINO: We're going to have you sign
12 off on them, Dale.

13 MS. MITZEN: I have a practical question
14 also. How much time do these deals take? I mean, if we're
15 talking about a time limit of six months, how long does it
16 take for these things to play themselves out so that we
17 would have data to actually look at?

18 MR. PHILLIPPE: Years. Really, it takes
19 years. I'm doing this in Ohio. It's in process of making
20 the deal. You can make deals within 6 months, but, really,
21 the process of -- because I'm doing this with a campus we
22 manage in Ohio. The owner is doing it, but you have to
23 have a plan first. How are you going to use the beds? You
24 have to go out and look with somebody that kind of helps

1 broker deals. You've got to get something -- and then
2 you've got to get it to the Department and have them
3 approve it. It's going to take years for the first idea of
4 doing it until the time that unit is open.

5 MS. MITZEN: So, when would we be able to
6 learn something from the pilot?

7 MR. PHILLIPPE: You would know within a year
8 how many people are interested in it, wouldn't we?

9 MR. SULLIVAN: In my mind, you would announce
10 it like in July -- January 2012 -- I'm sorry -- January 1st
11 2013, you announce it. July you start taking applications,
12 to give people the time to --

13 MR. PICK: Yeah, so the point I'm going to
14 make, it depends on what your measurement points are. If
15 the measurement is from the inception, it is years. From
16 the point of an application being made and submitted, to it
17 being processed here, six months, I think, is a reasonable
18 time frame, because as Dale said -- 25 applications
19 processed in a 6-month period seems to me to be a realistic
20 number, and I think Terry is exactly right. If it goes --
21 if it's announced in January, it's the following July where
22 the very first application would realistically be able to
23 show up, and that might be even early, and then once we
24 accept the first, then we say 6 months or 25, it may

1 actually be 10 in the first 6 months, because --

2 MR. PHILLIPPE: But then on the pilot, what we
3 would learn is the volume, the price, where the beds are
4 moving. Beyond that, we wouldn't know. We wouldn't know
5 the impact.

6 MR. PICK: Those are the three things we want
7 to know anyway.

8 MR. PHILLIPPE: The important things we want
9 to know.

10 CHAIRMAN WAXMAN: And what they're going to do
11 with them, what the buyer is going to do with the beds and
12 what the seller is going to do with the money. That is the
13 criteria we're really looking for. So I think the pilot
14 time frame would make sense.

15 MS. CREDILLE: Mike, you said the
16 parameters -- the seller has to put it back in a building.
17 Otherwise we're just creating somebody a free lunch in the
18 Caribbean.

19 CHAIRMAN WAXMAN: No, no. Either they reduce
20 their mortgage -- a percentage can go to reduce their debt,
21 because that would save them operating money and make them
22 financially sounder, or they have to improve their
23 facility. They can't put it in their pocket.

24 MR. GALASSIE: And does the sale and the

1 purchase have to be linked in coming through the CON or
2 limited CON process?

3 MR. FOLEY: Yes.

4 MR. GALASSIE: So, I can't just come in to
5 sell?

6 MR. SULLIVAN: No. They come in together.

7 MR. PICK: There has to be a match.

8 CHAIRMAN WAXMAN: In other words, we're not
9 going to allow Mike Waxman to start inventorying and
10 selling them at a later date.

11 MR. SULLIVAN: That will be on the stock
12 exchange.

13 (Laughter)

14 CHAIRMAN WAXMAN: No one can become an
15 investor in beds and distribute them at a later date.

16 MR. PICK: Actually, Chuck, what you were
17 saying earlier is running through my head now. If I need
18 money to sprinkle and I have these extra beds, that's a
19 solution to my problem. I'll sell the extra beds to fund
20 the improvement. Otherwise, I'm going to lose my whole
21 building.

22 MR. FOLEY: That's what I was hoping.

23 MR. PICK: August 13th is the deadline. It
24 doesn't mean that it is going to be extended. It's likely

1 it will.

2 MR. FOLEY: We have five years now to do this?
3 The latest I heard is that's a drop date.

4 MR. PICK: That's what they say, until the
5 bankruptcies are showing up. They don't want to push it
6 back, because they want to get it done. So, I think that
7 this offers the whole system an opportunity to allow for
8 these corrections, which it's good in many, many different
9 dimensions.

10 CHAIRMAN WAXMAN: You said there were over 200
11 facilities that have not complied yet?

12 MR. SULLIVAN: That are --

13 MR. PICK: With sprinklers.

14 MR. SULLIVAN: Not totally sprinklered, and
15 that's where the issue comes in. There are very few
16 facilities that are totally unsprinkled. Many of them have
17 them throughout the system, but the term "fully
18 sprinklered" is defined, and you have to have a sprinkler
19 head in the closet, and you have to have a sprinkler head
20 on your overhead hang on the facility, and if you have a
21 shed connected to the building, you have to have a
22 sprinkler connected to the shed, and a lot of the systems
23 have everything sprinklered -- and in the freezer -- don't
24 ask me why -- but all of that -- those 200 facilities, most

1 of them are not fully sprinklered. The trouble is, you
2 can't just break into an existing system and add a line to
3 the closet without weakening the system. So, there may be
4 a lot of facilities that have to totally replace the
5 system. That's where the expense comes in.

6 MR. PICK: More than 200.

7 CHAIRMAN WAXMAN: So we're talking about over
8 20 percent of the buildings.

9 MR. SULLIVAN: Um-hum. And there's the
10 question of, you may be sprinklered, but on August 13th,
11 say, the surveyors come in and there are two closets where
12 there aren't sprinklers. Now, does the facility shut down
13 because of that? At the moment, that's CMS's position. If
14 you're not fully sprinklered, you're closed. That's
15 la-la-land fantasy and lawsuits up the wazoo.

16 CHAIRMAN WAXMAN: Will the State make these
17 inspections, or CMS?

18 MR. SULLIVAN: No, the State will, our
19 esteemed, knowledgeable life safety --

20 MR. FOLEY: These are all being done during
21 our annual survey. They're not going to be cited until
22 December. Then they get a plan of corrections, and they
23 have to submit their POC. So you're into 2014 already.

24 MR. PICK: Even if your plan of correction is

1 that you're going to install the sprinklers, you get 12
2 months to do the job. So, if I'm cited on August 2013 --
3 and that's assuming that everybody is getting surveyed in
4 August. That's not what happens. So, the reality is my
5 annual is in October. They show up in October, and I'm not
6 fully sprinkled. I get cited by Life Safety. I now am
7 submitting a plan of correction, saying we're going to do
8 new construction. That means I have to submit plans, get
9 them approved. I have 12 months to do them. So, again,
10 the drop-dead is CMS saying they may not extend the date
11 anymore. There's still a whole sequence of things that
12 have to happen.

13 MR. PHILLIPPE: We are putting conditions on
14 this that maybe some states may not have, but they require
15 enforcement, I assume, right? There has -- right? Like
16 we're talking about how people spend the money. Then they
17 have to come back and report to somebody on how they spend
18 the money, and somebody has to inspect that, I assume, to
19 make sure it's true, to verify, and do we -- is that going
20 to be onerous?

21 MR. FOLEY: That's a good question.

22 MR. GALASSIE: Yeah, like Claire said, there's
23 a ton of things to be shaken out of this shed. It's the
24 broad brush right now. You're feeling you're in the 8th

1 inning.

2 MS. KENDRICK: We work on the honor system
3 with regard to post-permit reporting.

4 MR. PHILLIPPE: We learned that in an earlier
5 meeting.

6 MR. PICK: Much to our surprise.

7 MR. PHILLIPPE: That you can just willy-do
8 anything you want after you get approved, because nobody
9 checks you, basically. I don't know if that's good or bad.
10 I just, as public policy -- this is my bias. I don't like
11 having laws that are not enforced.

12 CHAIRMAN WAXMAN: We're an honorable facility,
13 so there is nothing to worry about, Tim.

14 MR. PICK: I think it goes back to a buyer and
15 seller. In order to qualify to participate in this
16 process, they have to demonstrate good compliance history,
17 that they're citizens in good standing. Well, then we
18 should accept their attestation, that they're -- all of a
19 sudden, because of this, they're not going to change their
20 stripes. But I agree with you. I mean, we do need to have
21 some -- even if it's random, that you pull one or two just
22 to verify, particularly in a pilot --

23 MS. MITZEN: This is a pilot. This is
24 something else that we need to be testing, I think. I

1 mean, that's -- we have to demonstrate that it's -- that
2 there is some accountability here.

3 MR. GALASSIE: If I might just -- the
4 Legislature created this very robust CON, revised process.
5 Now, in that provision, there is also a directive to
6 establish -- what's the institute?

7 MS. AVERY: The Comprehensive Center for
8 Planning or something -- Center for Comprehensive Health
9 Planning.

10 MR. GALASSIE: It hasn't been funded, but if
11 it were, this is exactly the place where that pilot would
12 be reviewed and studied. It would be a wonderful place for
13 it to start.

14 MR. GALASSIE: That point will be made with
15 the Legislature, as things go forward.

16 CHAIRMAN WAXMAN: We're heading towards two
17 o'clock, so I'd like to get some closure on this one issue,
18 if possible, which is to allow the Staff to come back to us
19 in October with a plan for a pilot. I think we now agree
20 that the -- we're looking at statewide, 25 or 6 months,
21 whichever happens faster.

22 Are you gentlemen comfortable saying that the
23 beds can move statewide, or do you want to define it
24 differently for the pilot?

1 MR. SULLIVAN: Let's go statewide.

2 MR. PHILLIPPE: It's only 25.

3 MS. MITZEN: And then we'll reevaluate it.

4 MR. WILL: Just listening. The reason I

5 wanted to tease it out, I thought it was worth discussing.

6 Also, what I heard is that statewide would make sense for

7 some market reasons on a trial sake, that would be

8 reluctant to sell to a potential competitor in a geographic

9 area, and Tim saying that some of the problems that we want

10 to address deal with dynamics that are over, you know,

11 major part of the state, mainly central Illinois and the

12 Chicago metro, for example, which makes sense. You know,

13 the one reason that I wanted to flag it is, it seemed just

14 intuitively that we would then want to watch for what it

15 did in terms of access, the impact on access, and there's

16 an argument that you would want to do the pilot statewide,

17 do it in a way that if it created access issues, it was

18 something that you could clearly admit to people, by

19 agreeing to the pilot statewide, that you would look at

20 that rigorously, address it where it came up, and just see

21 if that happened. I haven't heard anyone say -- like, some

22 of these areas that we could look at would, you know, make

23 sense to be -- like, if we drew these lines, we could get a

24 handle on minimizing access issues. There are other things

1 in -- and this, I think, goes into what the proposal would
2 be with Staff, because I think Claire said at the
3 beginning, there are other things there that would help to
4 be safeguards on the access question, the question of
5 Medicaid certification, things like that.

6 MR. GALASSIE: Can I just ask -- it would seem
7 to me as though for us to give the charge to the Staff
8 right now to come back to the next meeting with just a
9 rough concept of how this might work, without having had
10 discussion on seller requirements and buyer requirements --
11 I'm not sure how they're going to put flesh and bones -- it
12 seems to me as though this body needs to have its next
13 discussion, going point by point through seller and buyer.
14 If you disagree, say so.

15 CHAIRMAN WAXMAN: Unless we let them assume
16 that those are buyer -- seller/buyer requirements.

17 MR. URSO: With all of the discussion you've
18 had so far on every point, I can't believe you could make
19 an assumption.

20 CHAIRMAN WAXMAN: Point well taken, Frank.

21 MR. PICK: I think what I heard earlier, not
22 in this discussion, but, I think, when we were on the
23 conference call, is that there are currently, for CON
24 applications, requirements for the applicant in order to be

1 a qualified applicant, that we use those same criteria for
2 this rather than trying to create new criteria, use the
3 same background of the applicant to be the same for this as
4 we do for CON, and that way, we're not having to reinvent
5 the wheel.

6 MS. CREDILLE: This is very simplistic. Why
7 can't that be between the buyer and the seller? The buyer
8 can buy and the seller wants to sell.

9 MR. PICK: Here's the reason you can't:
10 Because if you're in a de-cert track, I'm going to sell
11 beds, and we don't want buildings that are being
12 de-certified.

13 MR. SULLIVAN: Why not? And I have that
14 question of -- if I'm in de-cert and I need to sell beds in
15 order to upgrade and get back into certification, why not
16 sell some of those beds?

17 MR. PICK: My bias is that we don't want to
18 promote the solution to -- in fact, we don't want to
19 promote operators running buildings into the ground,
20 getting to the point of de-cert, having no intention to
21 clean it up, and just sell off as many beds as they can and
22 then sell what's left to anybody who is willing to buy it,
23 because they're not willing to take the time and invest the
24 money and really make a commitment to improve things.

1 MR. SULLIVAN: But if I need money to turn
2 around my facility --

3 MR. PICK: Then you should be doing that long
4 before you're in a de-cert situation.

5 MR. SULLIVAN: What if I'm that facility that
6 you were talking about this morning?

7 MR. GALASSIE: I still need to get
8 clarification from Staff, before we leave this room, as to
9 whether or not you think it's of value to try to put
10 together how this thing would work between now and the next
11 meeting, or do you need for them to have this dialogue?

12 MS. BURMAN: I think it would be more helpful
13 to go through the whole thing first.

14 CHAIRMAN WAXMAN: All right. In that case, I
15 think we've done an awful lot of accomplishment on this
16 issue, but -- you want to raise one more issue?
17 Mr. Scavotto has Chaired a Subcommittee --

18 MS. AVERY: Before you leave, can I make a
19 suggestion real quick, that you give us in writing some
20 feedback on some of the questions you may have, and we can
21 probably have those ironed out by the next meeting, also.
22 So, if everybody will go through the document and send the
23 comments or questions or clarifications to Claire or
24 myself, I think that will make the next one run smoother.

1 like to join and help Mike -- first of all, do the two of
2 you still want to hang and be part of the process?

3 MS. CREDILLE: I mean, I've had limited --
4 we've had some e-mail exchange, and we haven't done
5 anything -- Mike has sent an e-mail, but we haven't done
6 anything past the last decisions that were made.

7 MR. SCAVOTTO: That's right.

8 CHAIRMAN WAXMAN: So, I know Mike is anxious
9 to get the issue done, so he's looking for some help to do
10 that process. So, yes, no?

11 MS. HANDLER: I'm really not that available
12 right now. I have a couple of big projects at work, so --

13 CHAIRMAN WAXMAN: Okay. Are you interested?

14 MS. CREDILLE: Yeah.

15 CHAIRMAN WAXMAN: Anyone else in this group
16 like to become part of that group?

17 MR. PICK: I can help out.

18 CHAIRMAN WAXMAN: Anybody else?

19 MS. BURMAN: I would just like to comment that
20 since a lot of unresolved issues that are tagged as changes
21 to the application, these are really rule changes, and part
22 of the big agenda for this group is to amend the existing
23 rules. We might want to just approach it as a whole group
24 and everybody can look at the rules and make a list of all

1 of the things they think need to be changed.

2 CHAIRMAN WAXMAN: Mike, your feeling?

3 MR. SCAVOTTO: Well, that's up to you. You
4 appointed the Subcommittee. If you want to continue that
5 process, fine. If you don't, that's your call.

6 MR. PICK: I would suggest work as a working
7 committee and then bring -- because this is such a huge
8 undertaking as a group, we'll be mired in this for decades.
9 So, I think as a small work group, we can work -- we can
10 deal with the smaller stuff and bring to the group what are
11 the major issues that we need the whole group to work
12 through, and then it will accelerate the process.

13 CHAIRMAN WAXMAN: So, again, if any of you
14 decide you want to, contact Mr. Scavotto. If you do a
15 conference call, I will be there, too. All right. We will
16 gather --

17 MR. URSO: Are we going to get into the Open
18 Meetings Act situation? That's what happened last time
19 with Tim's subcommittee.

20 CHAIRMAN WAXMAN: Okay. I won't be on the
21 call.

22 MR. PICK: We can't have more than four.
23 There can't be more than four members on this call, right?
24 We get over four -- Chuck, you don't count towards that

1 four.

2 MS. BURMAN: Do you want Staff involved,
3 because Staff wouldn't count.

4 MR. PICK: Staff won't count.

5 MR. PHILLIPPE: Remember what I learned. If
6 your group gets larger than the subcommittee of 10, it
7 ceases to be functional.

8 MR. PICK: Yeah, it's not a work group
9 anymore.

10 MR. GALASSIE: I'd like the record to note
11 that Juan did not get his 50 words in.

12 CHAIRMAN WAXMAN: He didn't say a thing.
13 We're not leaving the room until he speaks.

14 MR. MORADO: Adjourned.

15 CHAIRMAN WAXMAN: Again, I'd like to thank all
16 of you for coming. I think it's been a very, very
17 productive meeting. I apologize that we were missing a
18 person to make a quorum. We will send out a telephone
19 date, as we did last time.

20 MS. AVERY: But you all decided on the date
21 before we left.

22 CHAIRMAN WAXMAN: So, before we leave, can we
23 pick a date to try to get a quorum, please?

24 (Discussion held off the record.)

1 CHAIRMAN WAXMAN: We are going to have a
2 conference call on August 28th at 10:30, the purpose of
3 which will allow us to have a quorum and approve the agenda
4 for today's meeting, the minutes for today's meeting, and
5 the bylaw changes. Staff will have to help us to make sure
6 we get 12 members that are needed to make the quorum.

7 And, also, for the record, I would like to
8 please include that we thank Dale for joining us today and
9 spending the day with us.

10 MR. GALASSIE: My pleasure.

11 CHAIRMAN WAXMAN: It's been educational for us
12 to learn more about what he is looking at from the CON
13 Board. Please know you can come any time you like.

14 And thank you all for coming, and we will meet
15 again on October 9th and a conference call on August 28th.
16 Thank you again.

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18 END TIME: 1:59 P.M.

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CERTIFICATE OF REPORTER

I, KAREN K. KEIM, CRR, RPR, a Certified Court Reporter in the States of Illinois and Missouri, do hereby certify that the proceedings in the above-entitled cause were taken by me to the best of my ability and thereafter reduced to writing; that I am neither counsel for, related to, nor employed by any of the parties to the action, and further that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.



KAREN K. KEIM
CRR, RPR, CSR-IL, CCR-MO

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