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CITY OF SPRINGFIELD

STATE OF ILLINOIS

LONG-TERM CARE ADVISORY SUBCOMMITTEE

WORKGROUP MEETING

LONG-TERM CARE ADVISORY SUBCOMMITTEE

WORKGROUP MEETING, held on October 13, 2015, between  
the hours of 10:00 o'clock in the forenoon and  
twelve o'clock in the afternoon of that day, at the  
Department of Public Health, 535 West Jefferson  
Street, Springfield, Illinois 62702, before Ann  
Marie Hollo, CSR, RDR, CRR.



1 MR. MORADO: Let's do the approval of  
2 the agenda, and it looks fine to me. Does anyone  
3 have any objections or anything to add?

4 Okay. All right. Let's move on to  
5 the next thing, which is the report that Nelson  
6 prepared that was posted on the website just  
7 recently. And, Nelson, do you want to take it from  
8 here?

9 MR. AGBODO: Okay. Thank you. Hi,  
10 everybody. Well, I think today we are going to talk  
11 about the bed need methodologies from the CON  
12 states. It was once provided to you by Courtney,  
13 but before we get to this presentation, I would like  
14 to kind of recall what you have done so far. The  
15 previous reports, if you look through the reports,  
16 you will see that the main idea of that report was  
17 to find a methodology that allows an allocation of  
18 beds. That's the main thing I was trying to  
19 accomplish. Today that's the work we'll be doing.  
20 I think we would need to acknowledge some of the  
21 results that the data already proves to be and  
22 proves to be solid findings.

23 The first result that we got from the  
24 report was that the form of the bed methodology,  
25 it's sound. So it's taken use rates and applied to

1 projected population to get the projected bed needs,  
2 that projection. Now you can complicate -- you  
3 know, by making assumptions about use rates, about  
4 the population projections. And if we look at that  
5 state, that's what this is, but the main idea was to  
6 take a current use and apply -- make some  
7 assumptions about that for the future use and apply  
8 it to the future population. And in Illinois, the  
9 methodology is doing that.

10                   The other findings that we already  
11 established that, you know, the total projected beds  
12 are high enough to cover the state's needs. That is  
13 a fact. It's true. We have seen that over 10  
14 years. It's happening. And the third one is that  
15 the allocation of total beds between the area is not  
16 optimal due to the assumption built into the  
17 methodology. So specifically the assumption on a  
18 projected use rates needs to be revised.

19                   MR. GAFFNER: Excuse me. What needs  
20 to be revised?

21                   MR. AGBODO: The assumption about the  
22 projected use rates.

23                   THE REPORTER: Use rates, user rates?

24                   MR. AGBODO: So if we acknowledge  
25 these facts, then the job will become easier, but if

1 we don't, then we'll have to go back and review the  
2 data again. So the only thing for me today that we  
3 need to do is to be able to clearly define what is  
4 fair, equal, optimal of appropriate allocation of  
5 projected beds.

6 THE REPORTER: I'm sorry. Allocation  
7 or location?

8 MR. AGBODO: Allocation of projected  
9 beds.

10 So I received some comments about  
11 this specific definition, and I think it's just the  
12 comment it's all about how we define appropriate  
13 allocation of beds. Appropriate can also mean  
14 equal, equality, you know. It depends on what goes  
15 in the definition. So equality must take into  
16 account the difference in population size and  
17 population needs. We can't just use one flat rate  
18 and apply it to all the planning area in the state,  
19 that that's the equality. We can't ignore the  
20 population size. We can't ignore the specific needs  
21 of the area population.

22 So the current methodology, you know,  
23 the administrative rules suggest that the projection  
24 for each area would cover a hundred percent and  
25 guarantee an extra 10 percent of the needs. So this

1 allocation is not happening for most of the health  
2 planning area, and that is the key finding from the  
3 methodology of variations that I provided. So the  
4 goal should be to find -- to improve this outcome.  
5 How do we choose the current formula or review the  
6 current formula to make sure that each has plenty,  
7 the areas receive a hundred percent of the bed needs  
8 and maybe some extra beds, 10 percent, 5 percent.  
9 How do we do it? And at the same time not allow  
10 overbedding? I think that's the main challenge.  
11 And if we find a method that provides that  
12 100 percent coverage to most of the planning area,  
13 let's say, 95 percent of the health planning area,  
14 the problem we are seeing today would be solved.

15                   So I do agree with the comment from  
16 some of -- you know, the comment from HCCI that said  
17 the next step should be to run sophisticated models  
18 to see if what we're trying to accomplish with this  
19 formula will happen. I was afraid that if we do  
20 that, we run into some of the complications that I  
21 have seen in some of the states where they use a  
22 wood square, you know, things like this. In the  
23 formula, how do you translate it to the law? That  
24 was my problem, but it looks like HCCI suggests that  
25 we do the status carrier (phonetic) first, and see

1 how we can put that in our rules.

2 MS. AVERY: This is Courtney Avery.  
3 We received the responses this morning from HCCI.  
4 That's why they weren't distributed to everyone, and  
5 I'm not sure if we received anything yet from you,  
6 Kirk, right?

7 MR. RIVA: No.

8 MS. AVERY: Okay. Great. And we  
9 have HCI -- we got it this morning. So Nelson  
10 hadn't had a chance to really evaluate it until like  
11 8 o'clock this morning. So since he was making  
12 reference to their comments, I just wanted to let  
13 everyone know they had not been distributed yet.  
14 Thank you. Sorry.

15 MR. AGBODO: That's okay. Thank you.

16 So that's my recall from what we have  
17 done so far. And if you guys have any questions, we  
18 can maybe process all this information, and then if  
19 you allow, I will go through the presentation for  
20 the day.

21 MS. AVERY: Okay. Go ahead, Nelson.

22 MR. GAFFNER: Courtney, may I ask a  
23 question? Thank you.

24 Nelson, I was trying to write as you  
25 were speaking. So am I correct in understanding

1 that your goal is trying to achieve a 95 percent  
2 compliance, as I would call it, in each health  
3 planning area that achieved a 100 percent bed  
4 projection, plus a margin of 5 to 10 percent? So if  
5 achieved at a 95 percent health planning area level,  
6 that's your goal; is that correct?

7 MR. AGBODO: Yes. You see status  
8 carrier (phonetic), when you reached 95 percent  
9 satisfaction, and everybody should be happy about  
10 the method you have used. So I'm not saying that we  
11 can really achieve that, but if we get close to  
12 that, it might be something better than what we  
13 currently have. Currently I think the best out of  
14 the five methodologies that I have evaluated, I  
15 would say 26 percent, 26 percent of the health  
16 planning area had the 100 percent to 110 percent  
17 need coverage.

18 MR. GAFFNER: That was through CIM-3?

19 MR. AGBODO: Yes, CIM-3, if I  
20 remember. So for me, it's still low, you know.  
21 It's still low. And we didn't really change too  
22 much on the current formula, but like I said, we can  
23 now put this in a modern process and get the formula  
24 that might look totally different from what we  
25 currently have, and then be able to have a

1 95 percent of the health planning areas with a  
2 hundred percent need coverage, but that formula  
3 might be complicated. That's what I'm worrying  
4 about.

5 MR. GAFFNER: That was your reference  
6 in the last paragraph of the executive summary?

7 MR. AGBODO: Right.

8 MR. GAFFNER: Thank you.

9 MR. AGBODO: Thank you.

10 So going back to the five  
11 methodologies evaluation. I would say that the  
12 summary I provided gave what was done, and I should  
13 actually call it a summary, executive summary,  
14 because executive summary should actually talk about  
15 the requirements, you know, what was the background  
16 information, and things like that, but this went  
17 straight to the results. So tomorrow, summary. I  
18 started writing, and I'm like, well, maybe what you  
19 guys really need to know is what all this is really  
20 talking about. So I should wait, the summary.

21 So I know that in this report, you  
22 know, the formula, it's kind of distractive -- or  
23 you know, not complicated, but hard to understand.  
24 I provided the formula in the document, so if  
25 someone wants to know exactly how we did the

1 calculation, that person can get the information,  
2 but really you can skip that. You can skip that,  
3 and go to Page 17 where you actually have the raw  
4 data. You have all the five methodologies. There  
5 are projections for each area. Then you can compare  
6 the methodology to methodology, and see how it  
7 breaks the total number of beds to a specific area.  
8 And from there, I believe that you can have a  
9 preference, but for me, to summarize, all the  
10 tables -- Page 17 to 53, I have to have an educator.  
11 So my educator of this report is those three  
12 categories, and that's supply and appropriate supply  
13 of beds. Really, if you take them to read that the  
14 definitions of those three categories, it's not hard  
15 to understand. All I was trying to do was to see  
16 which methodology projects a number of beds that  
17 goes in a -- that's 100 percent to 110 percent for  
18 each health planning area. So which methodology has  
19 the best outcome, you know, highest percentage of  
20 number of health planning in that group category.

21 So if you allow now, I can go to the  
22 projection, the Power Points on the CON states  
23 formula. On Page 2 in this presentation -- I don't  
24 know if everybody has a copy, but that's the one I  
25 was talking about. The ones that have the CON

1 States: Bed Need Methodologies.

2 Okay. First, as you know from the  
3 last meeting, I received the assignment to review  
4 the methodologies for the other CON states. So the  
5 total number of CON states is 36, and we are able to  
6 collect seven methodologies from seven states. And  
7 13 states out of 36 have a bed moratorium, so they  
8 are not using that methodology anymore. And so this  
9 report that I'm going to present compiles these  
10 costs and compares the CON states bed methodologies.  
11 So the seven methodologies that we were able to  
12 collect.

13 So the next page actually shows the  
14 CON states, and the states that have the long-term  
15 care bed moratorium. Like I said, there are 13 all  
16 together.

17 So the next page, CON states. That's  
18 comparable to Illinois. So I got this information  
19 from area reports from -- I think it was Governor  
20 State University that did a research on CON states,  
21 and they suggested that New York, Michigan,  
22 New Jersey and Florida are compatible to Illinois  
23 because of some of the criteria that's similar for  
24 those states.

25 So now starting from Page 5, bed

1 needs for each states, the first one is Mississippi.

2 I don't know if you have that.

3 MR. GAFFNER: We have Florida.

4 MR. AGBODO: Florida. All right.

5 MR. GAFFNER: We can go to

6 Mississippi if that's what you like.

7 MR. AGBODO: That's okay. Florida.

8 So Florida. So Florida, bed methodology. They

9 actually calculated the bed needs for districts. So

10 they would take an estimated bed rate, multiply by a

11 projected population, which is similar to what we do

12 here in Illinois, but a difference is that they

13 don't have 6 to -- or zero to 64 age group category.

14 And the use rate assumptions, which is also

15 different, and the occupancy factor. So we use

16 90 percent occupancy factor, and that should not be

17 understood as occupancy rate. I think somebody made

18 that correction in the previous meeting. I think

19 it's just a factor that, you know, that has been

20 used in the formula to achieve a goal that I don't

21 know for sure, but it's about the 90 percent

22 occupancy rate, the occupancy rate that is used in

23 CON review process. It's just in the formula, and I

24 believe that number was provided based on data

25 analysis. So they use 0.92 as occupancy factor, and

1 we use 0.90.

2 Does anybody have a question about  
3 Florida methodology? I'm not looking at the screen.  
4 I'm sorry for doing that.

5 MS. AVERY: You're fine.

6 MR. AGBODO: Okay. So the next one  
7 on your --

8 MR. FOLEY: South Carolina.

9 MR. AGBODO: South Carolina. So  
10 South Carolina, they have a different formulation.  
11 It's different from Illinois actually. So here they  
12 use a projected growth for zero to 64, and then  
13 65-plus age group, and multiply that growth by the  
14 projected number of patients. So my discussion  
15 about that is that, you know, growth of long-term  
16 care beds might not be the same as the growth of the  
17 general population. For some reason, that's what  
18 they use. So that's growth -- it kind of is a proxy  
19 of use rates, and if we don't have use rates data,  
20 then we can go for a proxy, but we do have that  
21 data. So for me, personally, we should not use a  
22 proxy when we actually have the actual data.

23 MR. FOLEY: That's true.

24 MR. AGBODO: And the occupancy factor  
25 is 75 percent. As I said, our occupancy factor is

1 90 percent.

2 Then the next one.

3 MR. FOLEY: New Hampshire.

4 MR. AGBODO: So New Hampshire has a  
5 different formulation of the methodology. They use  
6 original population at 65 times 40 of 1,000. I  
7 mean, actually a state flat use rates. So 40 beds  
8 of a thousand population. So here they actually use  
9 the region population of age 65 and multiply that by  
10 the flat use rate of 40 beds by a thousand  
11 population. So the assumption in that, by doing  
12 that, for me the assumption is that 4 percent of the  
13 65-plus population would need long-term beds,  
14 long-term care beds. That might be based on the  
15 data analysis. They have analyzed the data and  
16 found that, okay, maybe over 5 to 10 or 20 years, we  
17 have seen consistently 4 percent of 65-plus  
18 population in long-term care beds. That might not  
19 be true for Illinois. That is not actually true.

20 Then we go to --

21 MR. FOLEY: Iowa.

22 MR. AGBODO: Iowa. Okay. All right.

23 MR. FOLEY: Nelson, can I ask a  
24 question please? Do we know what the data reporting  
25 period is? I mean, is this data of each one of

1 these states one-year-old data versus two-year-old  
2 versus three-year-old data?

3 MR. AGBODO: I know that for some of  
4 the states, not all of them.

5 MR. FOLEY: Okay.

6 MR. AGBODO: I have to look through  
7 my --

8 MR. FOLEY: Because I think as we had  
9 discussed in previous meetings, that no matter what  
10 methodology we use, it's only as good as the data  
11 that we have.

12 MR. AGBODO: Right.

13 MR. FOLEY: If we have two-year-old,  
14 three-year-old data, that's not really giving us a  
15 true picture, and I think that's what our current  
16 problem is, is that we don't have that current data.

17 MR. AGBODO: Okay. Well, I was not  
18 involved in the previous computation of the bed  
19 needs, but I mean this year, I've been involved from  
20 the very first step, which is the population  
21 projection, and then with Mica Mitchell (phonetic),  
22 we need the bed projection itself, and the way I  
23 look at it, if we are to make the process, it should  
24 not take too long. It should not take too long to  
25 have the final results. I will say the whole

1 process should not take more than months. So I'll  
2 guarantee that if I'm here, we should have the data  
3 pretty quick -- I mean the projection pretty quick.  
4 Having said that, I have to break our needs to  
5 specific components.

6           The first one, projection -- to do  
7 the projection, we need vital records of data of  
8 birth and death and migration. The birth and death  
9 data comes from IDPH, and they don't have it. I  
10 mean, they are kind of behind updating. Today, I  
11 think they already published 2013. They did not  
12 have 2015. I mean, they can't have 2015 because  
13 it's not over yet. And that's not too old, you  
14 know. Because actually for this year projection,  
15 our beds year was 2013, and we do have the data for  
16 that specific year.

17           MR. FOLEY: But we only projected out  
18 five years, which is 2018. So we're halfway through  
19 that already, and we just got the information just a  
20 couple months ago.

21           MR. AGBODO: Right. So for the  
22 components, which is our data, the utilization data,  
23 we do have the data every year. After we do  
24 the -- solve it, we started solving January, and we  
25 finished in February. We'll clean the data out

1 pretty much over one month. So in April, we should  
2 have a clean data for the utilization. And I think  
3 the rules, they require us to provide projection  
4 every two years. I mean the revised version every  
5 two years. And for me, actually, we don't have any  
6 reason to not be able to do that. We should be  
7 doing that now. And every year when we are ready to  
8 revise the projection, we should not take more than  
9 a month. That's what I have experienced.

10 MR. FOLEY: More than one month?

11 Okay.

12 MR. AGBODO: So if we want to take  
13 two years period for the revision, I think that  
14 needs to go through the rule revision. That needs  
15 to change first before we can implement that, but I  
16 don't see any reason why we should not be able to  
17 comply with the current rules.

18 MR. FOLEY: Okay.

19 MR. AGBODO: So for Iowa, they use  
20 two different formulas, depending on the area of the  
21 country. So they have rural counties and urban  
22 counties. So for the rural, they actually have  
23 90 percent and 70 percent coefficient. So 90  
24 percent times population, 65 and plus, plus I will  
25 say 0.15 percent times population 65, and then times

1 110 percent. That's for the rural. And for urban,  
2 they actually multiply the population 65 plus by  
3 7 percent and then add 0.50 percent times population  
4 65 plus to that, and then multiply everything  
5 together by 110 percent. I find this interesting,  
6 because, you know, that's really taking into  
7 consideration the characteristic of the geography,  
8 but you know, I don't know how we can evaluate this  
9 here in Illinois because then we'll have to define  
10 what is rural counties and urban counties. Yet they  
11 define the rural county as population -- the  
12 counties that have less than 50,000 people. I think  
13 that's how they define that. So they are the  
14 multiplier. It's similar to a hundred percent,  
15 similar to Illinois, because yet when we do -- when  
16 we have the first projection of bed needs and  
17 multiply that number by -- we divide that number by  
18 90, it's just like we are multiplying that number by  
19 1.1, which is 110 percent. So that multiplier is  
20 the same thing that we use here.

21 So the next one is --

22 MR. BELL: Mississippi.

23 MR. AGBODO: All right. So

24 Mississippi, it's a strange formula. This is the  
25 formula that used square roots. So the bed needs

1 equal average daily census plus K times square root  
2 of average daily census, and the K is the  
3 coefficient factor of 2.57.

4                   So looking at this, you will agree  
5 that they have done kind of a modeling status  
6 formulation to get this type of formula. So, you  
7 know, square roots of average daily census, what  
8 that will mean, you know, in terms of the  
9 regulation. You know, I don't know exactly what  
10 this number is. So that's what I'm saying, that if  
11 we want to run the most sophisticated modeling on  
12 our data to get the formula, we may get something  
13 like that, and it's not easy for everybody to  
14 understand. So that's one of the typical examples  
15 of formula that might come out of the sophisticated  
16 model. And I believe this is much more complicated  
17 than what we do. It doesn't really look like a  
18 projection formula. It's not the traditional way to  
19 project.

20                   MR. GAFFNER: Excuse me, Nelson. Do  
21 we know why they have bought into or endorsed this?  
22 Just as in Iowa, do we know why they went with an  
23 urban and a rural designation?

24                   MR. AGBODO: Well, I haven't had a  
25 chance to talk to any of these people. I send them

1 an e-mail, and they send me their formula. Some of  
2 them, actually. This one did not send. We went to  
3 their website and found a formula. They actually  
4 have, you know, on some pages explained the formula,  
5 but they did not really give us the rationale of the  
6 formula, you know, why they come up with this  
7 formula, but just what we see is their explanation  
8 of the formula, what goes in the formula, things  
9 like that. But if you want to know, I can  
10 definitely call them and speak to them on the phone,  
11 and say -- actually, one of the states I was able to  
12 exchange an e-mail with the person, and the person  
13 told me, well, he does not understand the formula;  
14 he just applies the formula. If I want to --

15 MR. RIVA: He doesn't understand it?  
16 He just applies it?

17 MR. AGBODO: So I want to ask  
18 questions. Then he will contact -- he will connect  
19 me to somebody on the team actually that works on  
20 this, this formula. Then I didn't go that far. But  
21 if you're interested in that, I will definitely  
22 contact them.

23 MR. GAFFNER: Thank you.

24 MR. AGBODO: You're welcome.

25 So I think the next one should be

1 Connecticut, right?

2 MR. GAFFNER: Yes.

3 MR. AGBODO: So Connecticut has a  
4 two-step formula. One, it's utilization based, and  
5 the model is, well, kind of criteria based, I will  
6 say.

7 So the first -- so in general, the  
8 transition base goes this way. They actually take  
9 the age base group for a thousand population and  
10 multiply that by the projected population. So each  
11 age group has kind of a coefficient, a multiplier.  
12 So below 65 percent, they multiply is 0.7. 65 to  
13 74 percent. They use 10.0. 75 to 84, they used  
14 39.3, and 85 to, you know, and over, they use 160.  
15 So those are the coefficients they use. So then  
16 they will take the coefficient and multiply that by  
17 the projected population, and I believe at the end,  
18 they sum up all the numbers and get state-level  
19 projection.

20 Then they have some criteria. So for  
21 the transition base that we use, the maximum of  
22 10 percent of licensed capacity or 10 -- the maximum  
23 of 10 percent of licensed capacity and 10 beds. So  
24 which of those two numbers is the highest? That's  
25 what they will use. So they actually consider that

1 number of the previous 12 months. Their occupancy  
2 factor is 90 percent. So what they will do is once  
3 they calculate each number for an area, then they  
4 will see before they are allowed the bed to a  
5 facility, they will see if the facility is at  
6 90 percent occupancy, has no approved beds or  
7 licensed beds, acquired beds from a facility that  
8 averaged 70 percent or less occupancy. If the  
9 facility is located in a county without population  
10 based needs, if the facility is not located in a  
11 county where the number of approved beds, a licensed  
12 bed equals 10 percent or more of the county,  
13 licensed bed, has no acquired maximum of 10 percent  
14 of licensed capacity or 10 beds, then they will  
15 offer the -- I mean, they will approve the CON for  
16 that facility.

17                   The other criteria is expansion of 70  
18 beds. That can be approved for the facility with  
19 less than 60 licensed beds during the previous 12  
20 months, and if that facility has an average of 90  
21 percent or greater occupancy or has no approved beds  
22 or licensed beds. So it's kind of, you know, a lot  
23 of criteria that they use to grant beds to  
24 facilities.

25                   So the next one, I think, is Ohio,

1 which you're already familiar with. The discussion  
2 about Ohio methodology is that they use flat rates,  
3 but flat rate is computed using current utilization  
4 bed and all age populations. So I mean, the  
5 utilization for all age population. So they take  
6 all the utilization for all age population and  
7 divide that number by the 65-plus population. That  
8 is not coherent, you know, because actually when you  
9 calculate the rate, it's always the number of cases  
10 divided by the number of at-risk population. So the  
11 at-risk population for long-term care is the general  
12 population. It's the type of population. So that's  
13 my main argument about this methodology.

14                   And I know for our methodologies,  
15 some of you requested that we factor in assisted  
16 living, and you know, and all the data to long-term  
17 care. I keep arguing that, well, if you are using  
18 the traditional projection methodology, you should  
19 not take those type of people out of your -- when  
20 you calculate the use rates. So Ohio used actually  
21 a 98 percent occupancy factor like we do here.

22                   So I will go to Illinois that we also  
23 know. That's the last one. So we use a projected  
24 use rate times projected population divided by 90.  
25 If you look at this formula, it's similar to

1 Florida's formula, but just our assumption about  
2 projected use rates, it's unique. And like I  
3 reported before, that's the assumption we need to  
4 review to make sure that the new assumption allows  
5 us to better distribute the beds between the health  
6 planning areas.

7                   So in conclusion, you realize that  
8 the methodologies are unique for each review states.  
9 There are differences found in the formulations,  
10 coefficient and assumption. I think it's just based  
11 on data that they have seen that over certain years  
12 this is what is happening all the time. So we just  
13 perpetrate that going forward. And the mathematical  
14 formulation of Illinois, it's similar to Florida's.  
15 But Illinois' formula, it's simple and robust. What  
16 I mean by "robust" is the fact that the use rates  
17 carried the long-term care needs, the  
18 longterm -- they're changing the long-term care  
19 needs. With each year, the long-term care needs  
20 change based on how many people come in the system  
21 and how many people get out or how many people go to  
22 other type of care. So that needs changed. So if  
23 you are taking that forward, you are updating your  
24 needs. And the population projection carries  
25 population change as far as growth of the

1 population, migration and aging, because when we do  
2 population projection, we make assumptions on  
3 migration. We make assumption on birth and death  
4 for the projected years. So by doing that for each  
5 health planning area, you are also updating the  
6 change in the population going forward. So that's  
7 my conclusion.

8                   And shortly I will say the only  
9 things we needed to do to this formula is to review  
10 the assumptions and make sure that the new formula  
11 does what we want the formula to do, and it's  
12 possible. And you don't have to copy other states  
13 because we don't know how they come up with their  
14 formula. Their data doesn't look like our data.  
15 And we just need to better understand Illinois and  
16 change assumptions that doesn't work anymore and  
17 have a better projection.

18                   So thank you for your attention. If  
19 you have any questions, I'll be glad to help.

20                   MR. FOLEY: Well, first of all,  
21 Nelson, I think you did, once again, a very good  
22 job.

23                   MR. AGBODO: Thank you.

24                   MR. FOLEY: I would describe it as  
25 being amusing, but yet confusing.

1 MR. RIVA: To say the least.

2 MR. FOLEY: But it is understandable,  
3 and I think what we're getting out of all of this is  
4 the fact that each and every single state is  
5 different. They have their own set of unique  
6 circumstances as to why they have their own specific  
7 methodology that they use.

8 So in Illinois, we're different.  
9 Illinois, we are the lowest reimbursement rate state  
10 in the country, okay, which also somewhat explains  
11 our methodology in a roundabout way, so to speak,  
12 okay? Other states are a little bit more loose, you  
13 know, than what Illinois is, might be, and there are  
14 states that are worse than Illinois.

15 But I think you presented a picture  
16 here that is somewhat -- if I may say, somewhat  
17 understandable. You are correct in that we do have  
18 to look at the assumptions. I think the assumption  
19 that we use is very important. I think we should  
20 take another look at the 90 percent figure, okay,  
21 and see if that could be tweaked downward somewhat  
22 to maybe 80 or 85 percent and just see what that  
23 does to the methodology, but I think more  
24 importantly than that, I think it's really up to the  
25 industry. I think we need to find the industry -- I

1 said this at the last meeting. Of our associations,  
2 we need to find out from them exactly what do they  
3 want? What do they want to see in Illinois? Do  
4 they want to see more construction? Do they want to  
5 see more beds? Do they want to see more existing  
6 facilities modernized? You know, existing  
7 facilities are going to be modernized what they can  
8 afford, and with the lower reimbursement rate,  
9 obviously they can't afford to do much. So we're in  
10 a quandary here, so to speak. We don't know what to  
11 do first.

12 We do know for a fact that we have a  
13 lot of aging facilities, and that is affecting the  
14 long-term care industry's reputation. You know,  
15 this is why we have a lot more alternatives, i.e.  
16 home healthcare, assisted living, supported living,  
17 you know, et cetera, because people don't want to go  
18 to existing nursing homes because they're old and  
19 dilapidated.

20 So then how do we solve this? You  
21 know, what are we going to do? I mean, we do have a  
22 provision in the Act that talks about relocation of  
23 beds. So we do have the opportunity for a lot of  
24 our existing facilities to be able to -- replacement  
25 facilities under the Act, and some facilities are,

1 in fact, doing that, you know, and that should be  
2 encouraged for more facilities to do it, but somehow  
3 we've got to figure out how can we help out our  
4 existing providers out there, the small providers.

5                   You know, our overall goal objective  
6 here, to my understanding, is to look at all these  
7 beds, to identify the dead beds out there, which is  
8 very, very difficult to do as we have been  
9 experiencing over these last several, several  
10 months. It's hard to ask a provider to give up  
11 beds, you know, even though they're not using them,  
12 because unlike hospitals, these beds are tied into  
13 reimbursement rate, and this and that, and what have  
14 you. So that really cannot be done. So is the  
15 buy-sell concept the way to go? You know, we really  
16 don't know that yet, okay? Unless the industry  
17 themselves will come up with an idea as to how we  
18 can, in fact, give up beds, how can we encourage  
19 existing providers, you know, to modernize, period.

20                   So, again, I do want to thank you. I  
21 think you did an excellent job. I think a lot of  
22 time and effort went into this. I would like to see  
23 if it's possible if we could use our current  
24 methodology, tweak it to look at those assumptions  
25 that you're talking about and to maybe look at it,

1 80 percent or 85 percent occupancy rate, and see  
2 what that does. I think we want to encourage  
3 providers to renovate, and one way to do that is by  
4 showing a bed need, because they are always under  
5 the assumption that there's not a bed need. I can't  
6 do anything. You know, we have a lot of excellent  
7 providers out there that are sitting there with the  
8 high occupancy rate, but unfortunately they're in an  
9 area where there's not a bed need, so therefore they  
10 think they can't do anything. You know, and we have  
11 to take a look at all of this and to encourage those  
12 providers, you know, to modernize, to add beds, to  
13 relocate beds, or you know, do whatever. So I think  
14 the task in front of us is monumental, but I think  
15 there are things that we can do.

16 MR. AGBODO: Thank you. Actually, we  
17 look at the 80 and 85 occupancy factors. We  
18 actually put them in the formula and see how the  
19 projection looked like. I will tell you that when  
20 you go down from 90 percent down, the projection,  
21 that's no more -- that's a hundred, 110 percent need  
22 coverage goal that we want to see. What you will  
23 see is overbedding. So the area that's taking more  
24 beds is just taking even more. In the area that  
25 don't have enough beds are losing more beds. That's

1 what I have seen when I change --

2 MR. GAFFNER: I don't understand.

3 That seems almost counterintuitive from a  
4 mathematical -- and this is helpful. Thank you for  
5 mentioning that. I believe it's the first time I  
6 heard it said, that it's been modeled at 80 and 85.  
7 Did that just happen since we were last together?

8 MR. AGBODO: Yes, it actually did,  
9 when I was evaluating the five methodologies. I was  
10 going to add those as options, the different  
11 methodologies to S1, but once I realized that the  
12 result doesn't explain the hundred, 110 percent need  
13 coverage, I just dropped those options. But like I  
14 say, it's pretty easy now, because the computation  
15 has been automated.

16 So even if you want to look at my  
17 screen, I can just show you the results. And I can  
18 send it to you guys, if you want to look at it, but  
19 really that does not happen with the goal of  
20 achieving 100 to 110 percent need coverage for the  
21 health planning areas. Maybe we need to get to  
22 agree on the definition of equal or appropriate  
23 allocation of beds, and then those options might  
24 make sense. Because if it's the goal -- I mean, if  
25 we define the allocation -- appropriate allocation

1 of beds like I did in this report, then like I said,  
2 going downwards on occupancy factor does not help.  
3 I don't know if -- I'm trying to be clear on that.

4 MR. FOLEY: I don't follow you.

5 MR. GAFFNER: Are you saying that the  
6 overbedding is still -- you're saying it's getting  
7 worse?

8 MR. AGBODO: Worse, when we use lower  
9 occupancy factors.

10 MR. RIVA: From 90 to 85?

11 MR. FOLEY: From 90 to 85, there's a  
12 higher number of excess beds. Is that what you're  
13 saying?

14 MR. AGBODO: When you use, for  
15 example, 85, which is lower than 90, you have more  
16 overbedding.

17 MR. FOLEY: You have more  
18 overbedding.

19 MR. GAFFNER: Again, I don't see how  
20 there can be more overbedding.

21 MR. AGBODO: Because we are dividing  
22 the number. You see, we do this off the projection,  
23 and then we take that first number is just the use  
24 rate times the projected population. Then we take  
25 that number, and we divide it by 90, okay? For

1 one -- you know, for what we do right now. So if we  
2 drop that 90 down -- because it's in the middle. If  
3 we drop that down to 85, the result is going bigger.

4 MR. FOLEY: The result is bigger.

5 MR. AGBODO: If you divide 6 by 2.

6 So it is 2, right? And you get 3. If you divide 6  
7 by 1, the result is the 6. It's not bigger than 3.

8 So if you have a number, you divide by 90, and you  
9 have the same number and you divide it by 85. In  
10 the second case, you have the higher number than the  
11 first case. So overall the result is overbedding.  
12 And that overbedding, if it was going to the area  
13 where the need is not covered, that might be okay,  
14 but what is happening is those overbeds are going to  
15 the area that are already overbedded. So that's not  
16 something we would like to see, and that  
17 distribution actually goes to the second level where  
18 we actually have assumption on the use, the  
19 projected use rates.

20 MR. FOLEY: Is that what we're going  
21 to have to change yet, our projected use rate?

22 MR. AGBODO: Right. So for me what  
23 I'm seeing in the process is the assumption on the  
24 use rates to get projected rates, because that's  
25 where you actually distribute the beds between

1 health planning areas. I don't want to make this  
2 complicated, but it's just a simple -- that if you  
3 are dividing the same number by 90, and you are  
4 dividing the same number by 85 or 80, you are  
5 actually increasing the overall results. That's the  
6 first thing that we understand, right?

7                   So the next thing is that result.  
8 How do you allocate that between 95 areas? Right  
9 now, we have some areas that don't get enough beds  
10 and some area gets more beds. But when you divide  
11 your number by 80, okay, to have the projection for  
12 the state? More beds that you are adding there, you  
13 are adding and are going to the area that already  
14 have more beds. So it's like you are increasing the  
15 overbedding issue by doing that, which is not a good  
16 outcome. Well, I wish we could speak French. You  
17 do understand, right?

18                   MR. CORPSTEIN: Absolutely. Mike,  
19 maybe you can help.

20                   MR. CONSTANTINO: That's right on,  
21 Nelson.

22                   Who is on the phone? Who is on the  
23 phone?

24                   MR. FLORINA: John Florina,  
25 F-L-O-R-I-N-A. I've been here since the beginning.

1 I appreciate the information, Nelson.  
2 I have several questions that you reviewed. It  
3 appears that we can -- it's a two-tier matter here.  
4 We can set the total number of beds need on a  
5 statewide basis taking account into the aggregate  
6 population, or we can run into what we had here in  
7 Illinois. I think for quite some time is that we  
8 have planning area discrepancies between what the  
9 need is and what the available beds are. Did you  
10 find anything in your analysis of other states that  
11 would indicate that one system would be more  
12 advantageous in determination planning areas  
13 utilization and bed needs rather than on an  
14 aggregate basis? Because, if I recall, Ohio had a  
15 pretty good outcome under statewide, but when you  
16 looked at the marked figures that you had, they  
17 didn't have such a good outcome on the county, the  
18 planning area basis. So they had a disproportionate  
19 share of beds within each planning area, but on the  
20 aggregate for the state, they were pretty much on  
21 target. So in your review of other states, did we  
22 come up with anything that would help us sort this  
23 out so we can address our planning area issues?  
24 Because I'm sure there's a lot of overlap where  
25 patients are going to, even though they're coming

1 from a different planning area.

2 MR. AGBODO: Well, I said I like the  
3 idea of breaking the number of the methodology down  
4 to urban versus rural, but I don't know exactly if  
5 we already have the format to finish it that we can  
6 use to do that because I'm not going to define my  
7 own, you know, concept of rural and urban.

8 MR. CORPSTEIN: You can do above IAA  
9 and everybody else.

10 MR. AGBODO: Right. So if we agree,  
11 it's all about definition. If we agree on a  
12 definition about urban, you know, rural and urban,  
13 then I can put that in the formula and see if that  
14 will improve the allocation. I'm talking about  
15 improving the allocation. We need to know what's  
16 the appropriate allocation. So far, I'm saying that  
17 the administrative rules say the intention of that  
18 rule is to be able to have a projection that covers  
19 100 or 110 percent of the needs. If we all agree on  
20 that, it will be easier to try new ideas like the  
21 one we were talking about, the different level of  
22 geography. And, again, the position of all this is  
23 how, what is -- what this committee accepts as a  
24 definition of appropriate allocation of beds. And I  
25 really want to hear from you guys about this so we

1 can use everything we do on what we agree on.

2 But the way I look at all the states  
3 where we didn't have the formula, but there are  
4 data -- Kentucky and Michigan. And I realize their  
5 bed needs are all negative. I mean, like Kentucky,  
6 there's no bed needs at all. You know, all the  
7 counties. I can pass that around if you want to  
8 look at it. And Michigan has the same issue. It  
9 looks like not having bed needs is not just an  
10 Illinois issue or the states share the same type of  
11 issue. So you should look at the last column, and  
12 you will see that their formula does not project bed  
13 needs. It's all excess of beds.

14 MS. AVERY: Nelson, can you have that  
15 posted when you get a chance?

16 MR. AGBODO: Okay.

17 MS. AVERY: So everyone will see the  
18 report.

19 MR. AGBODO: The one on Michigan.

20 MS. AVERY: The document that you  
21 just passed.

22 MR. AGBODO: All right.

23 MR. CORPSTEIN: Has the Board denied  
24 anything in recent memory?

25 MR. CONSTANTINO: Just matter of

1 care.

2 MR. CORPSTEIN: The one out of the  
3 49, 51 and 1?

4 MR. CONSTANTINO: Yeah.

5 MS. AVERY: Three or four years ago,  
6 Paul?

7 MR. CORPSTEIN: That was the last  
8 time the Board denied anything for LTC.

9 MR. CONSTANTINO: Yes.

10 MS. AVERY: And going back to  
11 Charles' comments, I'm not sure why there's a  
12 hesitancy to come to do modernizations on the  
13 existing facilities, especially when they're adding  
14 beds, because there have been some that have been  
15 approved when they were adding beds. They weren't  
16 establishing new, but they were adding beds to their  
17 existing, and I can't recall any that's been denied  
18 or not approved, have you, Charles?

19 MR. FOLEY: No, but I say the problem  
20 is we still receive a lot of phone calls, and I  
21 think people here representing the associations  
22 would comment also that because we  
23 received -- people are still hesitant to file an  
24 application to add beds in an area where it's  
25 overbedded. Yes, we have done it. Yes, we have

1 done it successfully, you know, a few times, but  
2 there's still a lot of people out there that just  
3 put on their cap, and says, "Okay. There's not a  
4 bed need in my area; so, therefore, I cannot add  
5 beds, period."

6 Our rules do not allow for a variance  
7 to the state's computed bed need. That will allow  
8 them to more freely -- to more freely come in and  
9 file an application. We have been successful a few  
10 times, as you well know, in convincing clients to  
11 come in, but in doing so, I also strongly encouraged  
12 them to sit down, have a meeting with the state  
13 staff first, because nothing obviously is  
14 guaranteed. And that has happened successfully.  
15 But I think that if we had a provision in our rules  
16 in terms of a variance of some kind, data will allow  
17 providers to come in and to file an application in  
18 an area where there's excess beds. They might feel  
19 a little bit more comfortable in doing so. I don't  
20 know. And, again, we got representatives here from  
21 the three associations. I would love to hear their  
22 comments and their thoughts on this.

23 MR. RIVA: I missed the part of  
24 the -- are you talking about -- what are you talking  
25 about, about a high occupancy? Or something of that

1 nature or what?

2 MR. FOLEY: We're talking about the  
3 fact that I made a comment, Mr. Riva, that there are  
4 at times out there when providers are reluctant to  
5 even look at filing an application to add beds to an  
6 existing facility because there's not a bed need  
7 period, okay? Applications, however, have been  
8 filed in areas where there's not a bed need and have  
9 been successful, but that's only been a very few  
10 cases. I think, by and large, most providers are  
11 reluctant to file an application or to even think  
12 about filing an application where there's not a bed  
13 need. Would you agree with that?

14 MR. RIVA: Yeah, yeah. I mean, I  
15 know we have got a couple facilities currently  
16 building replacement facilities.

17 MR. FOLEY: That's absolutely  
18 correct, yeah.

19 MR. RIVA: But, yeah, I would agree  
20 with that.

21 MR. FOLEY: Okay.

22 MS. AVERY: Kirk, they're currently  
23 building replacements?

24 MR. RIVA: We have a facility not too  
25 far from here that's looking to build a replacement

1 facility.

2 MS. AVERY: And that's probably  
3 because the issue of meeting life safety codes and  
4 expansion. There's a need in the community that  
5 they can document in doing their internal analysis  
6 or seeing what's needed in the community, which in  
7 those cases, from the ones that you're mentioning,  
8 Charles, that came in and demonstrated that there is  
9 a perfect storm in their area, an aging facility not  
10 meeting IDPH or other licensure requirements, and  
11 people in the community are saying, "We want to stay  
12 in our community. Our community is aging. We need  
13 these number of beds."

14 So there are sometimes when you can  
15 document those issues that the Board is sympathetic  
16 towards, and thus approve the application even  
17 though there isn't a bed need. Now, if those don't  
18 exist when the agency or facility is just wanting to  
19 add beds, and we bill them their comp, that's a  
20 little different.

21 MR. FOLEY: That's why I said, you  
22 know, I think if we had some sort of a variance, and  
23 I mean, in essence, an application that we file,  
24 Courtney, we kind of basically created a variance,  
25 okay? And documented a variance because we show

1 that -- we were able to show in those specific cases  
2 where even though there was not an identified bed  
3 need, there was a need "because of," and it was that  
4 "because of," it was able to document. You know, so  
5 we kind of did that in a form of a variance  
6 ourselves. So we are able to document that these  
7 beds could, in fact, be billed. But I guess what  
8 I'm trying to say is that if we had a variance -- I  
9 mean, I've been doing this for 35 plus years. What  
10 I'm saying is if we had a variance to the state's  
11 computed bed need, facilities out there, in general,  
12 would feel a little bit more comfortable in filing  
13 an application. As Mr. Riva --

14 MS. AVERY: I guess I'm missing a  
15 clarification on what type of variance. As opposed  
16 to are you saying a CCRC variance?

17 MR. FOLEY: Just what you said. It's  
18 just what you said, where can -- I'm sorry. Excuse  
19 me. Can an applicant document that there is a need,  
20 okay?

21 MR. RIVA: Are you talking about even  
22 in an area where there's no bed need?

23 MR. FOLEY: Where there's no bed  
24 need. Just because there's not a bed need, does  
25 that mean that there's not really a bed need? If a

1 facility is sitting there with a 90 percent plus  
2 occupancy rate, and turning patients away. If  
3 patients have been going to other planning areas  
4 because there's no beds or there's no beds available  
5 for whatever reason, those are variances that one  
6 could actually document, and that's what we had  
7 tried to do, you know. We got letters from doctors  
8 indicating that, yes, we could, in fact, refer, you  
9 know, patients here. That could be part of a  
10 variance documentation.

11                   And I think Mr. Riva just pointed out  
12 another one, which was a high occupancy variance,  
13 which I had brought up, you know, many times in the  
14 past if the facility is experiencing a 90 percent  
15 plus occupancy and has been over the last few years,  
16 he is sitting there, cannot add beds, he's being  
17 penalized that they can't add beds because there's  
18 not a need for beds in that area. I think if he's  
19 full, that means people want to go there for some  
20 reason. They don't want to go to other facilities  
21 for whatever reason, and that's what needs to be  
22 documented under a variance to the state's computed  
23 bed need.

24                   MS. AVERY: So what you're describing  
25 is something that the Board already does, but you

1 want it to be more of a formalized rule?

2 MR. FOLEY: That's absolutely  
3 correct. Thank you, Courtney. Yes, ma'am. Which  
4 would make it easier for the providers in general,  
5 you know, to not feel reluctant in filing an  
6 application.

7 Right now we only have two variances.  
8 Define population and a CCRC, you know. So most  
9 facilities in the state obviously don't fall under  
10 those two categories. So we need to create  
11 something else. Years ago, we used to have what was  
12 called an accessibility variance where one would  
13 document that there's an access problem, you know,  
14 for whatever reason. There's facilities in my area  
15 that don't take Medicaid patients. They're all  
16 private paid facilities. So that limits, you know,  
17 access. I mean, there's all kinds of reasons under  
18 an accessibility variance that used to be able to  
19 document. So we need to relook at this somehow to  
20 help out our providers.

21 MS. AVERY: My only comment on that  
22 just, you know, you're permitting certain variances  
23 to the exclusion of others, and right now because  
24 there's no variance, the board can kind of consider  
25 anything as an exception. It's not really an

1 exception because our criteria is -- our criteria is  
2 simply that, criteria. It's not necessary a set  
3 formula. So the Board can look at certain factors  
4 and approve a project, but if we put in place  
5 variances, they're only limited to approving people  
6 who meet those variances and can't consider other  
7 factors.

8 MR. FOLEY: Well, I mean, it's other  
9 factors, or could also come in under a variance,  
10 whatever those factors are.

11 MS. AVERY: But we have to answer all  
12 those things and put that in the statute.

13 MR. FOLEY: Exactly correct. I think  
14 Bill is shaking his head positively, and Mr. Riva is  
15 shaking his head positively. I have not seen  
16 Mr. Gaffner give any indication.

17 MR. GAFFNER: That's because I'm  
18 taking notes.

19 MR. FOLEY: Oh, I see. Okay.

20 MR. BELL: He's an attorney and knows  
21 better.

22 MS. AVERY: My thought and comment is  
23 that facilities and owners should not have -- should  
24 not be hesitant to come in to ask for the technical  
25 assistance and the guidance and to have a

1 preliminary discussion with staff. And that's been  
2 one of the issues that has kind of been a barrier to  
3 us providing that is that they call on others  
4 instead of coming in and saying, "This is our  
5 situation. We would like to go before the Board  
6 with it." And I know that they pay a lot of money  
7 to do that, and it's a risk that the Board doesn't  
8 approve the application. So I understand all that,  
9 but that first layer of discussion is baffling to me  
10 that owners are hesitant to come in to present that  
11 as a preliminary, and work with staff and try to  
12 figure something out. You know, I don't think  
13 there's any way that the Board would deny an  
14 application that the facility is aging, can't meet  
15 life safety codes, is patching together things. I  
16 just don't see -- I see that the facilities are  
17 hesitant to put the money into the facility. They  
18 want to keep the beds growing, but they want to keep  
19 the physical plant as is. They're not putting money  
20 into the actual physical plant.

21 MR. FOLEY: That's absolutely  
22 correct.

23 MS. AVERY: So it's not the Board.  
24 It's the facility that's doing it.

25 MR. FOLEY: Yeah, but at least with

1 the variance option, I would think that it would put  
2 the Board in a more positive position when they do,  
3 in fact -- could, in fact, approve a project because  
4 they did, in fact, meet entitlement to a variance.  
5 So in line with what you're saying also, somebody  
6 may file an application, and, again, there's no  
7 guarantee. They may not be able to document  
8 entitlement to that variance, and that then gives  
9 the Board the opportunity, if they so choose, to  
10 deny an application for whatever reason, because  
11 they did not meet entitlement to the variance.

12 MR. CORPSTEIN: There's no evidence  
13 that they're denying.

14 MR. FOLEY: At this point in time,  
15 that's absolutely correct, because people are still  
16 reluctant to file an application.

17 MR. CORPSTEIN: So we're examining  
18 all of this because of the industry's reluctance? I  
19 don't understand. Like Courtney said, they can come  
20 in and talk to Mike and work this all out.

21 MR. FOLEY: They don't know that.  
22 It's up to our associations to get the word out  
23 obviously.

24 MR. CORPSTEIN: Okay.

25 MS. AVERY: Yeah, I agree with that.

1 It is.

2                   And in going with the associations, I  
3 was asked to talk to IDPH about coming to a meeting  
4 that is occurring in a couple weeks. That request  
5 has been denied at this point, so we'll have to find  
6 another avenue to have a discussion with the  
7 associations or their representatives regarding the  
8 issues of the dead beds, defining that, and some of  
9 the others, some of the other issues internally.  
10 They didn't cancel the meeting. They just said that  
11 for me to come to the Board was not appropriate -- I  
12 mean to the associations is not appropriate at this  
13 time.

14                   MR. FOLEY: So the associations are  
15 still going to meet then?

16                   MR. RIVA: Right, survey issues and  
17 other related matters, yeah.

18                   MR. BELL: We wanted to see if they  
19 could add the item to the agenda, and they said  
20 "no."

21                   MR. GAFFNER: I see.

22                   MS. AVERY: So I'll work on trying to  
23 get an audience with the associations at another  
24 time.

25                   MR. RIVA: Okay. And that can be an

1 issue to discuss to find out what are the barriers  
2 to filing applications, to hear directly from them.

3 MR. FOLEY: No. Courtney, you're  
4 absolutely correct, but we have talked to  
5 several -- if I may use the word "potential" clients  
6 out there. We tell them what we've done in the  
7 past. We tell them that the Board looked at each  
8 situation differently, but honestly also have to  
9 tell them what you just said, that the process could  
10 be very expensive. Whether they use a consultant or  
11 not, it's still an expensive process. And they're  
12 kind of reluctant to do anything. So they're asking  
13 me what's my odds of getting something approved?  
14 It's really kind of hard to say, you know, because  
15 we don't know what the Board is going to do. All I  
16 can repeat is it's just what Paul just said, the  
17 fact that the Board has not turned down too many  
18 projects within the last five years. So then I  
19 would assume that the odds would probably be in your  
20 favor, but I don't know that for certain either.  
21 And sometimes that just scares them away. They  
22 still don't want to do anything.

23 MR. CORPSTEIN: But isn't that  
24 helping with the overbeddedness in Illinois? Here's  
25 the industry from 2000. Half a percent, quarter

1 percent, percent, half a percent, quarter percent.  
2 It's a long, slow slope, right? With the stats,  
3 with what I do, with the percentage of occupancy  
4 from 85 down to 75 or 15 per year, it's just a half  
5 a percent, quarter percent all the way down. So the  
6 industry is going like this slightly, slowly  
7 decline. Everybody wants to add beds, adding  
8 variances and other ways -- I mean, there's no  
9 evidence that the Board is disapproving anything  
10 anyway. You're adding more beds when the industry  
11 is going this way, and you're adding more beds on  
12 top of it, and their numbers are going to be  
13 dropping farther, putting you farther in a bind,  
14 farther behind than you're going to put them in the  
15 position where they're actually going to start  
16 saying "no." So I don't know adding a variance or  
17 whatever makes it more easy for the board to say,  
18 "yes." They are saying "yes" already, but I don't  
19 know how is that going to help the overbeddedness in  
20 any way? I don't understand. Having that  
21 percentage out there, having them being reluctant to  
22 come add beds is good for the industry, because it's  
23 not adding to the overbeddedness.

24 MR. FOLEY: But also you are not  
25 providing -- you're not giving the opportunity for

1 our residents to live in the state-of-the-art  
2 facility because you're not encouraging any  
3 renovation or modernization or replacement of beds  
4 if you just want to leave it stagnant.

5 MR. CORPSTEIN: There's no hold to  
6 replacement facilities. Are you stopping any  
7 modernization project, any replacement?

8 MR. FOLEY: There's still that  
9 reluctance even to build replacement facilities.  
10 There's still that reluctance out there because  
11 there's not a bed need. So do I need a market study  
12 to show us that there's a continued bed need?  
13 Most --

14 MR. CORPSTEIN: Since all of Illinois  
15 is going down in the slight gradual slope, then I  
16 would say "yes."

17 MR. FOLEY: Some of this, some of  
18 this could be taken care of quite possibly  
19 through -- let me reverse this and say that most of  
20 the facilities in the State of Illinois are owned by  
21 multi-facility owners. I think everybody at the  
22 tables would agree with that. Proprietary  
23 facilities, our individual facility owner/operators,  
24 and I'll use the definition of those who own less  
25 than five facilities. Those kinds of people are

1 going away. So it's multi-facility providers that  
2 really today has the control of the industry.

3 So having said that, most of the  
4 applications that would be filed, one could assume  
5 would be filed by those that are multi-facility  
6 owner/operators, okay? If a lot of those  
7 facilities, a lot of those owner applicants have  
8 other facilities in the state with excess beds, and  
9 they want to come in and add beds or build a new  
10 facility or even build a new replacement facility,  
11 this could be a time when the state could come in  
12 and possibly ask them to use some of their existing  
13 underutilized beds, you know, with the percentage  
14 that they would give up more beds than they would  
15 actually want. Therefore, you would, in fact, see a  
16 decline in beds in the state.

17 MR. CORPSTEIN: Is that within the  
18 Board's purview, to ask them to return beds in any  
19 way?

20 MR. FOLEY: They used to be able to  
21 do that.

22 MR. CORPSTEIN: What's he talking  
23 about there?

24 MR. CONSTANTINO: They haven't done  
25 that since I've been here.

1 MR. FOLEY: But they have done it  
2 years ago is what I'm saying.

3 MS. AVERY: I think with the  
4 hospitals.

5 MR. FOLEY: I'm sorry?

6 MS. AVERY: It is with the hospitals.

7 MR. FOLEY: It was with long-term  
8 care also years -- I remember it back in the days  
9 when a certain chairperson would sit down and work  
10 with providers and say, "Hey, before we allow you to  
11 add any more beds, let's use your existing beds that  
12 you're not utilizing first." You know, that had  
13 happened in the past.

14 MS. AVERY: That was before us.

15 MR. FOLEY: That was before. That is  
16 absolutely correct.

17 MS. AVERY: There were a lot of good  
18 points about that.

19 MR. FOLEY: But it worked, not for  
20 those reasons.

21 MS. AVERY: Is that declinement for  
22 that kind of --

23 MR. FOLEY: So fine. We create a  
24 rule. We just create a rule then that would allow  
25 that. That's all.

1 MS. AVERY: But we operate under the  
2 premises that we want the support and input of the  
3 industry. So the industry's reluctance to address  
4 this issue with the overbedding and the appropriate  
5 way that would get us to an accurate inventory on  
6 the dead bed issue is on them. It only stagnates  
7 the growth for them, but the Board gets blamed for  
8 it, because the Board, when we cleared the inventory  
9 for the hospitals, the Board asked the hospitals  
10 about doing so and what will be the repercussions  
11 and all that, and they agreed that it needed to be  
12 handled because it was stagnating the growth in the  
13 State of Illinois. Hospitals couldn't be built,  
14 beds couldn't be added, but also did the exception  
15 with the 10 percent 20 rule. So without the input  
16 or the support of the associations and the facility  
17 owners, I don't think that the Board would just  
18 write a rule to do it.

19 MR. LAVENZA: Anyone else?

20 MR. GAFFNER: Thank you, Steve. I  
21 hope I can add a little bit of context that might be  
22 helpful. And, Paul, what you said, I think, is  
23 really important. I must say I never believed that  
24 the bed need methodology work group was sparked by  
25 fear of application submittal or a planning board

1 denial of applications or a lack of good technical  
2 assistance or collaboration by IDPH or planning  
3 board staff. I think the three of us were at the  
4 last bed buy-sell ad hoc work group meeting where  
5 all three associations were in agreement that there  
6 were aspects of the bed need methodology that -- and  
7 Kirk and Bill can correct me if I'm wrong  
8 here -- that contributed to the overbedding numbers,  
9 and that that issue was really even more important  
10 to be addressed before adequate consideration could  
11 be given to buy-sell transfer.

12 MR. BELL: Right.

13 MR. RIVA: In other words, revising  
14 the current methodology. We all agree there was  
15 consistency on that.

16 MR. CORPSTEIN: To making it more  
17 strict? You're saying that the methodology that we  
18 are using is allowing the industry to be overbedded?

19 MR. AGBODO: To some extent, yeah, I  
20 do find that, too.

21 MR. GAFFNER: Yes, sir, that the bed  
22 need methodology has some -- at least from my  
23 perspective, and we all may differ on that. What I  
24 mean by that is, Charles is a professional planner,  
25 and he runs the association, and that there are a

1 multitude of factors that impact that, such as  
2 relevance of data, accuracy of data. Perhaps I was  
3 believing this 85, 80 percent occupancy was a  
4 factor. You know, you addressed that, Nelson, and I  
5 must say I had no idea that had ever been run  
6 because I certainly have been asking that. So if  
7 others knew that, I apologize for being the voice  
8 that was continuing to ask for that.

9                   So I just want -- you know, because I  
10 know Mike and Paul, you're so faithful in coming to  
11 all these meetings, that I don't see us here today,  
12 because of what especially you said, Paul, that was  
13 a problem. I don't believe that's it. And I see  
14 Bill and Kirk nodding their heads on that. We  
15 stepped back from buy-sell transfer to try to make  
16 sure that the formula wasn't contributing to that.

17                   And, Courtney, I still think, you  
18 know, you were so accurate. When you said at that  
19 last meeting -- and I'll ask Bill because he may be  
20 involved in setting up that quarterly meeting  
21 agenda. I thought your request was appropriate,  
22 that at that meeting, the three associations talk  
23 about two things: How to quantify the unused beds  
24 and the definition for the unused beds. And I  
25 immediately sent that back, you know, to the Health

1 Care Council of Illinois after our last meeting and  
2 indicated that it could be a topic of discussion.  
3 Is that on the agenda for the upcoming quarterly  
4 meeting, Bill?

5 MR. BELL: No. That's what we tried  
6 to get on.

7 MR. GAFFNER: They won't even let  
8 that be discussed, let alone --

9 MS. AVERY: And it hasn't been  
10 totally ruled out. I was very respectful in saying,  
11 okay, this is the first meeting. So here are the  
12 things, and then I'll go back to Darlene and Deborah  
13 and kind of plead that this might be something that  
14 you can put us on the agenda once a --

15 MR. BELL: We can raise that that's  
16 something we'd like to see discussed.

17 MR. GAFFNER: I apologize. I  
18 misunderstood. I thought that the bed need  
19 methodology formula was laid aside, but I see it's  
20 related to all these things.

21 MR. BELL: To the whole issues, yeah.

22 MR. GAFFNER: Because I believe in  
23 some way -- and I must say I don't know how to  
24 quantify the 22,000. You know, how many could never  
25 live to see another day and how many couldn't, but I

1 think that factors into, again, what we're  
2 considering, which is where and how those go.

3           A question for the legal staff,  
4 because I think that was a point you really made  
5 well that if variances are identified by their  
6 criteria, could that prevent what I think is one of  
7 the best parts of the planning board, and that is a  
8 nine-member group that gets to think about it.  
9 Otherwise you just might as well put it into a  
10 computer, and at the end of the day it's going to  
11 say CON application denied or approved. That has  
12 fears in my mind.

13           Is it possible if what Charles is  
14 citing -- and I understand the merits of a variance  
15 program he's talking about. Could that last  
16 variance somewhat be one that's called general? Or  
17 discretion variance that allows the Board to still  
18 do what they do today? Which I think is really,  
19 really important. And maybe that's something that  
20 has to be researched. But I agree that I don't  
21 think that important subjectivity should be lost.

22           MR. LAVENZA: I would say that, you  
23 know, Jean has made a very good point in regard to  
24 the variance. I think ultimately what the variance,  
25 what we're going to see or what could happen is

1 there may be an additional argument to not approve a  
2 project if it didn't meet that threshold, but  
3 ultimately the Board has discretion, right? We have  
4 the criteria that exists now. There are instances  
5 where projects do not meet all of the criteria, and  
6 yet because of a number of different factors, those  
7 nine folks that sit on that board approve a project.  
8 I don't know that that would change, but it may make  
9 things more difficult for folks that are unable  
10 to -- that are trying to make that case and can't  
11 hit the variance threshold.

12 MR. GAFFNER: All right. Thank you.

13 Nelson, of the 23 CON states, I  
14 believe there were seven that reported out to you.  
15 The other 16, did they just not give you anything  
16 that could have been included in this report, or was  
17 there a conscious decision made not to consider  
18 that? Because they differed in Illinois in some  
19 way. I'm just curious about kind of that 16 that's  
20 out there that we --

21 MR. AGBODO: They did not respond to  
22 my question.

23 MR. GAFFNER: They did not respond to  
24 your requests?

25 MR. AGBODO: Right.

1 MR. GAFFNER: I'm sorry they didn't.  
2 I don't know if there's a magic bullet out there in  
3 those or whether more of the same.

4 MR. AGBODO: And some of the states,  
5 I think I received two or three responses saying  
6 that they don't have a formula anymore since they  
7 have a moratorium. They don't have any current  
8 formula.

9 MR. GAFFNER: Right. I think of the  
10 23, they didn't have a moratorium, if I remember  
11 right.

12 MR. AGBODO: Some of them, yeah. I  
13 can see here. Well, yeah, yes. All together, 36,  
14 right? The total is 36. 13 are on moratorium.

15 MR. GAFFNER: That would leave 23.

16 MR. AGBODO: You're right. So, yes,  
17 we did not receive a response from them, but I'm  
18 going to follow up with them, and if you want, I can  
19 add more formulas.

20 MR. GAFFNER: I'm not trying  
21 to -- because I said to you coming up in the  
22 elevator, I think anyone in state government that  
23 deals with numbers, you know, as I said to you, your  
24 work is never done, and I'm not trying to add more  
25 work.

1 MR. AGBODO: It's okay. If that can  
2 help, I will definitely contact them. And I'll give  
3 the report on the formulas. For me, we are going to  
4 continue seeing a difference from the other states  
5 compared to Illinois. We just need, like I said, to  
6 understand Illinois and have a formula that's a  
7 clear approach, and that approach has to be defined  
8 by us. That's my need. I need to know what do you  
9 want this formula to do?

10 MR. GAFFNER: And I remain grateful.  
11 And, Courtney, I believe I said it to you the last  
12 time we met that it's really great that staff -- and  
13 Nelson has said it here around this table -- are  
14 asking us to weigh in, and we're given this  
15 collaborative opportunity, and not one where its  
16 being said, "Okay. Here it is, and now go live with  
17 it." So amidst all of this, you know, I, again,  
18 want to echo, you know, from at least the  
19 association that I'm representing, thank you for  
20 that. Thank you for that.

21 MS. AVERY: You're welcome. But part  
22 of it we understand is that there will be requests,  
23 which that's why staff is here to support the work  
24 group and the subcommittee. So if they're  
25 requesting things, if we can do it, we do it. If

1 it's not possible to do it, we'll say that. But  
2 we're taking our directives from the work group and  
3 from the subcommittee.

4 I just want to add one thing about  
5 the variances. If the industry is so inclined and  
6 think that this will be the key to it, there is  
7 nothing to prohibit introducing language for rule  
8 changes. As the administrator of the board, I would  
9 be reluctant to go before them and say you need to  
10 do this without the input or the initiative from the  
11 industry. So there's nothing to prohibit the  
12 associations to get together and say, "This is what  
13 we need done. Can you look at it, see how it will  
14 work?" And that's how we came about with all these  
15 other things that we've been working on. The staff  
16 has not made any recommendations or suggestions to  
17 what should come out of the subgroups or the work  
18 group -- the subcommittee or the work groups.

19 MR. RIVA: And the variance language  
20 that you just -- the variance language that we just  
21 talked about, that can be done just through rule?  
22 Is that what you just said?

23 MS. AVERY: It's possible.

24 MR. RIVA: I didn't know whether it  
25 had to be rule or statute.

1 MR. GAFFNER: Nelson, go ahead.

2 Pardon me.

3 MS. AVERY: No. Go ahead.

4 MR. GAFFNER: I would be interested  
5 at least in Iowa, I think they're a state that used  
6 a rural, urban. Their logic behind that only that  
7 Illinois certainly does have some very rural areas  
8 and some very urban areas. I would be interested if  
9 they would share their rationale with you and how  
10 that may have changed overbedding or accurate supply  
11 or undersupply in those respective areas.

12 MR. AGBODO: Okay.

13 MR. GAFFNER: Thank you.

14 MS. AVERY: We haven't reached any  
15 conclusions, right?

16 MR. LAVENZA: No. We have to get out  
17 of here in 10 minutes. Hello? Hi? We have to kind  
18 of wrap this up now because we have to vacate this  
19 conference room in 10 minutes. So does anyone want  
20 to suggest what the next item should be for the next  
21 meeting? I heard one thing was to model out Iowa as  
22 far as Illinois applies. Does anyone have anything  
23 else?

24 MS. AVERY: I do. Is it possible as  
25 the associations for you all to go back and get some

1 kind of, I guess, uniform input or comment on the  
2 information that's sent? I know we have got some  
3 things, but it's not really a concrete conclusion,  
4 but some things that Nelson can look at or  
5 suggestions based on the two documents that have  
6 been circulated, especially this other one, to give  
7 us some kind of guidance because it's kind of all  
8 over the map.

9 MR. RIVA: Have these documents that  
10 most people have -- I don't know. I didn't get the  
11 one on the states that have CON. Have these  
12 documents been sent to the full subcommittee?

13 MS. AVERY: They're on the website.  
14 What I did was sent an e-mail saying that they were  
15 posted. I think we talked -- Kirk, I just said  
16 they'll be posted by Friday, so I should have  
17 probably followed up with you to say that they're on  
18 there, but any documents that we send out are always  
19 posted on the website.

20 MR. RIVA: Okay.

21 MS. AVERY: Charles?

22 MR. FOLEY: You know, again, I think  
23 for the next meeting, Steve, in order to help  
24 Nelson, I think the three associations also need to  
25 decide what they actually want to see in terms of

1 the new beds. Whether or not they want new beds in  
2 Illinois, how do we get new beds in Illinois, I  
3 think that would help Nelson out in order to define  
4 ways to tweak the methodology that we currently  
5 have. So that the industry does in fact want to see  
6 new beds, new construction, whatever, that tells him  
7 one thing. If they don't, that tells them something  
8 else entirely. So I think the associations need to  
9 go back and say, "Okay. This is our opportunity to  
10 work with the Board and to suggest to them what we  
11 need versus what we don't need."

12 MS. AVERY: And I agree with that,  
13 but I will add that the association should also  
14 address the inventory.

15 MR. FOLEY: By all means. That's  
16 part of it, yes.

17 MS. AVERY: And get us accurate bed  
18 count information.

19 MR. FOLEY: That's very important,  
20 Courtney. Thank you. That's very important.

21 MS. AVERY: A room that has three  
22 residents in it that is now one, no way is it going  
23 back to three, take those beds out. A room that has  
24 been converted to office space and can no longer  
25 accommodate a patient that needs that level of care,

1 to move those beds, and let's get an accurate  
2 inventory or come up with a solution as to why  
3 they're holding on to those beds. If there is a  
4 legitimate reason, why that's a -- let's figure out  
5 how to remove those or count for those in the  
6 inventory.

7 MR. LAVENZA: Maybe make a separate  
8 category or something.

9 MS. AVERY: Answer that question.

10 MR. GAFFNER: That's what I was going  
11 to say, Steve. I wonder if it's another column that  
12 basically, you know, identifies that type of bed  
13 that would never go back into service.

14 MR. CONSTANTINO: Do you want to try  
15 that again?

16 MR. GAFFNER: As Bill just said, but  
17 it can't be removed either because of financing or  
18 whether an owner believes it has a value. I mean,  
19 that whole waterfront is another issue.

20 MR. FOLEY: If we're able to identify  
21 some of these beds that are not being utilized out  
22 there, we put them into a separate column, and then  
23 we have a column that says here's X number of beds  
24 that had not been used, identify a time period for  
25 the last three, four, five years, identify the time

1 period. Then as that number -- the difference of  
2 those number of beds, that we would use them to  
3 compute a bed need.

4 MS. AVERY: I agree with what you're  
5 saying, Charles.

6 MR. FOLEY: That's right. That's  
7 right. And those beds could not be reused unless  
8 they go back to the Board.

9 MS. AVERY: I think it is reasonable  
10 what you're saying, but, again, we would like for  
11 that to come from the industry with the three  
12 associations sending us something to work on, right?

13 MR. LAVENZA: Yes. Nelson?

14 MR. AGBODO: What I really need is a  
15 clear and a measurable definition of appropriate  
16 allocation of beds. That's the ground for all this  
17 work I've been doing, and I will provide that and  
18 finish it. I don't know if you guys agree with that  
19 definition or not, but like I said, the definition I  
20 have right now is projection that cover 100,  
21 110 percent of needs for every health planning area,  
22 and that derives from the current bed needs  
23 methodology. I really want to know if everybody  
24 agrees with that definition or what else do you want  
25 to add or subtract from that definition so we move

1 forward with, you know, the common concepts that we  
2 agree on. I saw a comment from IHCA saying the  
3 appropriate definition, they would like to see equal  
4 allocation, so the equal allocation to appropriate  
5 allocation. I didn't have the definition of equal  
6 allocation from them. That makes my work harder  
7 then. So I try to compare what they want as equal  
8 allocation to what we already have as the definition  
9 of appropriate allocation, and I've seen that really  
10 there's no difference for me, but I still need to  
11 hear from everybody about the concrete definition,  
12 and that will help a lot.

13 Thank you.

14 MS. AVERY: Okay.

15 MR. FLORINA: This is Florina. If I  
16 could make a comment.

17 We talked about identifying the beds  
18 regarding nursing homes' unidentified beds, licensed  
19 beds. Have we expressed concerns before regarding  
20 the unidentified beds that are components in  
21 long-term care, such as assisted living, that has an  
22 important impact on bed needs? Do we still need to  
23 address that as to how that figures into our  
24 calculation of beds needed and the percentage of the  
25 population that's going to need nursing home beds

1 versus assisted living type beds?

2 MR. CORPSTEIN: I would say, no. I  
3 already calculated 15 years' worth of stats. Since  
4 2000 to 2015, last month, the same half a percent,  
5 quarter percent, 1 percent, every year decline is  
6 the same. Assisted living came into being in 2002,  
7 or 2000 -- I don't know. It's on my spreadsheet.  
8 But it made no appreciable difference in bed  
9 occupancy or number of beds. The same decline  
10 before assisted living came into being is the same  
11 decline afterwards.

12 MR. FOLEY: I disagree with that.

13 MR. CORPSTEIN: I'll send the  
14 spreadsheet.

15 MR. FLORINA: Assisted living does  
16 have an impact on nursing homes.

17 MR. CORPSTEIN: That may be, but the  
18 numbers do not show any significant difference from  
19 when they came into being. The same percentage  
20 decline over 15 years is unchanged. And, of course,  
21 if you know there's nursing home residents in a  
22 assisted living, then you should do the right thing  
23 and file a complaint. Of course, we will  
24 investigate it.

25 MR. FLORINA: But we're not

1 specifically including any data regarding assisted  
2 living in our calculation. Are you assuming we  
3 should just accept what the data shows from --

4 MR. CORPSTEIN: I need to see  
5 something that shows assisted living is poaching or  
6 whatever.

7 MR. GAFFNER: I guess the only thing  
8 I could add there, Paul --

9 MR. CORPSTEIN: Other than anecdotal  
10 is all I'm saying.

11 MR. GAFFNER: That's what I'm going  
12 to say. I understand as a statistician how you  
13 can't do that, and I'd have to look at my other two  
14 colleagues here. When I think of the Fair Oaks  
15 situation where I previously worked, and when the AL  
16 opened in town, there was a distinct change in the  
17 census within Fair Oaks Nursing Home. Now, again,  
18 that's anecdotal. You're absolutely right.

19 MR. CORPSTEIN: All I can provide is  
20 numbers. So the numbers --

21 MR. GAFFNER: I respect that.

22 MR. CORPSTEIN: -- are the same.

23 MS. AVERY: So maybe we can look at a  
24 way to incorporate the stats and the data that Paul  
25 has given us to -- something for the next time so

1 you all can look at it because I thought it was very  
2 impressive and made a good argument that the stats  
3 that he put together for the Board staff.

4 MR. FOLEY: I would love to see that.

5 MR. AGBODO: In addition to that, the  
6 Board intern here, Mr. Chavan, right? He is working  
7 on a literature review. Maybe that will add  
8 qualitative analysis to the data. So if you can  
9 quickly say what you're doing.

10 MR. AASHAY: Well, I'm currently  
11 looking at just Illinois and how the assisted living  
12 facilities, nursing home, like at-home, on-site, how  
13 those are comparing to like how the data is changing  
14 for the last five years and how it's predicted for  
15 the future. So it's kind of tweaking the formulas  
16 to kind of change with the times, so to speak. So  
17 basically that much.

18 MR. FOLEY: That's good.

19 MR. AASHAY: Every year they  
20 make -- like how Nelson has said that the people he  
21 spoke to in Iowa, they only apply the formula. They  
22 don't know how to kind of project it, but so  
23 basically what I'm trying to look at is how they  
24 kind of change the formula based on training trends  
25 because it's not a very -- it's a very dynamic

1 formula.

2 MR. FOLEY: What you're saying is  
3 we're only looking at part of the picture, not the  
4 total picture?

5 MR. AASHAY: Yeah. And like he also  
6 said earlier, the question about Iowa, the rural and  
7 the urban one, it's very similar to Illinois,  
8 because rural communities have less population.  
9 They have a larger distance of travel, so that's why  
10 they have kind of a different formula than the urban  
11 ones because they need to travel further. Maybe  
12 their response time for that ambulance is longer,  
13 for them to get to where they need to go to. So,  
14 yeah.

15 MR. AGBODO: I think what he is doing  
16 will help out to see a bigger picture of what we  
17 have been providing in the analysis so far. So it's  
18 just a qualitative aspect of the work.

19 MR. FOLEY: I think that's what we've  
20 been talking about all along.

21 MR. AGBODO: All right. Thank you.

22 MR. FOLEY: Thank you, Steve.

23 MR. LAVENZA: You're welcome. We're  
24 looking at dates to give the associations time to  
25 get a response, and to, you know, redo the models

1 and everything. I think the next meeting should be  
2 the first week in December. Actually, the first  
3 full week, first full week, either the 7th, 8th  
4 or 9th. What does everyone think?

5 MR. FOLEY: I'm okay.

6 MR. BELL: I'm okay. That's  
7 Wednesday.

8 MR. FOLEY: Monday, Tuesday or  
9 Wednesday.

10 MR. GAFFNER: I would suggest the  
11 7th or 9th, if possible.

12 MR. LAVENZA: I hate to do it on a  
13 Monday. I know how busy people are on a Monday.

14 MR. FOLEY: The 9th is fine, Steve,  
15 as far as we're concerned here.

16 MR. LAVENZA: I am checking my  
17 calendar here. Yeah, the 9th is good for me.

18 MS. AVERY: Wednesday,  
19 December 9th. We'll check on locations and get  
20 back to you.

21 MR. CONSTANTINO: Is that good for  
22 you, Paul?

23 MR. CORPSTEIN: I'm here every day.

24 MR. LAVENZA: Thank you, and  
25 everybody else. Thanks again, Nelson, for your

1 report.

2 MS. AVERY: John, is the 9th okay  
3 with you?

4 MR. FLORINA: That's fine. Thank you  
5 for checking.

6 MS. AVERY: You're welcome. Okay.  
7 Thanks everyone. All right. Thank you.

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9 (Meeting ended at 12:00 p.m.)

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CERTIFICATE OF REPORTER

I, Ann Marie Hollo, Certified  
Shorthand Reporter within and for the State of  
Illinois, do hereby certify that the preceding  
meeting was taken by me to the best of my ability  
and thereafter reduced to typewriting under my  
direction; that I am neither related to, nor  
employed by any of the parties to the action in  
which this meeting was taken.

\_\_\_\_\_  
Certified Shorthand Reporter  
State of Illinois

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