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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 SUBCOMITTEE  
MEETING

The meeting of the State of Illinois Health Facilities  
and Services Review Board, Long-Term Care Advisory  
Subcommitee was held on April 23, 2013, scheduled to begin  
at the hour of 10:00 a.m., at Bolingbrook Golf Club, 2001  
Rodeo Drive, Bolingbrook, Illinois.

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1 MEMBERS PRESENT:

Michael Waxman - Chairman

2 Cece Credille

Carolyn Handler

3 Greg Will

Phyllis Mitzen

4 Terry Sullivan

Tim Phillippe

5 Toni Colon

6 ALSO PRESENT:

Frank Urso - HFSRB Legal Counsel

7 Juan Morado - HFSRB Legal Counsel

Courtney Avery - HFSRB Staff

8 Mike Constantino - HFSRB Staff

George Roate - HFSRB Staff

9 Cathy Clarke - HFSRB Staff

Claire Burman - HFSRB Staff

10 Nelson Agbodo - HFSRB Staff

Bill Dart - DPH

11 Charles Foley - healthcare consultant

John Florina - nursing home administrator

12 Cathy Nelson - LSN

Leslie Green - LSN

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16 Reported by:

Karen K. Keim

17 CRR, RPR, CSR-IL, CCR-MO

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1     START TIME:   10:09 a.m.

2

3                   CHAIRMAN WAXMAN:   Thank you all for coming.

4     I hope none of you are suffering any water damage.

5                   We are one short of a quorum.  The two people  
6     that we are expecting to be quorum and over, one is ill and  
7     the other one we don't know where she is.  So maybe she'll  
8     show up.  So we'll continue through the agenda, doing what  
9     we can.  We just can't take a vote at the moment.

10                   So, if we can do a roll call, I think the  
11     easiest way is to simply identify ourselves for the Court  
12     Reporter.  Is anyone here for the first time?

13   (Pause)

14                   CHAIRMAN WAXMAN:   Nelson is.

15                   For people who haven't been here before,  
16     please, to help the Court Reporter, identify yourself when  
17     you speak, so that she -- I know she knows most of us but  
18     doesn't know all of us.  Especially if you haven't been  
19     here before, she doesn't know you at all, so you need to  
20     help her.

21                   Terry, can we start with you?

22                   MR. SULLIVAN:   Sure.  Terry Sullivan, Alliance  
23     for Living, and the Illinois Nursing Home Administrators  
24     Association.

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1                   MS. CREDILLE: Cece Credille, Illinois  
2 Healthcare Association representative.

3                   MS. MITZEN: Phyllis Mitzen, Health and  
4 Medicine Policy Research Group.

5                   MS. HANDLER: Carolyn Handler, Rainbow Hospice  
6 and Palliative Care.

7                   MR. FOLEY: Charles Foley, healthcare  
8 consultant.

9                   MR. FLORINA: John Florina, licensed nursing  
10 home administrator.

11                   MS. BURMAN: Claire Burman, Board Staff.

12                   MR. WAXMAN: I'm Mike Waxman, Chair.

13                   MS. AVERY: Courtney Avery, Board Staff.

14                   MR. URSO: Frank Urso, counsel to the Board.

15                   MR. CONSTANTINO: Mike Constantino.

16                   MR. DART: Bill Dart, Department of Public  
17 Health.

18                   MR. AGBODO: Nelson Agbodo.

19                   MS. AVERY: Nelson is the new person with the  
20 Board. His position is in Springfield, but he's on the  
21 Board Staff, not IDPH, and he is our Data Manager. So he  
22 replaced -- all of you who knew Bob Green and Anu Meka, he  
23 replaced them.

24                   MR. PHILLIPPE: Tim Phillippe, Christian

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1 Homes.

2 MR. ROATE: George Roate, Illinois Department  
3 of Public Health.

4 MR. WILL: Greg Will, SEIU.

5 MS. GREEN: Leslie Green, LSN guest.

6 MS. NELSON: Cathy Nelson, LSN guest.

7 MR. MORADO: Juan Morado, Jr., Board Staff.

8 CHAIRMAN WAXMAN: I guess we're not going to  
9 go around again. So, we did everybody.

10 This is Greg's first meeting as an official  
11 member. So, welcome, Greg. Everybody knows Greg. He's  
12 been subbing for someone else. So -- but he's been here  
13 religiously -- maybe "religiously" is not the right word,  
14 but he's been here regularly.

15 Also, I was just informed that this is your  
16 last meeting, so we're going to miss you. Do you want --  
17 can I share or do you want to share where you're going?

18 MR. MORADO: Sure. This is going to be my  
19 last -- I'm going over my word limit first, Mike.

20 (Laughter)

21 MR. MORADO: This is going to be my last  
22 meeting with the Long-Term Care Sub-Committee. I recently  
23 accepted a position in the Governor's office as an  
24 Associate General Counsel, and I'll be starting there May

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1 1st.

2 (Applause)

3 MR. MORADO: It's been a pleasure working with  
4 you all. Thank you.

5 CHAIRMAN WAXMAN: So it had nothing to do  
6 with Frank being your boss?

7 MR. MORADO: Frank is a great boss.

8 MR. FOLEY: You don't have to lie.

9 MR. MORADO: I think fondly of our time.

10 CHAIRMAN WAXMAN: Our quorum is parking her  
11 car, so we'll be in good shape then.

12 Okay. We can skip to Item 5.

13 MR. URSO: Okay. I think most of the  
14 people -- thank you -- have completed their ethics  
15 training. We still have a couple of outstanding people. I  
16 won't mention their names and put them on the spot, but  
17 they need to get their ethics training materials back as  
18 soon as possible, their certification of completion; but I  
19 want to thank the people that have completed their ethics  
20 training. You did a great job.

21 CHAIRMAN WAXMAN: Okay. Thank you, Frank.

22 Mike Scavotto is not here. Cece, do you have  
23 anything on the --

24 MS. CREDILLE: We don't have an update.

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1                   Courtney, I know you sent a document late  
2 yesterday evening that I didn't even have the opportunity  
3 to review. So we do not have an update.

4                   MS. AVERY: Well, the last meeting that was  
5 scheduled, we had to cancel it, but we never rescheduled  
6 it. So he was waiting on a document to be sent, which we  
7 thought had been sent. We put the information in a  
8 different format and sent it in one document. So I'm  
9 assuming you all will probably discuss that and schedule  
10 another meeting before our next -- we just consolidated the  
11 information into one document.

12                  CHAIRMAN WAXMAN: Okay. Do we have another  
13 meeting scheduled?

14                  MS. AVERY: No. You all decide the schedule  
15 as you go.

16                  MS. CREDILLE: And we've typically done it all  
17 via conference call. It's been Eli and myself and Mike,  
18 relating -- it's the CON application review.

19                  CHAIRMAN WAXMAN: Is Mike okay? Do you know  
20 why he isn't --

21                  MS. CREDILLE: He sent me an e-mail late  
22 yesterday evening that he would not be able to attend, and  
23 that's all.

24                  CHAIRMAN WAXMAN: All right.

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1                   We need to move on to Item 7, Long-Term Care  
2 Reforms Discussion, addressing under utilization of  
3 long-term care beds. Courtney, are you leading that or do  
4 you have documents or --

5                   MS. AVERY: I sent the document, the  
6 attachment --

7                   CHAIRMAN WAXMAN: Okay. We'll go back.  
8                   Toni, as soon as you settle in, would you  
9 identify yourself, please?

10                  MS. COLON: Sure. Toni Colon, DPH.

11                  CHAIRMAN WAXMAN: And, Toni, you do make the  
12 quorum, so now I can go back and do some things we didn't  
13 do earlier on. So I need a motion to approve the agenda.

14                  MR. PHILLIPPE: So moved.

15                  CHAIRMAN WAXMAN: Need a second.

16                  MS. CREDILLE: Second.

17                  CHAIRMAN WAXMAN: All in favor?

18                               ("Ayes" heard)

19                  CHAIRMAN WAXMAN: Any opposed?

20                               (No response)

21                  CHAIRMAN WAXMAN: Okay. Approval of the  
22 agenda is good. I also need a motion to approve the  
23 February 19th meeting transcripts.

24                  MR. PHILLIPPE: (indicating)

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1                   CHAIRMAN WAXMAN:   Need a second.

2                   MS. HANDLER:   (indicating)

3                   CHAIRMAN WAXMAN:   All in favor?

4                   MR. SULLIVAN:   Discussion?   There are two  
5 things I noticed in the transcript.   One, on page 121, I  
6 had just -- was talking about the 15,000 beds and was  
7 calling it a "confiscation of beds", to which Ms. Kendrick  
8 said, "You wouldn't call that confiscating beds", to which  
9 the transcript then says I said, "You wouldn't", period, as  
10 if it implies that I was agreeing, when, in fact, the  
11 statement was more like, "You wouldn't?", more like a  
12 sardonic, rhetorical question followed by three or four  
13 question marks.   So, rather than indicate agreement, I, in  
14 fact, was not indicating agreement.   So I would like to, at  
15 least, have the transcript reflect not a period, but at  
16 least one question mark following my statement.   That was  
17 the first one.

18                   CHAIRMAN WAXMAN:   Can we do that?

19                                   (Discussion held off the record.)

20                   MR. SULLIVAN:   The second one was on page 119,  
21 and I remember doing this in my head.   We were talking  
22 about the impact of the bed tax upon reducing 15,000 beds,  
23 of which I quickly went in my head of 15,000 beds times  
24 \$6.00 times 300 and came up with 70.5 million.   That was





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1                   CHAIRMAN WAXMAN:    Does anyone have a feeling  
2    that, on this list, there are some possibilities that don't  
3    work at all and we can eliminate them and move on to others  
4    that seem to be more useful or more efficient?

5                   MR. SULLIVAN:    In the CON Review Criteria  
6    Amendments, 3 and 4 -- C3 and C4 -- I'm sorry to say, I  
7    don't quite understand what it is a solution to.  Like, 3  
8    is no moratorium, no buy/sell program; and if no one wants  
9    to sell beds -- well, if we don't have a buy/sell program,  
10   how is somebody going to be selling or buying beds?

11                  MS. AVERY:    I think there's some confusion for  
12   us that comes into play, is that those two issues seem to  
13   be meshed together -- the selling of the beds, the  
14   buy/sell/exchange program -- and what we can do for  
15   addressing the under utilization of beds in Illinois.  So I  
16   think it kind of gets a little cloudy when we mix in both.  
17   So, if possible -- I mean, if there is a consensus here  
18   that the two need to be looked at, then fine, and we'll  
19   just try to figure out how to address both with the one  
20   issue, or separate them out.  So I guess we need to figure  
21   out how we want to look at it.  Do we want to tie them  
22   together; do we want to keep them as separate issues?

23                  MR. SULLIVAN:   I think, certainly, the three  
24   issues -- should we have a moratorium, should we have a

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1 buy/sell program, and if we have a buy/sell program, what  
2 if somebody doesn't sell beds -- I think there are  
3 certainly three different discussions. I don't -- you  
4 know, linking them together makes a more complicated  
5 process, because somebody can be in favor of a buy/sell  
6 program but not in favor of a moratorium. So the question  
7 is, do we argue moratorium first and then if a moratorium,  
8 do we have a buy/sell program, and if we have a buy/sell  
9 program, do we want to have a provision if somebody doesn't  
10 sell -- I mean, if somebody can't buy beds? So in my mind,  
11 there are three progressive discussions, but I don't know  
12 if I would automatically link them. That's my opinion.  
13 That's not a strong one.

14 CHAIRMAN WAXMAN: And I think Courtney raised  
15 a good issue, and that is, are these issues that we should  
16 discuss separate and draw some conclusions about them  
17 separately, or do they need to be linked? I mean, in my  
18 mind I think they're separate, but -- Tim?

19 MR. PHILLIPPE: I see them as separate issues,  
20 because, really, it depends on how you -- but there's  
21 relationships. Like what would happen if nobody would sell  
22 beds or transfer beds? That really is mostly determined by  
23 how the program is set up. Because if the buy/sell program  
24 is set up statewide, then it just becomes a market issue,

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1 really, and the question is, what are the beds worth and is  
2 it worth buying beds to build in the state of Illinois in  
3 the location where somebody wants to build? So it just  
4 becomes an issue. So I don't think they necessarily have  
5 to interact.

6 CHAIRMAN WAXMAN: So then, just to move things  
7 along, can we start our meeting or start our discussion on  
8 the whole issue of moratorium and talk in that direction.

9 Mr. Foley?

10 MR. FOLEY: I guess to start it off, the  
11 reason why we're here in the first place, is in terms of a  
12 long-term care subcommittee, and, obviously, a moratorium  
13 would not be practical, as I see it, at least at this stage  
14 of the game, that it would be advisable to maybe down the  
15 road see what happens in the industry in general, how  
16 Managed Care is going to come into play and everything  
17 else, which we don't know anything about that just yet.  
18 But for right now and to move along, I think we should  
19 maybe just take out the issue of a moratorium and just look  
20 at the other issues.

21 CHAIRMAN WAXMAN: That's an opinion.

22 Terry?

23 MR. SULLIVAN: I don't have a strong opinion  
24 about a moratorium from my public policy point of view.





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1 currently, right?

2 MS. COLON: Well, they're going to many  
3 different locations. What we're finding is that they are  
4 transitioning into the community, back into the families.  
5 They are not necessarily being transferred back to a  
6 licensed facility.

7 CHAIRMAN WAXMAN: Okay.

8 MS. COLON: So it's very difficult to  
9 determine what those numbers are.

10 CHAIRMAN WAXMAN: Thank you.

11 MS. HANDLER: I was going to say -- plus, I  
12 think if a facility closes, whatever unoccupied beds they  
13 have are going to come out of inventory.

14 CHAIRMAN WAXMAN: And I quickly jumped,  
15 assuming if you came out of a nursing home, you would go  
16 into another nursing home, and Toni obviously has better  
17 information than I do. So, -- Cece?

18 MS. CREDILLE: The moratorium, I'm assuming,  
19 is predicated upon the fact that the bed-need formula that  
20 exists today is not what we would consider and -- because  
21 we've leaped to moratorium, which must mean we all agree in  
22 the room that the State is over-bedded and the current  
23 bed-need formula must be flawed, because the bed-need  
24 formula indicates there is a bed need in some areas. So

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1 I'm a little conflicted that our first agenda item here is  
2 moratorium.

3 MS. AVERY: They're not listed in any order of  
4 importance. That's just a coincidence. Maybe I should  
5 have put them in alphabetical order. But they're not  
6 ranked at all.

7 MS. CREDILLE: But is that what the assumption  
8 is?

9 MS. AVERY: No. This is to generate a  
10 discussion for you all. No assumptions.

11 MR. SULLIVAN: Can I suggest that even though,  
12 legislatively, this committee has been tasked with making  
13 recommendations to the Board about long-term care policy,  
14 probably from my experience with the associations, this  
15 committee is probably not going to reach a consensus about  
16 a moratorium. That's not an issue that you're ever going  
17 to have consensus, in total agreement. It's something that  
18 generally gets imposed in each of the states by the  
19 Governor's office or the legislative leaders that say "This  
20 is going to be our solution, whether you like it or not".  
21 And then everyone sort of adjusts to it. But I don't know  
22 if this committee is going to be able to say, "Yes, we'll  
23 take a vote, and we'll vote by five to three that we should  
24 have a moratorium" or not. And I don't know what the Board

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1     does with that. I think at some point, if the Governor's  
2     office and the Department want to do a moratorium, you go  
3     ahead and you do it; and "thank you for asking our  
4     opinion", but you're not going to get a clear answer from  
5     this committee, I think.

6                   CHAIRMAN WAXMAN: So, Frank, does the concept  
7     of moratorium mean that the law has to be passed?

8                   MR. URSO: I think ultimately. Ultimately, it  
9     would have to be considered. I think maybe moratorium  
10    should be defined. There could be different levels of  
11    moratorium, different periods of time for moratorium. I  
12    think you need to qualify moratorium. So I think that  
13    might need to be part of the discussion on what kind of  
14    impact is this term "moratorium" actually going to have,  
15    and I think the impact will be created by the definition  
16    that you all agree to, all agree upon. Claire and  
17    Courtney, I think, mostly were talking about the  
18    moratorium. Is there a definition that we can toss out  
19    there that, you know, might lead to an understanding of  
20    what is meant by "moratorium" in this context?

21                   MS. BURMAN: Generally, it means you don't add  
22    any more beds in the inventory. That's the generic, but --

23                   MR. FOLEY: That's period? 20 bed 10 percent  
24    won't --

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1                   MS. BURMAN: Right. But you can tweak it, if  
2 you will. So, like in Ohio, they have a moratorium;  
3 they've had it for a long time, but you can still get beds,  
4 because they have a buy/sell program. That's the only way  
5 you can get beds in Ohio, is through the buy/sell program,  
6 and you are allowed in Ohio to use the beds you purchase to  
7 open a new facility. Some states that have a buy/sell  
8 program only allow adding beds as needed to your facility  
9 and not opening a new facility with those beds. So,  
10 there's any number of ways that you can tailor it to what  
11 you think the need is.

12                   CHAIRMAN WAXMAN: Thank you.

13                   Tim?

14                   MR. PHILLIPPE: I don't want to make it sound  
15 academic, but I'm going to, I guess, in a way, because the  
16 moratorium really depends on what our goals are for the  
17 state. For example, a lot of -- when we just talk about  
18 beds as if a bed is a bed is a bed, it sounds like  
19 gasoline. You know, when I was young, my father would only  
20 buy Standard or whatever, because he said their gasoline  
21 was so much better than anybody else; and I came up in a  
22 generation that no, gasoline is all about the same, it's  
23 all about price. However, I don't think that long-term  
24 beds are a commodity. They're not all exactly the same.

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1     There's a standard of care that is expected out there and  
2     is supervised by CMS and the State, and it's not all the  
3     same.

4                     And one of the difficulties we have is, most  
5     of the beds are not providing what the consumer wants. The  
6     consumer wants private bedrooms with private baths. Just  
7     ignore, kind of, staffing and other things; just talk about  
8     the facility. And so it doesn't -- so we're not really  
9     thinking about what the citizens -- consumers want if we  
10    treat every bed the same. And also I think there are  
11    providers -- and probably Terry is familiar with some on  
12    the LSN side -- who would like to have room for innovation,  
13    to say if you're freezing it, then that means we cannot  
14    build anything new. So that would be a concern. So, if  
15    the moratorium is -- by itself what it does do is protects  
16    current providers, in a sense, in the market, but it does  
17    not really allow for innovation to meet consumer need and  
18    changes really. And so it depends on our goals. If we're  
19    trying to just protect the providers, we do one thing. If  
20    we're trying to kind of continue to innovate and allow  
21    opportunity for new services, then we go a different  
22    direction. So I personally do think that the moratorium  
23    makes sense, as long as we have a very open buying and  
24    selling of beds. That seems like it's a compromise in the

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1 middle. It still allows for innovation, for new programs,  
2 for new facilities, but does it in a way that doesn't make  
3 it too expensive to buy the beds.

4                   CHAIRMAN WAXMAN: I think, if I have an  
5 understanding of our years of discussions around this  
6 table, it is that we, as a committee, have a consensus that  
7 we are looking for innovation in programs; we want  
8 operators who are providing good services to continue and  
9 increase those services, as well as to make sure that there  
10 is the needed beds for Public Aid recipients to have. So,  
11 I guess I think I'm agreeing with you, that moratorium that  
12 just says "no more beds" is not anything that we, as a  
13 group, have ever talked about, because of the things that  
14 you have defined, that we do want innovative programs, and  
15 I think the market is driving us towards innovative  
16 programs. I think the fact that Toni is aware -- and  
17 probably all are in some level -- that some homes cannot  
18 make it economically anymore kind of points out that the  
19 market conditions are doing what market conditions are  
20 supposed to do, which is, you know, help people decide  
21 where services are going to be provided. So, I think -- I  
22 guess what I'm hearing is that there is some agreement at  
23 this committee that moratorium is not something that we  
24 would advocate. Can I assume that?

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1                   MR. PHILLIPPE: As a stand-alone.

2                   MR. SULLIVAN: As a stand-alone. I think Ohio  
3 is probably a good model with the buy/sell program, is that  
4 the buy/sell program is most effective when you have a  
5 moratorium, although I personally never advocated linking  
6 it, because the moratorium in and of itself is pretty  
7 controversial. I wouldn't want the buy/sell program to  
8 sink because it's linked with a moratorium.

9                   CHAIRMAN WAXMAN: So what you're suggesting is  
10 that the direction we should take is to, if possible,  
11 define buy/sell/exchange program, and under that criteria,  
12 include or not include a moratorium as part of that?

13                   MR. SULLIVAN: Um-hum, I would lean that  
14 direction.

15                   MS. CREDILLE: I would too.

16                   CHAIRMAN WAXMAN: Okay. Is that a consensus  
17 opinion.

18                   Cathy, as an LSN rep, what are you thinking in  
19 terms of that discussion?

20                   MS. NELSON: I think what Terry said makes a  
21 lot of sense.

22                   CHAIRMAN WAXMAN: Don't agree with Terry.

23                   MS. NELSON: Don't agree with Terry? I'm  
24 inclined to do so today.

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1                   MR. WAXMAN:  Claire?

2                   MS. BURMAN:  I just had a question, because  
3 I'm probably not an expert in long-term care, but if we're  
4 talking about entering into new programs to provide these  
5 services, is a new facility going to be required in all  
6 cases?  Do you really have to have a new facility, or does  
7 someone who has an existing facility renovate enough to  
8 provide the new approaches?

9                   CHAIRMAN WAXMAN:  Absolutely.

10                  MS. BURMAN:  So that would not entail adding  
11 beds, because they already have beds.

12                  CHAIRMAN WAXMAN:  It may entail adding new  
13 beds to that facility, because what we're all aware of,  
14 certain facilities in certain locations have the ability to  
15 provide very sophisticated or higher acuity level services,  
16 and people are looking for that.  So there could be a home  
17 next door that's not as well equipped -- staff wise,  
18 training wise -- and therefore, the demand is there and  
19 that building has filled, as people want to be in that  
20 facility because of the training.  So again, even though a  
21 building may have 200 beds and 200 occupied beds, they may  
22 need more beds because they are creating the programs that  
23 people are looking for or need.  There's no doubt that  
24 people are coming out of the hospital sicker than ever







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1                   MS. CREDILLE: No. We have -- I don't want to  
2 be misquoted, but we have 15 facilities in downstate  
3 Illinois in very rural areas on the Manor Care side.

4                   CHAIRMAN WAXMAN: I wasn't aware of that. So  
5 you have the same issue?

6                   MS. CREDILLE: Yes, we do.

7                   MS. MITZEN: What might be the impact,  
8 though, on those Medicaid beds and the need the State has  
9 for maintaining a certain level of Medicaid beds that  
10 people will need?

11                  MR. PHILLIPPE: I will give you my bias. This  
12 is clear bias.

13                  MS. MITZEN: I like your bias.

14                  MR. PHILLIPPE: What somebody said earlier is  
15 I know at times there's access issues for Medicaid, and  
16 people say they don't certify all of their beds for  
17 Medicaid and so they may have empty beds. However, in my  
18 experience downstate -- excepting Chicago, which I don't  
19 know well -- downstate I hear people arguing sometimes  
20 about building a new building for Medicaid or new beds for  
21 Medicaid, but when that is built, they are not serving  
22 Medicaid, because they cannot afford to serve Medicaid. I  
23 mean, it's just a practical -- and I've heard some  
24 presentations on that. But if you look at the rates

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1     downstate you have to operate on and what it costs per  
2     capita, you know that rates are very good and capital is  
3     good. I just don't think people are building new buildings  
4     for Medicaid residents downstate.

5                   MS. MITZEN: I guess it's the new buildings  
6     but also the selling. I mean, if we are selling beds, are  
7     we selling Medicaid beds?

8                   MR. PHILLIPPE: It just increases the cost.  
9     One way to think about it, if I'm going to expand my  
10    building rather than coming -- I've got two choices, let's  
11    say. I can come to the Board, I can go through the cost  
12    and the expense of getting new beds approved, or I can buy  
13    the beds. Well, if I buy the beds at, say, eight or  
14    \$10,000.00 a bed -- like happened recently in Cincinnati  
15    that I know of -- then that's another expense on top of the  
16    building of the facility. So personally, I think it would  
17    be very difficult to build new facilities, to buy beds, to  
18    borrow money, and build for Medicaid. I just think it's a  
19    practical issue.

20                   MR. FOLEY: The only way you could do that,  
21    obviously, is contra to what you were saying earlier. You  
22    cannot build a private facility, i.e. all private rooms; it  
23    all has to be all public rooms.

24                   MR. PHILLIPPE: Very efficient.

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1                   MR. FOLEY: Right. In a compact facility, and  
2 you would not be able to provide the programs, the  
3 innovative programs, that you want to.

4                   MS. MITZEN: I get that. I mean, I  
5 understand what you're saying, because you're talking about  
6 it from a business sense. You've got to look at what is in  
7 the best interests of your business model. But I guess  
8 from a state's perspective, don't we have to ask about that  
9 access question of, do we have the beds that we need to  
10 provide access to those people who can't afford to pay the  
11 private pay rates but need that level of care? And is  
12 there -- I mean, where does that enter into this  
13 conversation?

14                   MS. COLON: I think you make a very good  
15 point. Conducting a needs assessment. That's something  
16 that we can look at doing, potentially. I hear your  
17 concern regarding the disparity around the state, maybe  
18 city areas versus rural. But that's a very, very good  
19 question. I don't have the answer to that, but I think  
20 it's worth looking into. But then again, I hear what Tim  
21 is saying. Operationally, once we have the data, can you  
22 operationalize that? Are you going to make the investment  
23 when it's going to create a day-to-day challenge to  
24 maintain and sustain that operation, is the question. I

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1 think it's a double-edged sword.

2                   CHAIRMAN WAXMAN: Following up with something  
3 Chuck and I were talking about -- actually, Chuck's  
4 concept, when we were walking in -- if we're going to  
5 project out a year or two the change in Managed Care and  
6 the switch to Managed Care and Obama Care, what aspect is  
7 that going to have -- are you throwing your hands up?

8                   MR. SULLIVAN: I don't think that anyone  
9 knows, but there's no question that making major changes to  
10 the system, just as we are about to come into major change  
11 to the system, there are going to be unintended  
12 consequences that I don't know if anyone can predict. I  
13 mean, we can hire a great statistician and time liner to  
14 figure it out, but I think they're going to go, "Good  
15 guess".

16                   Responding to Phyllis, I think at the moment,  
17 the access issue is something we pay attention to.  
18 Although, with 20,000 empty beds in the state, a Medicaid  
19 client may not be able to go to the nursing home they want  
20 to, but generally they're going to find a nursing home.  
21 You know, maybe sometime in the future, particularly if we  
22 significantly reduce beds in the state, access will be  
23 maybe an issue. But generally a Medicaid client can find  
24 service in most parts of the state.

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1                   MS. MITZEN:    I recognize that that's the case  
2   now.  I guess -- but I'm thinking about the discussion that  
3   we're having and the incentives that we're providing in  
4   this discussion, and I raise the issue of --

5                   MR. SULLIVAN:  On the reverse side of Tim, who  
6   also said that, yes, if I have to buy an \$8,000 bed just to  
7   build a bed, that increases the cost for that, but it also  
8   puts capital into the other side of the system to modernize  
9   and upgrade existing facilities and have private rooms.

10                  CHAIRMAN WAXMAN:  I think the whole concept of  
11   access is going to be different in a Managed Care world,  
12   because now the potential resident or Managed Care person  
13   is going to have to go to wherever the Managed Care  
14   organization has a contract with.  So they will not be able  
15   to pick and choose where they want to go anyway.

16                  MR. PHILLIPPE:  I just wanted to -- what Terry  
17   said, I think we do know where it's going to go with  
18   Managed Care.  We don't have the statistics, but we know it  
19   has happened in other states.  We know Managed Care  
20   companies are not doing this business as a gift to the  
21   State of Illinois.  So what do we know?  They're expected  
22   to keep costs flat or reduce expenses to the State.  They  
23   will make money, because they're publicly-traded companies  
24   or privately.  They have to make money.  And they're going

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1 to add overhead into the system. And what does Managed  
2 Care always do when they come into a market? They reduce  
3 institutional care, you know, and they move funds typically  
4 from institutional care to outpatient, home-based, if  
5 they're good, dependable companies, and they are more  
6 flexible with their funding, because it's easier for them  
7 to shift money. And I used to do this back in the older  
8 days, when I was still walking uphill maybe to school and  
9 back. It's been a long time, but the fundamentals are  
10 still the same. They're trying to move people out of  
11 institutional care. What do we know from all of us who are  
12 experiencing Managed Care today? Our length of stay on  
13 Medicare Advantage are much shorter than they are for the  
14 Medicare program, because they're aggressively saying they  
15 won't pay any more, and people sometimes are going straight  
16 from our building to the hospital again, because the family  
17 chooses. But whatever the issue is, it's not a right or  
18 wrong. I'm not trying to give a value judgment here. It's  
19 just that is what they do.

20                   If you're saying, Toni, that buildings close  
21 and people are going to continue to be home and community  
22 based. They are not only using nursing homes. That's more  
23 fodder, really, for the whole concept that more people  
24 could be treated at home, and Managed Care is going to try

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1 to do that. It's just what they do. So I do think we will  
2 find from the -- at least -- there's a lot of other issues,  
3 but from the volume issue, there's not going -- they will  
4 reduce institutional care, and some of it will come from  
5 the hospital to long-term care, but I think more -- it will  
6 still be more than balanced from pushing people out of  
7 long-term care to home, daycare treatment programs and  
8 other community-based programs. That's just what they do,  
9 isn't it?

10 MS. MITZEN: Yes.

11 MR. SULLIVAN: You're not wrong.

12 MS. MITZEN: And the opportunity for  
13 innovation, which may include the nursing facilities.

14 MR. PHILLIPPE: Yes. That's what I did. I  
15 did it years ago, a long time ago now, and it was kind of  
16 cool. I thought this was fun. I got this big pot of  
17 money, and we're wasting all of this money on the hospital  
18 side and people are leaving the hospital and they get a  
19 doctor's appointment. Three, four weeks later they're  
20 bouncing back to the hospital before they see their doctor.  
21 I'm like, I got this big pool of money, I'll just create  
22 what they need. The very next day, we put people in  
23 intensive outpatient programs and day-treatment programs.  
24 We reduce hospital spending by huge amounts of money and we

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1 added, really, outpatient services, basically. And I think  
2 good companies still do that, don't they?

3 MS. CREDILLE: It will be interesting in  
4 Illinois, though, because we're second to last in  
5 reimbursement. So, the states that have already done this  
6 have had much richer reimbursement, and so there is money  
7 to be had. It will be interesting to see how much this  
8 system can squeeze out of a ranking of 49 out of 50 states  
9 for Public Aid reimbursement, because what we see in our  
10 organization for Manor Care is that the State can't get  
11 home health providers to contract. We can't get -- they  
12 can't get doctors to see the patients, because the  
13 reimbursement is so poor already. So they're trying to  
14 contract, and people don't want to contract.

15 MR. PHILLIPPE: True.

16 MS. CREDILLE: Which is different than the  
17 experience that these Managed Care companies have had in  
18 other states, because I've met with several of them. They  
19 say, "This isn't what's happened in other states." I said,  
20 "Well, it's our reimbursement." So it will be -- again, it  
21 goes back to whoever has said, we don't really know,  
22 because really the dynamics in Illinois are different  
23 because of our reimbursement situation and then our debt  
24 situation, that it may make this even more interesting in

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1 Illinois. It goes back to we don't know what's going to  
2 happen to our bed need and where the patients are, and  
3 families are, going to be placed.

4 MS. HANDLER: It is true about the physicians.  
5 They're having a really difficult time building their  
6 medical network; and it's all founded on the concept of  
7 medical homes. So those primary care physicians are really  
8 key to the Medicare managed program in Illinois, and I  
9 don't think it's off to as strong a start as they were  
10 expecting or hoping.

11 MR. PHILLIPPE: One thing I wanted to pass  
12 along, as long as we were talking about access to Medicaid  
13 beds, there is -- if there's an issue with Medicaid access  
14 and somebody wants to come and add capacity in a market for  
15 Medicaid, that could be a good thing, I think; but then  
16 they should be held accountable for doing that, for not --  
17 they should not be able to come to meetings and say they're  
18 doing that but then not do that when they actually open  
19 their facility; and if we could do that and build that in  
20 somehow to the rules in the process, that could be a good  
21 thing. If people are able to come do it and there's an  
22 access problem and they build exactly for that and that's  
23 the people they build for, that would be a good thing.

24 CHAIRMAN WAXMAN: Isn't that part of the CON

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1 application process, that when people build special need  
2 nursing homes that we are now able to go back and verify  
3 that they really have --

4 MS. AVERY: We do it as much as we can.  
5 Recently that have certified that they will have a certain  
6 amount, and we've held them to it. So we're working with a  
7 few now. But I can't say that we've gone back and caught  
8 everyone that said they would do so, that they would have a  
9 certain percentage, unless it's called to our attention  
10 that they have not done so. And usually that's how we  
11 follow up, if someone complains that they can't find  
12 Medicaid-licensed bed, then we go and follow up and find  
13 out. "You stated on the record that you would do blah,  
14 blah, blah and you haven't done that." And one recently  
15 that we caught are working to have their beds certified  
16 now.

17 CHAIRMAN WAXMAN: Tim?

18 MR. PHILLIPPE: I was just going to say,  
19 certified is not always the same as people in the beds,  
20 though.

21 MS. AVERY: Right.

22 MR. PHILLIPPE: Certified beds -- I mean, in a  
23 legal way, you cannot have people in the beds --

24 MS. HANDLER: Right.



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1 I would assume in a case like that, you would have to come  
2 back before the Board, I would think; I would hope.

3 MR. URSO: Your client?

4 MR. FOLEY: No.

5 (Laughter)

6 CHAIRMAN WAXMAN: I don't think he would  
7 advise any clients to do that.

8 (Laughter)

9 MR. PHILLIPPE: Could I just mention something  
10 more personal? I guess it's a personal example as we think  
11 on the issues. When I came into the field, I was kind of  
12 naive. I came to Illinois twelve years ago, very, very  
13 naive in the field, and I would have people come to me from  
14 other markets. One was, I think, in Mt. Vernon, downstate.  
15 So there would be multiple providers, and the community  
16 people, who are churches typically, was wanting something  
17 new, and being naive, my idea was, then I'll just go buy  
18 the worst nursing home in town who is running 50 percent  
19 census, and I'll just tear it down and build a new one, and  
20 they said, "Oh, no, no, no. It's not that simple in the  
21 state of Illinois." You know, but if I could do that,  
22 that's innovation; just tear down something old, you build  
23 something new. But it's quite a long process. It's not a  
24 simple process. So we decided not to tackle it.

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1                   CHAIRMAN WAXMAN:  When in doubt.

2                   I guess what I'm sensing is that we can  
3 probably put aside the whole concept of moratorium then off  
4 this list, because it almost sounds like some of us believe  
5 that the market itself will help regulate the number of  
6 beds and where they are, and we don't really need a  
7 moratorium to make that happen.  Is there some agreement to  
8 that, or do we still need to discuss the concept of  
9 moratorium?

10                  MS. CREDILLE:  Well, if it's going to be  
11 imposed on us, like Terry is discussing, there's no point  
12 in discussing it.

13                  MS. AVERY:  Imposed by who?

14                  MS. CREDILLE:  Its going to come from a  
15 legislative act.

16                  MS. AVERY:  Today, we're going to figure out  
17 how to do it.  It's not going to be imposed on the  
18 long-term care industry.  There seems to be this thought  
19 out there in the industry that the Board is just going to  
20 push something through legislative-wise.  The Board is not  
21 planning to push anything through that does not come from  
22 this committee, within reason.  It's not going to be  
23 imposed.  We are hoping we get a consensus; that's why we  
24 have this meeting.  We're trying to get something that you

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1 all send to the Board that the Board can work with. It's  
2 not going to be imposed or forced on anybody  
3 legislative-wise. That is not the Board's agenda. I don't  
4 know where that information is coming from.

5 MR. SULLIVAN: Courtney, can I ask the  
6 Staff -- the Committee leaning towards a moratorium is  
7 probably not a good idea at the time -- at this time,  
8 particularly what we're going to be heading towards in the  
9 next couple years, although this is -- I don't think we're  
10 pounding our fists on the table and saying no moratorium.  
11 I mean, I think if it came in, we'd all adjust. But I  
12 guess I'm asking the Staff, are you comfortable with the  
13 discussion we've had, or is there a stronger feeling among  
14 the Staff that we need to do something proactive to reduce  
15 beds, or at least -- a moratorium doesn't reduce beds, but  
16 they are being reduced on a regular basis anyway.

17 CHAIRMAN WAXMAN: Right.

18 MR. SULLIVAN: Are you comfortable with that?

19 MS. AVERY: We're comfortable with whatever  
20 comes out of the committee, within reason, that we could  
21 take back and say this is what we're focusing on and this  
22 is the direction that the long-term care subcommittee is  
23 going in.

24 MR. SULLIVAN: Okay.

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1                   MR. PHILLIPPE: I think there's advantages to  
2 a moratorium, so I'm not totally against the moratorium.

3                   MR. SULLIVAN: I don't disagree.

4                   MR. PHILLIPPE: I think as long as we have  
5 some avenue for innovation, and that could easily be bed  
6 buying and selling, and then you're making the system more  
7 efficient, because, clearly, you know, if buildings are  
8 operated at 60, 70 percent, they're not very efficient.

9                   CHAIRMAN WAXMAN: Right, and I think what we  
10 talked about earlier or mentioned is that moratorium could  
11 be a piece of buy/sell/exchange program and not a  
12 stand-alone concept. So I guess I'm just asking if we have  
13 agreement on that so we can move into some other  
14 discussion, so that we can say, as a single concept, this  
15 committee does not advise the Mother Board to look at  
16 moratorium as a solution.

17                   Do we need a vote on that issue? Or you have  
18 agreement of consensus by heads nodding all in favor? Is  
19 that all you need to move it, to be comfortable with that  
20 concept?

21                   MS. AVERY: Yeah. I don't think it has to be  
22 a formalized vote, but I also wanted to reiterate that one  
23 of the issues that the Board is faced with and applicants  
24 are faced with when they come to the Board and their

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1 applications get denied, is that applicants are saying --  
2 again, I've said this almost every meeting -- there is a  
3 need because these beds are not set up and ready to go if a  
4 patient presents themselves at the doors of some of these  
5 nursing homes, the long-term care facilities. So the Board  
6 is turning down applicants -- who are upset -- and saying,  
7 "there is a need, there is a need". These beds do not  
8 exist, but in our inventory they exist. So that's the  
9 whole purpose of what we want to do, is to get our  
10 inventory accurate, see where there is a legitimate need.

11 MR. WAXMAN: So it appears -- I don't know  
12 what we can do as a subcommittee. I may be missing  
13 something. Your list under Item B, "Accurate Bed Count",  
14 is very, very significant.

15 MS. AVERY: Well, early on there was  
16 discussion about the bed formula, the bed need, how we're  
17 counting beds; and we kind of moved away from that with the  
18 issue of buy/sell legislation that came up last year  
19 pertaining to the buy/sell and exchange program. So we  
20 kind of lost focus on that. Remember, we had a list of  
21 priorities. So we lost that.

22 CHAIRMAN WAXMAN: Well, I would suspect  
23 everyone at this table agrees that we need an accurate bed  
24 count, and I guess that then goes back to one of Frank's

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1 issues, is we have some definitions of what is a bed and  
2 how do we count it.

3 Mr. Foley?

4 MR. FOLEY: I think our biggest issue that  
5 goes round and round and round is without any solution, and  
6 that is that we're hearing out there that a provider cannot  
7 reduce their bed count because it could, in fact, affect  
8 your loan, be it a commercial loan or be it a HUD loan. So  
9 we're hearing all kinds of stories out there and that it  
10 does affect and it doesn't affect. I mean, we're -- I'm  
11 hearing clients out there saying that, you know, it's just  
12 a matter of bottom line, it's not a matter of how many  
13 licensed beds you have, it's a matter of bottom line.

14 Other people are saying, no, my bank said or HUD has told  
15 me that we can't without going through a change, if you go  
16 through a change. You talk about a HUD application, one  
17 gentleman at the last meeting said, to my recollection,  
18 that it could cost thousands of dollars -- I think he gave  
19 the figure of \$50,000 -- to hire an attorney just to change  
20 all of the paperwork at HUD if you go from a 100-bed  
21 facility down to a 50-bed licensed facility.

22 MR. PHILLIPPE: I'll give him a card for my  
23 attorney.

24 MR. FOLEY: Excuse me, but I believe that is

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1 what was said the last time.

2 MS. AVERY: I'm not questioning that, but  
3 logically, I cannot figure out how that works. If you're  
4 licensed for 100 beds, but you changed your rooms to single  
5 room occupancy and those beds are now gone, where does the  
6 discrepancy come in? You're not generating any revenue  
7 from those beds, so how does it tie back to your financing?  
8 Your financing, is it based on the beds that you have  
9 operational and you've taken those beds out informally?  
10 How does it tie back to it? I'm not making a connection  
11 here.

12 MR. FOLEY: You know, again, I think we're  
13 getting different answers. I guess I can't really answer  
14 that, because -- I'm sorry. Go ahead.

15 MS. HANDLER: We don't operate beds, but we  
16 have a loan. So, when we executed our loan application, we  
17 have loan compliance requirements. We have to report on a  
18 regular basis. So here's a change in our business. If  
19 there's a change in the business, the bank wants to know  
20 about it. Right? So if the conditions under which they  
21 approved our loan changed, then it could impact the bank's  
22 continuing confidence in our ability to deliver on the loan  
23 obligations. So, if these facilities have loans that were  
24 founded on or related to a bed count -- a licensed bed

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1 count -- and that condition changes, whether or not it  
2 really, truly changes their ability to meet their loan  
3 obligations, it changes the documents under which you  
4 applied for that loan. Even if you buy a house, you know,  
5 most people when they buy their home, there's a stipulation  
6 in the loan documents that require you to occupy that  
7 property for a certain period of time. You can't apply for  
8 the loan as a resident of that property -- that mortgage,  
9 and then not live in it, because you aren't -- I mean, you  
10 can, but it's not -- I don't want to say it's not legal,  
11 but obviously you're not complying with the loan document  
12 requirements.

13                   So, I think that's what I'm hearing, and I  
14 don't know how long-term care loans are approved, but it  
15 sounds like licensed beds may be, in some cases, part of  
16 that application process.

17                   CHAIRMAN WAXMAN: Well, you know, from an old  
18 banker's perspective, what you're looking at is: How do  
19 you generate revenue in a long-term care facility? It's  
20 putting a body in a bed. The body in the bed generates X  
21 amount of dollars, depending upon who is paying for that  
22 bed. So, the percentage of beds that are going to be  
23 reimbursed by Medicare dollars generates a lot more dollars  
24 than a Medicaid, and somewhere in the middle of that or

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1 above that is your private pay. So there is a formula  
2 that, you know, every nursing home goes through in  
3 projecting their budget in which you are projecting what  
4 percentage of your beds are going to be occupied. Then, of  
5 that number, because you can never project a hundred  
6 percent -- I did once, and I got killed in a presentation  
7 when they said, "Did you forget about male/females?" I  
8 said, "Oh, yeah." So you can never fill a hundred percent  
9 of your beds, no matter what you do, because they never  
10 come through the door the right way. So you're never going  
11 to have a hundred percent occupancy, but then you pick your  
12 occupancy and then you take that occupancy and divide it  
13 between your payor sources, and they're all -- which makes  
14 healthcare so unique in that there are a hundred different  
15 rates, depending on what clientele you're serving. So,  
16 anytime you mix or impact your original formula of how you  
17 arrived at your revenue and therefore your profit, it  
18 impacts the ability to borrow or what they believe you are  
19 borrowing on.

20                   So that's, I believe, where this gets back to  
21 HUD and to the lending institution, because they've made  
22 their decision based upon the budget you projected. Bottom  
23 line is that no one really cares, as long as you make your  
24 payments. It's the moment you don't make your payment that

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1 everybody scrambles to look at what the application looked  
2 like, and then they start asking questions.

3 MS. HANDLER: Well, we have compliance  
4 reporting requirements. You're making your payments, but  
5 you have to follow certain requirements that you have to  
6 report in.

7 CHAIRMAN WAXMAN: And a lot of banks are now  
8 sending in third parties to do audits or reviews. It's  
9 getting more and more of that.

10 MR. FOLEY: At the last meeting, I thought  
11 Mr. Carvalho indicated that he was conversing with HUD  
12 personally to try to find the answer to see what impact it  
13 would have on a HUD loan, whether it should -- is that  
14 correct?

15 MS. AVERY: I know he met with them, but I  
16 don't know if that was the focus of the meeting. So I  
17 don't know.

18 MR. FOLEY: The issue came up at the last  
19 meeting, and that's when he made the comment, I thought,  
20 that he was meeting with HUD. You know, if it is the goal  
21 of this subcommittee to reduce beds in this state, maybe a  
22 possible solution for discussion would be to try to pursue  
23 this on a volunteer basis, maybe to have the State write a  
24 letter to each one of the nursing home operators in the

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1 state and explain exactly what it is the State is trying to  
2 do and why, and see if they would be willing to give up  
3 some beds. Obviously, you're not going to receive a large  
4 response, that they're going to give up hundreds and  
5 hundreds of beds, no. But I think in this letter, if  
6 there are problems as to why they cannot give up beds  
7 because of the loan descriptions, then I think, simply,  
8 maybe a letter from their lending institution would suffice  
9 to see whether or not they can or cannot give up beds.  
10 Maybe that's, you know, a possible -- I don't know.

11 CHAIRMAN WAXMAN: Phyllis?

12 MS. MITZEN: I was just reflecting on  
13 meetings that we had a number of years ago and, of course,  
14 the banking industry has changed since then. But we talked  
15 to them about the notion of beds and what the bankers said,  
16 and I think it's pretty much what you were saying, Michael,  
17 is that as long as the loan is being paid, they don't care  
18 how many beds you have. That wasn't the issue. The issue  
19 is, what is your business model, and they also talked about  
20 the partnership between the business and the banker and  
21 that as your business model changes, there shouldn't be any  
22 surprises and that -- so every time I hear the argument  
23 about the banks won't let us do that, I reflect back on  
24 that; and these were people at that time -- LaSalle Bank

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1 and --

2 MR. SULLIVAN: MB.

3 MS. MITZEN: Health and Medicine actually had  
4 a meeting before that meeting, but they were major banks,  
5 and I think they gave us the same message at both of these  
6 meetings, saying that the bankers are willing to talk about  
7 what your business model is and how are you going to pay  
8 the loan.

9 CHAIRMAN WAXMAN: Right.

10 Tim?

11 MR. PHILLIPPE: I understand the practical  
12 issue. The practical issue is we have unused beds and  
13 they're not being used in the community, and so there's an  
14 access issue. So it seems like a real issue. I don't  
15 think the banker issue is the major issue here.

16 MR. FOLEY: I don't either.

17 MR. PHILLIPPE: It varies across the board. I  
18 have multiple -- actually, it's just the opposite for me.  
19 Actually, I have -- on our bond holders, we have kind of  
20 conference calls twice a year, or whatever, with the big  
21 bond holders; and the last meeting, it was recommended by  
22 investment bank that we should actually put a footnote in  
23 and take those number of licensed beds off our report,  
24 because if they're not set up, it makes us look bad, and so

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1 the ones -- they're the ones that could be set up that  
2 we're not choosing to use currently at any one time, we  
3 needed the full space for whatever reason. They said just  
4 the opposite, actually. It makes you look bad because your  
5 census is lower. And so it probably varies across banks  
6 and all of that.

7 I think the practical issue for providers is  
8 that as long as we've been talking about buying and selling  
9 for four years -- it seems like it's got to be four, maybe  
10 it's five, really. I had hair back when we started the  
11 discussions. And I assume this is not a secret: People  
12 have been talking about this; and being a provider in  
13 Illinois is very, very hard, really. It's very hard. It's  
14 getting harder every year, and so if there is some way of  
15 bringing capital into the marketplace to help, people need  
16 it. And so my guess is, as long as we are talking about  
17 this for four years, and then people think they have an  
18 asset and then we're talking about taking the beds away, it  
19 changes the whole attitude, kind of. That's probably the  
20 biggest issue.

21 MS. CREDILLE: You can't buy/sell if you don't  
22 have any beds to sell. The concept goes away if the  
23 inventory is gone and you have no beds to sell; the concept  
24 doesn't make any sense.

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1                   MS. AVERY: Is that part of the motivation for  
2 providers to keep the beds and be under utilized?

3                   MS. CREDILLE: No, because we don't have a  
4 buy/sell option.

5                   MR. FOLEY: A year ago -- yeah, about a year  
6 and a half ago, this subcommittee made a decision, I  
7 thought, that, okay, let's go to the buy/sell concept on an  
8 experimental basis and let's pick a time period when  
9 applications would be filed and let's just see what happens  
10 and let's just learn from it.

11                  CHAIRMAN WAXMAN: There was discussion on  
12 that.

13                  MR. FOLEY: And still nothing has happened.  
14 So, I mean, if you're going to do it, let's just do it and  
15 set up some parameters and let's just do it and see if, in  
16 fact, it's going to work.

17                  CHAIRMAN WAXMAN: I think we kind of got  
18 bogged down as to whether we do it statewide or is that too  
19 big of a test area? Do we do it region-wise?

20                  MR. FOLEY: Well, that discussion, I thought  
21 we said, limit it to the county -- or the Planning Area,  
22 and then there was discussion about let's go out to the  
23 contiguous area; and because there are boundary lines where  
24 one facility could be across the street from another

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1 facility with a boundary line right in the middle, maybe  
2 let's go statewide. I mean, if it is the -- at least it  
3 was my understanding that we were going to talk about  
4 statewide so that would not have an impact on anybody  
5 locally, so if somebody wanting to build a facility in  
6 Chicago was able to buy beds downstate, it's not going to  
7 affect anybody.

8 MR. SULLIVAN: And I agree with Chuck. I  
9 mean, in my recollection it was the discussion that -- the  
10 test was going to be time oriented, of let's do it for a  
11 year and a half and let's do it statewide. I remember the  
12 discussion and who was sitting here.

13 And I more than agree with Tim. We have been  
14 talking about this for five years.

15 And, Courtney, you have applicants who say,  
16 you know, "There is a bed need in our area but you're  
17 saying we don't have a bed because the beds are not used."  
18 It would be great if you could say to them, "Well, why  
19 don't you go out and buy some beds and then you would be  
20 able to build what you want to build or whatever." But we  
21 can't do that right now. I guess we are reaching a certain  
22 level of tired frustration of, come on, let's try  
23 something. This -- I'm not advocating that a bed exchange  
24 program is the be-all and end-all of all of the problems

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1 that we deal with, but it certainly is not a bad step in  
2 the right direction that can help the system, can infuse  
3 some new energy and cash and some innovation in the system.  
4 I think there are far more up sides than down sides. I'm  
5 sorry. I think we've talked about it long enough.

6 CHAIRMAN WAXMAN: So then we have to define  
7 the terms of buy/sell/exchange.

8 MR. FOLEY: You have to make them on a ratio  
9 basis. The overall objective is to reduce beds. You can't  
10 make it on just a one-to-one, because all you'll be doing  
11 is shifting beds from one part to the other; you're not  
12 affecting a total statewide number. So they have to give  
13 up two beds in order to get one bed or three beds to get  
14 one bed, whatever number. Otherwise we're just moving beds  
15 across counties.

16 CHAIRMAN WAXMAN: Let's clarify our role. Our  
17 role is to make a recommendation to the Mother Board to  
18 implement a yet-to-be-defined buy/sell/exchange program,  
19 correct?

20 MR. URSO: The last statutory amendment was to  
21 evaluate the buy/sell program, evaluate, and ultimately,  
22 that would lead to -- after an evaluation is conducted,  
23 lead to recommendations to the Mother Board, I would think.

24 CHAIRMAN WAXMAN: So, is our discussion the

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1 evaluation process?

2 MR. URSO: The discussion is part of the  
3 evaluation process. I think you'd want more. That's just  
4 my thought.

5 CHAIRMAN WAXMAN: I'm just trying to figure  
6 out what this committee needs to do to put the test into  
7 place. Since there seems to be some agreement that we need  
8 to move forward with some action, and an action is to  
9 institute a test under certain a set of circumstances, how  
10 would we do that?

11 MR. URSO: Claire had something she wanted to  
12 say.

13 MS. BURMAN: As I recall when we had that  
14 major discussion about a buy/sell program and we were going  
15 through points of consideration, I thought it was decided  
16 to put together a pilot program for that, to test it out,  
17 not involve necessarily the whole state, but a pilot.

18 CHAIRMAN WAXMAN: Not to include the whole  
19 state?

20 MS. BURMAN: Yeah.

21 CHAIRMAN WAXMAN: But then you run into the  
22 problems of crossing county lines, city lines. Unless you  
23 do a whole state, I don't think it's going to work. I  
24 think the way -- I think the time limit gives it the test

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1 criteria. But I don't know that you'll have a true sense  
2 of accomplishment if you don't let the whole state  
3 participate. I don't know.

4 MR. FOLEY: The main issue that you're going  
5 to have is what beds can or cannot or will not be  
6 available. They may have thirty unoccupied beds. Again,  
7 they may be there for a reason. It may be that they don't  
8 want to de-license those beds for whatever reason. So I  
9 think what we need to do -- at least my opinion is to --  
10 you know, we got the information in the profiles that shows  
11 the potential number of available beds out there by  
12 facility and I think, you know, having an applicant contact  
13 facilities -- but, my gosh, the timing in doing that and  
14 trying to get a response, I think people are just going to  
15 get frustrated at the same time and say forget about it,  
16 it's not worth it; because by the time you have to rely on  
17 somebody to respond back to you, you've got an option on a  
18 piece of property, whether it's an addition to an existing  
19 facility or build a new facility. Those options are very,  
20 very expensive, obviously.

21 And so I don't know if there's going to be a  
22 quick way of doing this or not, but I think that needs to  
23 be taken into consideration.

24 MS. AVERY: It might go back to another

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1 comment in more of why we need an outside party to help us  
2 with this process. If the bed sell and exchange program is  
3 in place, what I'm hearing, it would have an implication or  
4 an impact on HUD loans, because still you have to go  
5 through their process of providing the documents and  
6 everything else if you sell the beds. So, it's still going  
7 to cost you money, even if you are participating in the bed  
8 sell/exchange program, because those documents have to be  
9 changed on both ends, correct, the buyer and the seller?

10 MR. FOLEY: I assume so.

11 MS. AVERY: So that to me still leaves  
12 questions why we should not rush into this. And I feel  
13 your pain. I feel everybody's pain. I'm so tired of  
14 discussing it. But every time we meet, something else  
15 comes up, and we don't have the power to look at it, which  
16 again gives the argument for an outside party to come in  
17 and help us. And there's no need to rush into it, in my  
18 opinion, and as the Administrator of the Board, to rush  
19 into this process when we don't know all of this; we can't  
20 just rush. "How are we going to do this?" "Florida's  
21 looking at some other issues." It's just -- we can't just  
22 say, "Oh, it worked there, it will work here"; and I'm  
23 hearing more and more reasons of other things. My list is  
24 getting longer and longer of what impact this would have on

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1 the providers and the residents of the state of Illinois.

2 MS. CREDILLE: Can I ask for clarification of  
3 what happened on the letter that was sent out?

4 MS. AVERY: It was sent out -- I looked at the  
5 letter yesterday. I neglected to put a due date to say  
6 that we needed a response by this date, because it occurs  
7 that we only have one response. So, tomorrow I will start  
8 following up on the universities that we sent them out to  
9 and say, "Are you interested or not", we say that "We have  
10 not heard back from you, and if you are not, we will move  
11 on." And if they are, I will add them to the list to send  
12 out to the RFP work group to look at. But the letter has  
13 been sent out. I just forgot to say please respond by  
14 blah, blah date. So I'll follow up on it tomorrow.

15 CHAIRMAN WAXMAN: It seems to me that as part  
16 of this concept of buy/sell/exchange, we still need to know  
17 an accurate count of beds, and, Mr. Constantino, how do we  
18 do that, other than we each take 10 nursing homes and go  
19 physically count? How do you --

20 MR. CONSTANTINO: Well, we thought the easier  
21 way is we would just use the current occupancy of  
22 facilities over a two or three-year time frame -- the  
23 average occupancy over a two or three-year time frame, and  
24 use that as the basis for each individual facility, and

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1     then anything over that average would be considered excess  
2     beds. That's what we were trying to bring across at the  
3     last meeting.

4                   CHAIRMAN WAXMAN: So just let me play with you  
5     for a minute. If a building is licensed for 200 beds and  
6     if their average occupancy over the last three years has  
7     averaged 160, then you're going to say that facility has 40  
8     extra beds, 40 unoccupied beds?

9                   MR. CONSTANTINO: Yes.

10                  MS. AVERY: Let me say this really quick.  
11     Again, it goes back to -- we based that model on what we  
12     did for the hospitals, and maybe it wasn't the right model.  
13     Again, it's not a cookie cutter approach to it, but we  
14     thought that would be the easiest way, because we did  
15     something similar with the hospitals and they -- the  
16     majority of them complied with it.

17                  MR. CONSTANTINO: Something else we did with  
18     the hospitals, we required the hospitals to hire an  
19     architect to count beds. Because it's costly, we didn't  
20     think the long-term care folks would want to go along with  
21     that program.

22                  MR. SULLIVAN: You need to be an architect to  
23     count beds?

24                  MR. CONSTANTINO: That's what we did for the

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1 hospitals, an architect or an engineer. The hospital had  
2 to hire them and they would attest to the number of beds in  
3 that facility.

4 MR. SULLIVAN: Mike, you can go into the  
5 bed-counting business.

6 CHAIRMAN WAXMAN: I was going to say, you can  
7 hire a third grade math teacher to do that.

8 MS. MITZEN: And you did that because you  
9 wanted an outside --

10 MR. CONSTANTINO: Right.

11 MS. MITZEN: You did not want it to be  
12 self-reported. So that's the issue. It's self-reported.  
13 So it may not be an architect. You need to have an outside  
14 counting.

15 MR. CONSTANTINO: CPA firm?

16 MR. SULLIVAN: Again, using the example, Mike,  
17 in terms of how beds are used, you have a 200-bed facility  
18 where the average occupancy for the past three years is 160  
19 or 80 percent, which is pretty close to reality; but at  
20 various times of the year, that facility will be filling  
21 180, maybe 190 beds. I mean, I think we saw from the  
22 various analyses that was done before, most facilities do  
23 operate at 90 percent at some peak periods during the year.  
24 So those beds do get used, but the average occupancy





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1 feedback from long-term -- from the long-term care  
2 industry.

3 CHAIRMAN WAXMAN: I think the difference,  
4 though, if I can guess, is that the margins are so small,  
5 so short in long-term care, they couldn't afford to pay an  
6 outside group to come in and do anything. So, hospital  
7 margins are probably a little longer and they could afford  
8 a fee.

9 MS. MITZEN: How do we get away from this lack  
10 of trust in the numbers that we're basing all of our  
11 decisions on?

12 CHAIRMAN WAXMAN: Good question.

13 MR. PHILLIPPE: I've got a question. I don't  
14 understand --

15 CHAIRMAN WAXMAN: We're looking for answers.  
16 You don't have any questions.

17 MR. PHILLIPPE: I don't understand State  
18 processes, because we have State people in our buildings,  
19 right? At least once a year, people -- and I don't want to  
20 add to their workload. They've got plenty to do, but  
21 they're already in there.

22 MS. COLON: To count beds? We go in and we  
23 verify your census, and again, we have to keep in mind that  
24 that's a snapshot view. And as Terry identified, is it a

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1 peak time? Is it not a peak time? And it could change the  
2 next week, depending on what occurs within the facility. I  
3 guess it -- I guess the bigger question is, as we get this  
4 data -- and we can report it up to whoever is inquiring. I  
5 guess that's an avenue, but I'd like to continue the  
6 discussion regarding our current mechanism for reporting  
7 and why is that such a challenge? Why is there such  
8 push-back related to reporting actual utilization within  
9 facilities? Because it seems that is the number one  
10 barrier to receive that correct information. Is there a  
11 possibility to develop some type of mandated reporting  
12 mechanism for facilities that are choosing -- because it's  
13 an option, that are choosing to shelf, bank their beds, so  
14 that we have real information to work with? Because we're  
15 charged with making such big decisions and/or  
16 recommendations, and we don't have good information  
17 currently to drive those decisions, and I think that that's  
18 something that we should possibly address, is how do we get  
19 this information.

20                   You know, the Department, from the survey  
21 perspective, can support getting this information during  
22 annual inspections. That's a component, but it's not the  
23 end all. It's part of the verification process. But we  
24 also have to push this back to the facilities and say, "You





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1 least know the peak days for every facility that files a  
2 Medicaid cost report, which is 870 facilities. There may  
3 be some, you know, non-certified licensed facilities that  
4 don't file a cost report, but the other one that everybody  
5 does file is the \$6.00 -- the Provider Tax, the \$6.07  
6 Provider Tax, and you report your occupancy for the month,  
7 and you get a good sense of, at least, the peak month times  
8 if you want. And probably, HFS could modify that to say,  
9 "And what was your highest occupancy day during the month?"

10           And so the data -- there are formats that  
11 would not take much modification that could collect  
12 peak-time data without a lot of grief or extra reporting on  
13 everyone's part; and the cost report, the accountant signs  
14 his license to it; and with the Provider Tax thing, you're  
15 basically threatened with sterilization if you don't  
16 accurately report it. I mean, you're definitely breaking  
17 the law, and, quite frankly, no one over-reports on the  
18 Provider Tax.

19           MR. PHILLIPPE: That's true.

20           MR. FOLEY: There's your answer, Michael.

21           CHAIRMAN WAXMAN: So how can this subcommittee  
22 implement the changes to the cost report form or the  
23 gathering of cost report information so we can get that  
24 information?



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1     may be on an individual facility-by-facility basis.

2                   CHAIRMAN WAXMAN:    But, I mean, we're  
3     theoretically only caring about the aggregate.

4                   MR. SULLIVAN:    Well, what the Staff get from  
5     applications is in the area that "I want to open up new  
6     beds".

7                   CHAIRMAN WAXMAN:    Point well taken.

8                   MR. SULLIVAN:    Although, again, that's always  
9     a statement that a new applicant will make.  I'm sorry I'm  
10    being a little biased there, but they're always going to  
11    complain about the existing providers not being totally  
12    forthcoming about what's occupied and what's not occupied.

13                   CHAIRMAN WAXMAN:    You're right.  So in the  
14    meantime then, do we go back and use Mike's formula to get  
15    a number that we can look at.

16                   Phyllis?

17                   MS. MITZEN:    My question is, do the people  
18    around the table, the people who know about this, agree  
19    that that kind of data analysis that Terry laid out for us  
20    will get us the information that we need?

21                   MS. AVERY:    It was just asked of Mike if that  
22    will help us, and we won't actually know until we see the  
23    report.  So,  --

24                   MR. DART:    But we'll be able to ask them what

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1 we would like to see.

2 MS. AVERY: What some of you are mentioning,  
3 it sounds like what we already collect on the survey. Is  
4 this self-reporting also?

5 MR. SULLIVAN: Cost Report is accountant  
6 certified, and the Provider Tax data is under threat of an  
7 awful lot of jail time.

8 MS. AVERY: And then my other thought is,  
9 looking at it, we'll have to figure out how it gets us to  
10 have an idea of what are the under-utilized beds. And then  
11 I am trying to find a report that Mike gave us that shows  
12 the number of accessed beds that we possibly have in the  
13 state, but I can't get to the drive.

14 MR. SULLIVAN: I think the Provider Tax  
15 reports, and I know that they've done some analysis because  
16 of all of the RUGs discussions on the reimbursement side.  
17 The trouble with the Public Health report is it's an annual  
18 one, whereas this would give you monthly data on every  
19 facility and occupancy during their highest month.

20 MR. CONSTANTINO: What does that report  
21 include, Terry? Is it based upon licensed beds?

22 MR. SULLIVAN: It's based upon occupied beds.

23 MR. CONSTANTINO: Does the report include  
24 licensed beds or occupied beds?

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1                   MR. SULLIVAN: You pay the tax on occupied  
2 beds. I haven't filled out the report.

3                   Tim?

4                   MR. PHILLIPPE: I don't personally do the  
5 reporting. Sorry. But it's about the occupied beds, is what  
6 we pay on.

7                   MR. SULLIVAN: And the advantage is that it  
8 will be pretty current data.

9                   MS. MITZEN: So then we have a basis of the  
10 licensed beds that we know -- that somebody knows who has  
11 licensed beds, and then you're talking about actual  
12 building and utilization, and that could be compared then  
13 facility by facility. So somebody would have to collect  
14 that and to analyze that data. Sounds like a reasonable  
15 way to get it, if we've got the resources to do it.

16                   MR. FOLEY: If we get three months of data  
17 from the Provider Tax, that would give us a lot -- that  
18 would help out a lot, just three months of data, and  
19 obviously continue to collect it.

20                   MR. CONSTANTINO: We'd be happy to set  
21 something up.

22                   MR. FOLEY: We could even update our  
23 inventory.

24                   MR. CONSTANTINO: We'd be happy to set

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1 something up with HFS, Courtney and Bill and us.

2 MS. AVERY: Nelson.

3 MR. FOLEY: Nelson, you've got a job now, Bud.

4 CHAIRMAN WAXMAN: So, we're going to ask Staff  
5 to figure out to how to do a sample report then, comparing  
6 the tax report, bed tax report, to licensed beds, which you  
7 have, and see if we can come up with a bed count number.  
8 Cool. Hey, we've accomplished something.

9 MS. MITZEN: So, what happens next? So,  
10 they'll collect that?

11 CHAIRMAN WAXMAN: Mike is going to go home and  
12 yell about what the committee is making him do, and Nelson,  
13 and they're going to go back and complain about what this  
14 committee is making them do, and after they quit  
15 complaining, we'll have a report that's going to deal with,  
16 I think, some clear information about what the number of  
17 unoccupied beds really are or occupied beds really are,  
18 compared to licensed beds. I think we all were trying to  
19 figure that number out. So, once we have that, then we  
20 really know what the problem -- the size of the problem  
21 we're dealing with.

22 MS. MITZEN: That's correct.

23 CHAIRMAN WAXMAN: Mr. Foley?

24 MR. FOLEY: In the meantime, I'm assuming Mike



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1 do.

2 CHAIRMAN WAXMAN: Is the rate higher?

3 MS. AVERY: So we want to try to extract the  
4 CCRC data?

5 MS. CREDILLE: Yes, and I would worry about  
6 the cost report, because that would only pick up centers  
7 who apply -- who participate in Public Aid. You have a  
8 whole lot of facilities that don't participate in Public  
9 Aid, and you can't exempt them from this, because that gets  
10 our whole problem exacerbated again.

11 MR. CONSTANTINO: But the provider base  
12 report -- I'm sorry. Provider Tax report does not --  
13 includes all licensed facilities?

14 MR. SULLIVAN: All facilities.

15 MR. CONSTANTINO: Does it identify CCRCs? Or  
16 do we have to do that from our data? Because our data is  
17 very scarce regarding CCRCs.

18 MR. SULLIVAN: You'll get a report on each  
19 CCRC.

20 CHAIRMAN WAXMAN: You'll have to know who they  
21 are.

22 MR. SULLIVAN: And you'll have to know what  
23 they're licensed for; but you know that, right?

24 MR. CONSTANTINO: We have them licensed for

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1 just skilled beds and we --

2 MR. SULLIVAN: Right, and that's all they pay  
3 on.

4 MR. CONSTANTINO: We don't identify them as a  
5 CCRC, Terry.

6 MR. SULLIVAN: Oh, I see. I don't think they  
7 have to be broken out, as long as we're collecting it.

8 MR. PHILLIPPE: I don't think we're any  
9 different. I think what you're talking about is a CCRC  
10 that has a small skilled unit, that's all private pay,  
11 because I don't think we're treated any differently.

12 MR. SULLIVAN: No, you aren't.

13 MS. MITZEN: Aren't they part of the  
14 inventory though?

15 MR. PHILLIPPE: Yes.

16 MS. MITZEN: They're part of the inventory,  
17 so why wouldn't we include them?

18 MR. CONSTANTINO: We consider them  
19 skilled-care beds. That's my only concern. That's going  
20 to take a lot of work.

21 MR. SULLIVAN: No, it doesn't have to be  
22 broken out.

23 MS. MITZEN: No, I don't think so. This is  
24 part of the growing industry. It's part of the inventory,



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1 all of those can be brought together at the same time. If  
2 they have been brought together --

3 CHAIRMAN WAXMAN: They probably haven't been,  
4 but once you have the number you're looking for, all Mike  
5 has to do is enter the licensed beds next to it.

6 MS. MITZEN: Right. That's all you have to  
7 do, Mike.

8 (Laughter)

9 CHAIRMAN WAXMAN: What, 970 nursing homes?

10 MR. CONSTANTINO: What is that, skilled care  
11 beds, 770, 790?

12 MR. SULLIVAN: Number of facilities?

13 MR. CONSTANTINO: Yeah.

14 MR. SULLIVAN: It's 850 that are  
15 Medicaid-certified. I thought it was closer to -- I  
16 thought it was over 900.

17 CHAIRMAN WAXMAN: I thought it was over 900,  
18 too.

19 MR. SULLIVAN: Including the small, 20-bed  
20 CCRC or skilled nursing unit in a hospital or whatever.

21 MS. MITZEN: So ultimately, the question  
22 we're asking of this data is how many licensed beds are not  
23 being used over a three-month period; is that right? I  
24 think that is the final question for you.

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1                   MR. SULLIVAN: Well, we have average  
2 occupancy. We're looking for the peak, peak months. So  
3 when, for each facility, are the maximum number of beds  
4 occupied during a particular month? We can't get down to  
5 the daily, based on current data, but at least what's your  
6 highest month of occupancy, to say how many -- during your  
7 highest month of occupancy, how many beds are you using, is  
8 the question we're trying to get at.

9                   MS. MITZEN: Yeah, but we're not asking them  
10 individually; we're asking the data to tell us that, right?

11                   CHAIRMAN WAXMAN: No, Mike will have it  
12 individually.

13                   MR. DART: From the data, derived from the  
14 data.

15                   MS. MITZEN: From the Provider Tax. We're  
16 only doing this from data that we have because of tax and  
17 licensing and cost reporting; is that right?

18                   CHAIRMAN WAXMAN: Nothing on the cost report  
19 that we can use yet.

20                   MS. MITZEN: Okay. So we're only taking a  
21 look from the data from the Provider Tax and the licensing.

22                   CHAIRMAN WAXMAN: And I think Terry's point is  
23 well taken, that nobody is going to fudge to the high side  
24 when -- on a report that says I'm paying tax dollars. So

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1    you're not going to pretend you have beds and want to pay  
2    more tax dollars.  I don't think anybody will do that,  
3    although I may be wrong.

4                   MS. MITZEN:    So do we need a year's worth of  
5    reporting to get that highest point?

6                   MR. PHILLIPPE:  Really, in the long run we  
7    need a year.  Like Terry said, there's peaks and valleys  
8    during the year, and we know because we have to budget.  We  
9    expect our highest numbers to be in February and March in  
10   most years.  Certain times it goes up and down.  So that's  
11   what you're wanting to find, rather than taking an average  
12   across the year.  If we took the highest month, that's  
13   better -- because we can't get to the highest day yet  
14   easily.  So, we want the whole year so we can see what the  
15   peak month is.

16                   MS. MITZEN:    So is that what we need to see,  
17   if this data gets us what we need?

18                   MR. SULLIVAN:  Mike or whoever is going to be  
19   collecting it, the report breaks out Medicare bed days  
20   separately -- and this is just background.  You don't pay  
21   the tax on your Medicare days.  So it's not just the days  
22   you pay tax on, but the Medicare days are reported on your  
23   report.  So just make sure you're not just asking for the  
24   days that you pay the bed tax on.  We also want to know the

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1 Medicare bed days for that month.

2 CHAIRMAN WAXMAN: Toni?

3 MS. COLON: I have some statistical  
4 information that I'd like to maybe present to the Board or  
5 to all committee members that breaks out the number of  
6 facilities that are currently licensed, total number of  
7 beds within each type of long-term care setting. It also  
8 breaks it down by those that are just strictly licensed,  
9 those that are certified, and those that are licensed and  
10 certified. It drills it down to number of beds by region.  
11 And so I think this would be some really good information  
12 for all committee members to review in preparation for the  
13 data collection and comparison analysis. So I can leave  
14 this with you, Mike, someone?

15 MR. CONSTANTINO: Sure.

16 CHAIRMAN WAXMAN: Any Staff member.

17 MS. COLON: Okay.

18 MS. HANDLER: Just for clarification, is the  
19 Provider Tax document signed annually or monthly?

20 MR. PHILLIPPE: Monthly. You get delays  
21 sometimes -- I think whether or not the State is choosing  
22 to pay us -- but it's paid monthly.

23 MR. FLORINA: The first month of data  
24 collection, I believe, was April of 2011. So you have

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1 almost two years of data.

2 CHAIRMAN WAXMAN: Great. Okay. So now we  
3 have a mechanism to determine what we will be looking at in  
4 terms of -- could be defined as excess beds in the state of  
5 Illinois and actually would be available by regions.  
6 You're doing it by individual facilities, so you can move  
7 them any way you want. That would be some great data.  
8 Also would help you and the Mother Board on applications,  
9 because now you have other data. So we're helping you.

10 (Laughter)

11 MR. FOLEY: As we are proceeding and now  
12 waiting for this data and waiting for our report -- senior  
13 moment. I'm sorry.

14 MS. AVERY: The RFP?

15 MR. FOLEY: Yeah, the RFP data. In the  
16 meantime, could this subcommittee proceed in terms of  
17 thinking about a process, procedures, for bed sell concept?

18 CHAIRMAN WAXMAN: Sure.

19 MR. FOLEY: Start working on it, start  
20 thinking about it?

21 MS. AVERY: We've been thinking about it.

22 MR. FOLEY: Yeah, I know.

23 MS. AVERY: What we did before was we went  
24 back and looked at the minutes. So, yeah, we can look at

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1     that.

2                   CHAIRMAN WAXMAN:  And, you know, again, on one  
3     hand, I think we've had some success with work groups, but  
4     I think this is such an incredibly important issue, I think  
5     it should be handled by the committee at large, unless the  
6     group feels it should be a small group effort. I think it  
7     should be -- I personally think it should be a  
8     committee-at-large kind of issue.

9                   MR. PHILLIPPE:  I agree.  If you remember when  
10    I had a work group, everybody from (inaudible) joined, so  
11    we had more people on the phone calls than we had for the  
12    meetings.

13   (Laughter)

14                   CHAIRMAN WAXMAN:  I remember that one.  So I  
15    think, Mr. Foley, you're correct; we need to move on in  
16    that direction.  So, can you -- will you be able, by our  
17    next meeting in two months, to go through the minutes?

18                   MS. AVERY:  Can I send out an e-mail to say it  
19    will be ready by blah, blah, because we still --

20                   CHAIRMAN WAXMAN:  Yeah, whatever you need to  
21    do.

22                   MS. AVERY:  Let us talk about it internally  
23    and set some timetables for all of the tasks and go from  
24    there and send out an e-mail with those.  But we will aim

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1 for the next two months.

2 CHAIRMAN WAXMAN: Fine with me.

3 MR. FOLEY: When is our next subcommittee  
4 meeting?

5 CHAIRMAN WAXMAN: We haven't set a date yet.  
6 This is the end of April. It should be sometime the end of  
7 June or the beginning of July. So pick a date at this  
8 point in time.

9 MS. AVERY: Our next Board meeting for the  
10 Planning Board is May and then June 26th.

11 CHAIRMAN WAXMAN: Is there a need for us to  
12 meet before June 26th?

13 MS. AVERY: I don't think we'll have any  
14 recommendations, so no.

15 CHAIRMAN WAXMAN: So --

16 MS. AVERY: But then you get into summer  
17 vacations in July.

18 CHAIRMAN WAXMAN: The first week of July is  
19 July 4th. So the second week of July, or the week before  
20 June 24th?

21 MS. CREDILLE: There's Tuesday, June 25th;  
22 Tuesday, June 18th.

23 CHAIRMAN WAXMAN: Anyone have any problem with  
24 those two dates?

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1 MR. FOLEY: Give me those again, Michael.

2 MS. AVERY: 18th or 25th of June.

3 MR. SULLIVAN: I have a problem with the 18th,  
4 if you don't mind.

5 MS. CREDILLE: 25th is good.

6 MS. AVERY: That's usually a little --  
7 depending on you all as a team, if we're ready for the  
8 meeting on the 26th. There are last-minute things that  
9 need to come up, and then it makes Staff travel two days  
10 overnight. But then we're in the week of the 4th of July.

11 CHAIRMAN WAXMAN: The week after that is?

12 MS. CREDILLE: July 9th.

13 CHAIRMAN WAXMAN: How about July 9th?

14 MR. PHILLIPPE: I'm gone, but that doesn't  
15 mean you can pick a date when everybody is here.

16 MS. CREDILLE: July 16th?

17 CHAIRMAN WAXMAN: July 16th work for  
18 everybody?

19 MR. PHILLIPPE: That's fine.

20 CHAIRMAN WAXMAN: Going once, going twice.

21 (Pause)

22 CHAIRMAN WAXMAN: I assume it's a Tuesday.

23 MS. AVERY: I will send out a notice with  
24 location.

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1                   CHAIRMAN WAXMAN: Do we want to go and pick a  
2     September date, or do you just want to wait until we get  
3     through July first?

4                   MR. PHILLIPPE: It's easier for me if we go  
5     ahead, and I can schedule around it when I know in advance.

6                   CHAIRMAN WAXMAN: Illinois Healthcare is July  
7     9th and July 12th, so I don't know if any of you are  
8     attending that.

9                   MS. CREDILLE: Tuesday, September 17th;  
10    Tuesday, September 24th?

11                  CHAIRMAN WAXMAN: How about the 17th?

12                  MR. PHILLIPPE: Okay.

13                  CHAIRMAN WAXMAN: Okay. Is that okay with  
14    Staff?

15                  MS. AVERY: Um-hum. Thank you. Okay. That's  
16    good.

17                  CHAIRMAN WAXMAN: So we probably can jump to  
18    Item 8.

19                  MS. AVERY: The last under "Follow-up", we  
20    have not had the opportunity yet to meet with IDPH on some  
21    of the other issues with long-term care and healthcare  
22    regulations, but we will get that scheduled soon. Bill is  
23    going to follow up on that, right?

24                  MR. DART: Yeah, we are going to follow up.

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1 That was to discuss the change of ownership and closure  
2 issues that we discussed last time.

3 MS. AVERY: And looking at the possible  
4 overlaps and combining. Everybody remember that  
5 discussion? So we haven't done it yet.

6 As I reported earlier, we sent out the letters  
7 for RFP to the major State universities and colleges, and  
8 we got the one response, so I'll be calling tomorrow --  
9 Cathy and myself -- to remind them and find out if they're  
10 interested in responding to the RFP.

11 CHAIRMAN WAXMAN: Do you remember how many you  
12 sent out?

13 MS. AVERY: Was it about eight, Cathy?

14 MS. CLARKE: Yes.

15 CHAIRMAN WAXMAN: Do you have a Plan B if  
16 seven more don't respond?

17 MS. AVERY: Then the one that responded was  
18 the University of Illinois-Chicago, which I figured they  
19 would. So we'll go with them. Yeah, we sent out eight:  
20 EIU, all of the U of I's, Governor State, SIU, and WIU,  
21 Western Illinois University.

22 CHAIRMAN WAXMAN: So you didn't go to any of  
23 the others, like Roosevelt or DePaul?

24 MS. AVERY: No. They're not State colleges

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1 and universities.

2 CHAIRMAN WAXMAN: No, they're not.

3 MS. AVERY: Remember, we discussed the process  
4 for procurement the last time.

5 CHAIRMAN WAXMAN: I do now.

6 MS. AVERY: That's it.

7 CHAIRMAN WAXMAN: Anybody have any new  
8 business or old business? I guess old first and new  
9 second.

10 (Pause)

11 CHAIRMAN WAXMAN: I know everybody wants to  
12 leave early, but --

13 MS. AVERY: Let me ask one other question.  
14 The summary that Claire drafted from the minutes --

15 CHAIRMAN WAXMAN: Excellent.

16 MR. PHILLIPPE: Great.

17 MS. MITZEN: Oh, my goodness.

18 MS. HANDLER: Thank you, thank you, thank you.

19 CHAIRMAN WAXMAN: I wrote myself a note to  
20 see -- we hadn't done this before. I thought it was a  
21 great idea, and I was going to ask who did it.

22 MS. AVERY: Format was okay? No suggested  
23 changes or recommendation?

24 MR. SULLIVAN: I missed the entertaining name

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1 calling. That's why I still read the transcript.

2 MS. AVERY: Well, it's clear that that is not,  
3 per legal advice, not replacing the transcript. That is  
4 not what we vote on to approve. We approve the transcript,  
5 not the summary.

6 MR. URSO: I still encourage you to read the  
7 transcript, if you want a full flavor of the meeting.

8 MR. PHILLIPPE: I think people like Terry, who  
9 find a mistake on page 109, deserve an award.

10 MS. MITZEN: He looks for his name.

11 CHAIRMAN WAXMAN: I'm wondering if -- just  
12 take a few minutes. If anyone has any idea of how or who  
13 we could try to figure out Managed Care and Obama Care and  
14 how it will impact long-term care. Is there anything out  
15 there that we could bring to this committee or any people  
16 out there?

17 MR. PHILLIPPE: I don't know if you know this,  
18 but you know Mike -- the guy from --

19 CHAIRMAN WAXMAN: Scavotto?

20 MR. PHILLIPPE: I had my senior moment. He  
21 actually did the training for LSN for the members. He  
22 had -- so he had sessions in both Springfield and Chicago  
23 area for LSN members, and so he is becoming an expert,  
24 really, on that. And he worked in the field out in

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1 California. He experienced some of it. So he -- and he  
2 also knows other people involved, because he's followed up  
3 on questions people had in the meetings.

4 MR. SULLIVAN: I think Mike is an excellent  
5 suggestion. FR&R has done an excellent job, with Betsy  
6 Anderson. But also there's a new Director of Finance and  
7 Reimbursement over at HFS; Muldota, I believe his last name  
8 is, who used to work for Aetna Better Health.

9 MS. MITZEN: Is that his name?

10 MR. SULLIVAN: Muldota, I think. But he  
11 jumped from Aetna Better Health over to HFS. So, he's up  
12 to his knees in all of this stuff.

13 CHAIRMAN WAXMAN: Do you think we could  
14 invite -- I'm happy to call Betsy -- we've been friends  
15 for a long time -- and have her come.

16 MS. HANDLER: Stephanie Altman was also doing  
17 quite a bit of stuff too.

18 MS. MITZEN: She's excellent. And actually  
19 Health and Medicine, we're doing a report for the  
20 Department on Aging and actually the Older Adult Services  
21 Advisory committee that is just about ready to go back to  
22 the Department. That's going to be very helpful, and what  
23 we have done is to take all aspects of managed care, and  
24 particularly the merger of the long-term care services and

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1 supports, so that -- but what we've done is take all of the  
2 initiatives that HFS is undergoing right now and changes,  
3 and that might be a helpful report for all of you to have,  
4 once it's approved.

5 CHAIRMAN WAXMAN: Maybe if we take a few  
6 minutes at the next two meetings to have these people come  
7 in or send us a report, maybe you and I can talk about who  
8 and when.

9 MS. AVERY: And my other thought is, is it  
10 possible to do a partnership with one of the other agencies  
11 for a teleconference on a day dedicated to that, outside of  
12 the meeting? It sounds like it will be the majority,  
13 unless we want to dedicate one of these meetings just to  
14 that agenda item.

15 CHAIRMAN WAXMAN: I don't think so. I'm  
16 pretty excited that we finally are making some progress on  
17 doing something with buy/sell and exchange and bed count,  
18 that we've made progress, and I don't want to stop that  
19 momentum. So I would not want to take one full meeting. I  
20 personally -- and I'm sorry for doing that -- would not  
21 recommend taking one of those days and stopping the  
22 momentum. It's not that we meet frequently. We meet every  
23 other month. So I would like to keep that momentum going.

24 MS. AVERY: Those who have participated in

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1 those round tables, I've heard that they are not really  
2 long, but beneficial, in a couple hours.

3 CHAIRMAN WAXMAN: I would have no problem to  
4 dedicating a couple hours of our meeting to that.

5 MS. AVERY: Should we extend the time?

6 CHAIRMAN WAXMAN: Yeah, another hour?

7 MS. MITZEN: I heard you say something else,  
8 Courtney. I heard you ask whether or not there might be  
9 benefit in bringing other people into that, and I would  
10 really say that there's a lot of people around this state  
11 and in State government that really need to have a better  
12 grasp on what's actually happening. So, I --

13 MS. HANDLER: It's complicated. I have sat  
14 through a few, and I have a good understanding of Managed  
15 Care, and I'm still trying to sort through. I've listened  
16 to Julie probably three times already, and every time I  
17 listen to her, I hear something new that sort of fits in.  
18 So I think it would be prudent for us to spend some time  
19 trying to understand it, because it is the future.

20 MS. MITZEN: It's overwhelming.

21 MS. AVERY: If we did a date with a  
22 teleconference or video conference, and we asked them to  
23 tailor it to long-term care --

24 MS. MITZEN: To nursing home, because

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1 long-term care --

2 MS. AVERY: Okay. Maybe working with HFS,  
3 IDPH, Health and Medicine, to figure out a date and do it  
4 as a statewide --

5 MS. MITZEN: Health and Medicine's will be a  
6 report, and once the report is in and ready to be  
7 circulated, I would make sure that Courtney got it and  
8 would send it out to all of you. But it's a very, very  
9 good foundational piece that goes broader than nursing  
10 home.

11 MR. SULLIVAN: Although I think what we -- we  
12 don't necessarily need a primer on what's going on now. I  
13 think we're looking for a futurist --

14 MS. MITZEN: That's what this is doing.

15 MR. SULLIVAN: -- to say what is going to be  
16 the impact on nursing homes in two years from now, three  
17 years from now with Managed Care. It's almost like -- I  
18 don't know if it's a report from another state, like  
19 Arizona, that's been doing it for 20 years, or some other  
20 state like Tennessee that just got into it. I mean,  
21 they're the ones who lived it already and know the changes  
22 that happened to the system.

23 MS. MITZEN: Texas.

24 MS. AVERY: Is Mike's tailored to Illinois, do

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1     you know?

2                   MR. PHILLIPPE:  Yes, at least for the LSN  
3     members, and other people were there, also.  I heard people  
4     from Evercare who attended and wondered how it was going to  
5     affect them.

6                                   (Laughter)

7                   MR. PHILLIPPE:  It does sound like it changes  
8     every week.  As people get more into it, they learn more;  
9     then they discover new issues, and they solve those issues.  
10    That's kind of what you're saying, too.

11                   MS. HANDLER:  It is definitely a moving  
12    target.  They don't know how to pay, they don't know how  
13    to -- I mean --

14                   MS. MITZEN:  And brighter side, they don't  
15    know how to charge.  So it's on both sides.  It's big and  
16    complicated.

17                   MS. HANDLER:  You don't know how to get  
18    authorization, you don't know where to send your claims.  
19    But there's also, who is coming down the pike with regard  
20    to eligibility, all of the members and how the membership  
21    is going to be constantly changing.  Members could opt in  
22    and out every 30 days.

23                   MR. PHILLIPPE:  That has happened in other  
24    states and that is not a nice -- that creates such havoc in



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

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