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1 STATE OF ILLINOIS  
 2 HEALTH FACILITIES AND SERVICES REVIEW BOARD  
 3 LONG-TERM CARE ADVISORY SUBCOMMITTEE  
 4 METHODOLOGY WORKGROUP  
 5  
 6  
 7 IDPH Administration  
 8 535 West Jefferson Street, 4th Floor  
 9 Springfield, Illinois 62671  
 10 -and-  
 11 HFSRB Administrative Office  
 12 69 West Washington Street, 35th Floor  
 13 Chicago, Illinois 60602  
 14  
 15  
 16 MEETING OF THE  
 17 LONG-TERM CARE FACILITY ADVISORY SUBCOMMITTEE  
 18 METHODOLOGY WORKGROUP  
 19  
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 21  
 22 Meeting of the Workgroup was held by  
 23 videoconference on Monday, July 27, 2015, scheduled  
 24 for 10:00 a.m.

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1 MEMBERS PRESENT IN CHICAGO:  
 2 Steven N. Lavenda, Chairman  
 3 Alan Gaffner  
 4  
 5 MEMBERS PRESENT IN SPRINGFIELD:  
 6 Charles Foley  
 7 William Bell  
 8  
 9 MEMBERS PRESENT VIA TELECONFERENCE:  
 10 Cecilia Credille  
 11 Carolyn Handler  
 12 John Florina  
 13  
 14 CHICAGO STAFF:  
 15 Courtney Avery  
 16 Juan Morado (via teleconference)  
 17  
 18 SPRINGFIELD STAFF:  
 19 Mike Constantino  
 20 Nelson Agbodo  
 21 Mike Mitchell  
 22 George Roate (via teleconference)  
 23  
 24 GUESTS:  
 25 John Knierly  
 26 Don Reppy (via teleconference)  
 27 Matt Hartman (via teleconference)  
 28 Amy Mitchell (via teleconference)

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1 AGENDA  
 2 CALL TO ORDER  
 3 1. Roll Call  
 4 2. Approval of Agenda  
 5 3. Workgroup Purpose and Goals -  
 6 Steven Lavenda  
 7 4. Illinois Health Care Association -  
 8 Don Reppy  
 9 5. Next Steps  
 10 6. Next Meeting Date(s)  
 11 7. Adjournment  
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1 (Meeting commenced at 10:00 a.m.)  
 2  
 3 CHAIRMAN LAVENDA: I thought we'd start  
 4 with some introductions. My name is Steve Lavenda.  
 5 I'm with the accounting firm called Frost in the  
 6 Chicago area, and I'm the chairman of this sub-  
 7 subcommittee.  
 8 MR. GAFFNER: Alan Gaffner with The  
 9 Alden Network, representative to the Long-Term Care  
 10 Subcommittee for Health Care Council of Illinois.  
 11 I'm attending today in my role of interest in the  
 12 topic rather than a member of the ad hoc workgroup.  
 13 MS. AVERY: Good morning. Courtney  
 14 Avery.  
 15 I don't know what that means.  
 16 CHAIRMAN LAVENDA: I think someone is  
 17 signing in.  
 18 MR. MORADO: Good morning, Juan Morado  
 19 for the Board.  
 20 MS. AVERY: Juan's on the phone. So  
 21 we'll do the individuals on the phone. We have  
 22 Juan. And who else?  
 23 MR. REPPY: Don Reppy.  
 24 MR. ROATE: George Roate, IDPH.

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1 MS. AVERY: Who was from IDPH?  
2 MR. ROATE: George Roate.  
3 MR. HARTMAN: Matt Hartman of IHCA is  
4 on as well.  
5 COURT REPORTER: I'm sorry, the last  
6 one again was?  
7 MR. HARTMAN: Matt Hartman of Illinois  
8 Health Care Association.  
9 MS. MITCHELL: Amy Mitchell is on the  
10 line.  
11 MS. AVERY: Is anyone else on?  
12 CHAIRMAN LAVENDA: Anyone else on the  
13 phone?  
14 MR. FLORINA: John Florina, part of the  
15 ad hoc committee.  
16 MS. AVERY: Okay. Anyone after John?  
17 (No response)  
18 MS. AVERY: Okay. Springfield?  
19 MR. CONSTANTINO: Mike Constantino,  
20 IDPH.  
21 MR. AGBODO: Nelson Agbodo, staff.  
22 MR. FOLEY: Charles Foley, committee  
23 member.  
24 MR. KNIERY: John Kniery, guest.

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1 MR. BELL: Bill Bell, Illinois Health  
2 Care Association.  
3 MR. MITCHELL: Mike Mitchell, IDPH.  
4 CHAIRMAN LAVENDA: Okay. I think we've  
5 got everybody.  
6 Okay. So, first, the first thing is  
7 approval of the agenda which Courtney sent out a  
8 couple days ago.  
9 Does anyone have any additions or any  
10 questions on it?  
11 (No response)  
12 CHAIRMAN LAVENDA: Okay, guess not.  
13 Moving on to the next thing, the  
14 workgroup purpose and goals.  
15 I've read the -- I've read Nelson's  
16 e-mail that he sent out last week. Did everyone  
17 get a copy of that?  
18 MS. AVERY: No. That was just sent  
19 through e-mails.  
20 CHAIRMAN LAVENDA: Oh, that was just  
21 e-mails. Okay. You know, I know we talked vaguely  
22 about this committee the last time we met.  
23 MS. AVERY: Did someone just join the  
24 phone conference?

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1 MS. CREDILLE: Yeah, Cece Credille with  
2 IHCA.  
3 MS. AVERY: Thank you.  
4 CHAIRMAN LAVENDA: We're just getting  
5 started here.  
6 We have to set a purpose for the  
7 committee. You know, we're trying to -- I think  
8 what the purpose as I see it, we're trying to see  
9 if the current bed need formula is adequate, and if  
10 it's not, you know, what can we do to suggest to  
11 revise it or to make it that it's more equitable  
12 and fair for all the different providers in the  
13 state.  
14 Does anyone have any comment on that?  
15 Any staff?  
16 (No response)  
17 CHAIRMAN LAVENDA: You know, clearly,  
18 there seems to be, you know, excess bed needs per  
19 the current formula in the more metropolitan areas  
20 and -- I said that back -- I'm sorry, excess beds  
21 in the metropolitan areas and a bed need in the  
22 more rural areas of the state and, you know, the  
23 question is how do we deal with that.  
24 MS. HANDLER: Excuse me. This is

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1 Carolyn Handler. I just joined. Sorry I'm a few  
2 minutes late.  
3 MS. AVERY: Thanks, Carolyn.  
4 CHAIRMAN LAVENDA: Has everyone had a  
5 chance to read over the Ohio rules, you know, as  
6 one of the suggestions as an alternate way of  
7 determining bed need? Does anyone have any  
8 comments on it?  
9 MR. AGBODO: No. I was waiting for  
10 Don's presentation.  
11 CHAIRMAN LAVENDA: Okay. I went a  
12 little bit out of order.  
13 Yes, Charles.  
14 MR. FOLEY: John, do you want to --  
15 MR. KNIERY: Well, let's have the  
16 presentation first.  
17 MR. FOLEY: Okay. Go ahead.  
18 MS. AVERY: Okay. So, no questions  
19 about the purpose and the goals. And I guess that  
20 will be evolving as we go.  
21 MR. FLORINA: This is Florina, if I can  
22 add one item here, more of an overreaching thing.  
23 We're also here to determine the best  
24 allocation of beds on a statewide basis for the

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<p>1 needs of the people of Illinois. 2 CHAIRMAN LAVENDA: Correct. Not 3 necessarily for the people running them but for the 4 needs for the people of Illinois, correct. 5 Shall we go ahead with the 6 presentation? Don, did you want to make your 7 presentation? 8 MR. REPPY: Sure, sure. That will be 9 fine. 10 My name is Don Reppy and I'm Director 11 of Health Planning for HCR-ManorCare and I've been 12 asked to make this presentation today on -- 13 MS. AVERY: Excuse me, Mr. Reppy. 14 We have a lot of paper pickups. So, if 15 we can mute, that will be great. And I'll do the 16 same here. 17 Okay. Go ahead. 18 MR. REPPY: Okay. I've been asked to 19 make this presentation today on IHCA's 20 recommendation to change the Illinois bed need 21 formula to a beds per thousand persons age 65 22 approach. 23 First, a bit of history I think. 24 Health planning generally came about to ensure</p>	<p>1 didn't need to address those goals because getting 2 beds in place to serve people was the goal. 3 And so now we fast-forward 40 years and 4 the long-term care marketplace is completely 5 different. Acute care has been divided into many 6 pieces so that services we once got in the hospital 7 we now get in long-term care and long-term care has 8 been divided into many pieces so that nursing homes 9 provide post-acute services and skilled nursing 10 care. And intermediate nursing care is generally 11 gone, replaced by assisted living with completely 12 different care standards and rules. And home 13 health care is much more prominent. And managed 14 care insurance is much more prominent in 15 controlling the types of services we provide and 16 how they're paid for. 17 In addition, the results of the effort 18 to distribute beds everywhere did have in many, 19 many states some unintended consequences, as 20 provided in the "Overview of Illinois Long-term 21 Care Bed Need Methodology" that Nelson prepared. 22 From 2000 -- and from that report it says from 2005 23 the formula's projected patient days remain higher 24 than actual patient days. That means that the</p>
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<p>1 economic and geographic access to care and control 2 costs without compromising quality. Federal funds 3 were in the mix. And it became clear that 4 providers -- very early in the process it became 5 clear that providers were much less willing to take 6 risk and develop new long-term care in less 7 populated or lower income areas, and so bed need 8 formulas were developed and enforced by each state 9 to encourage providers to develop where there was a 10 need rather than where the provider believed it was 11 most profitable or where there was the least risk. 12 And Medicaid provided the reimbursement. 13 Today we have the fruits of that 14 effort. SNFs were built all over the state in 15 places like Henry and Canton and Danville, as well 16 as more urban areas like Chicago and Peoria. The 17 goal at that time was to get long-term care beds 18 operational everywhere, and it was successful. But 19 the original approach didn't address beds out of 20 service, which beds to count, how adding long-term 21 care beds might impact other levels of care, the 22 economics of long-run operations, what to do when a 23 skilled nursing facility is 50 years or what 24 happens when a community loses population. It</p>	<p>1 formula has been overestimating patient days for 2 purposes of bed need for a long time, maybe ten 3 years. 4 There's a quote in here that says the 5 assumption that the use rate will remain the same 6 over the projection period is optimistic. To us, 7 that means that the formula will take current use 8 rates -- takes current use rates and assumes they 9 will remain the same in the future, but they 10 haven't. Most of the health planning areas do not 11 use their own total patient days, while some of the 12 health planning areas use over their projected 13 numbers. To us, this means that the formula 14 doesn't allocate new beds to the optimum advantage 15 of each health planning area. Those that may need 16 more beds get less and those that may need less 17 beds get more. The bedding methodology projects 18 number of patient days, therefore number of beds, 19 higher than the actual number used at the state 20 level. That's a quote from the report. 21 Once again, the bed need methodology 22 projects number of patient days higher than the 23 number actually used at the state level. And that 24 means the bed need formula projects more beds than</p>

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1 are needed on a statewide basis.  
 2 Use rates -- here's another quote: Use  
 3 rates for each age group vary significantly between  
 4 health planning areas. This means that there's not  
 5 equal access for the citizens of Illinois across  
 6 the state. Those areas that use more beds get  
 7 more.  
 8 And then it says here also, the  
 9 variability observed between projected and actual  
 10 use rates may be -- may be related to the  
 11 assumptions built into the methodology. To us,  
 12 this means that the methodology is flawed.  
 13 IHCA believes you cannot control an  
 14 industry -- in this case long-term care -- with a  
 15 formula that was developed 40 years ago.  
 16 Continuing to use the existing formula or a  
 17 modification of the formula will only make future  
 18 beds out -- might make future bed allocation more  
 19 equal. It's not going to change the past. What's  
 20 past is past. Nursing homes are built and they're  
 21 there. It's not going to change anything.  
 22 So, this sort of means no new  
 23 facilities in some areas for years and years, no  
 24 incentive for providers to upgrade, more unused

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1 licensed beds as providers in areas where the  
 2 population has shifted elsewhere take beds out of  
 3 service, no reason for providers to bring beds back  
 4 into service, more Medicaid liability for the state  
 5 as new beds are added, and no leverage to encourage  
 6 providers to close three-bed and four-bed rooms.  
 7 And we believe that the current methodology does  
 8 not and cannot address the big picture because it  
 9 perpetuates the status quo.  
 10 The current formula might work if there  
 11 was more timely and accurate data, a clear way to  
 12 account for migration of people from underbedded  
 13 areas, and more money to appropriately and  
 14 adequately process the data. However, that doesn't  
 15 seem likely under current circumstances.  
 16 We're proposing the adoption of the  
 17 Ohio approach that calculates a statewide use rate  
 18 and that applies that use rate to every county.  
 19 The approach would equalize access by creating need  
 20 in areas that are currently underserved or  
 21 underbedded.  
 22 The Ohio system is pretty simple. It  
 23 takes the statewide patient days and divides it by  
 24 total licensed bed days available to get the

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1 statewide occupancy. It takes the statewide  
 2 occupancy, multiplies it by the total licensed  
 3 beds, and comes up with the total licensed beds  
 4 occupied. And then we try -- then it tries to  
 5 figure out how many beds are needed to serve those  
 6 patients.  
 7 Well, if you assume 90 percent  
 8 occupancy, then 84,911 beds are needed to serve  
 9 76,420 patients. You take the 84,911 beds and you  
 10 divide it by the 65-plus population, you reach a  
 11 conclusion that Illinois needs about 50-51 beds per  
 12 thousand.  
 13 So, if everyone who has the chart can  
 14 look through the chart, what we did was we took  
 15 several counties, Cook, Champaign, DuPage, Kane,  
 16 Lake, McHenry, Sangamon, and Will, and we  
 17 calculated the current -- we came up with the  
 18 current 65-plus population. And we did this from  
 19 Pitney Bowes, their projections, not the Illinois  
 20 projections. And we calculated -- then, of course,  
 21 we came up with Illinois's existing beds and then  
 22 we used the need or excess under the current  
 23 formula and came up with the existing beds per  
 24 thousand. And then we took the total beds needed

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1 at 51 beds per thousand and you can see the  
 2 difference. There's a big difference.  
 3 Under the current formula Cook County  
 4 has an excess of 2800 beds. Under our formula it  
 5 has an excess of 5200. Will County currently has  
 6 an excess under the current formula of 169 beds,  
 7 but under our formula it has a need for 532.  
 8 Now, to take a step back, the reason we  
 9 used Cook County and not the individual planning  
 10 areas in Cook County is we didn't have the  
 11 population numbers for those areas. So we just  
 12 consolidated Cook County into one area.  
 13 But as you can see, there is  
 14 significant difference in where the beds would be  
 15 developed. And I think the gentleman who mentioned  
 16 what's in the best interest of the citizens of  
 17 Illinois, it seems to me that equal access is in  
 18 the best interest of the citizens of Illinois.  
 19 So, now we've sort of come to a place  
 20 where we see where the bed need is and where the  
 21 excess is. And now we want to look at this chart.  
 22 It's called Improving Bed Allocation Between Health  
 23 Planning Areas, Figure 11, page 29 of Nelson's  
 24 report. And it tells us a lot. It really tells us

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1 a lot. Because if you look here at the -- I hope  
 2 you have a color copy because you can see the red  
 3 lines on the color copy. And the red lines are the  
 4 actual use rate of nursing homes by the 65-plus  
 5 population. What's going on in Ford County? It  
 6 has an extremely high use rate. And what's going  
 7 on in Will County? It has a very low use rate.  
 8 Now, we don't know what's going on, but  
 9 why do the residents of Ford County have  
 10 significantly more access to long-term care beds  
 11 than the people in Will County? Does Will County  
 12 not have enough beds or does Ford County have too  
 13 many?  
 14 Another interesting question is: Is  
 15 the high number of long-term care beds in Ford  
 16 County crowding out opportunities to develop  
 17 assisted living? Why would an entrepreneur develop  
 18 assisted living if everybody goes to the nursing  
 19 home, if the patterns of medical practice in that  
 20 community send everyone to a nursing home? And  
 21 then -- but shouldn't health planning encourage the  
 22 lowest level of care appropriate rather than the  
 23 highest?  
 24 So, there's something going on there.

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1 I don't know what it is. Haven't looked at it  
 2 carefully, but it's very unusual that you would  
 3 have that kind of high use rate.  
 4 Then let's look at Will. Are Will  
 5 County patients going to DuPage or Cook for  
 6 services because there aren't enough beds there?  
 7 Are people sicker in Ford County than they are in  
 8 other parts of the state? Is that why they're  
 9 going to nursing homes? Is the pattern of practice  
 10 in Ford that we see on this chart with a high rate  
 11 of skilled nursing usage a good thing or is it a  
 12 bad thing? Is the pattern of migration from Cook  
 13 to DuPage because there's no beds in Will? Is that  
 14 a good thing or a bad thing? Will tweaking the  
 15 existing formula perpetuate these trends? And I  
 16 think the answer to that is yes. And if these two  
 17 patterns are undesirable, then should health  
 18 planning attempt to change them? So, those are  
 19 like some of the questions that are out there.  
 20 We believe that the only answer here is  
 21 equal access, the same -- approximate same number  
 22 of beds per person age 65 in every area. I mean,  
 23 we reallocate congressional districts and  
 24 legislative districts so everybody has equal

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1 representation. Why shouldn't everyone have equal  
 2 access? And also, this approach will then  
 3 complement any effort to transfer or relocate beds  
 4 from overbedded to underbedded areas.  
 5 The committee has been looking for a  
 6 way to address all of the issues that are in its  
 7 charge, things like innovation and private rooms.  
 8 And we think that using this formula with a  
 9 transfer or relocation system will kind of solve  
 10 all of those problems and make everybody a winner.  
 11 So that's basically where we're coming  
 12 from. And if we have any questions or discussion,  
 13 whatever, I'm open or everybody else is open too,  
 14 I'm sure.  
 15 MR. FLORINA: Don, this is John  
 16 Florina. Just a quick question on the calculation.  
 17 You have the sheet titled Ohio Formula Applied to  
 18 Illinois that has the few counties listed.  
 19 MR. REPPY: Uh-huh.  
 20 MR. FLORINA: Did you devise that  
 21 sheet?  
 22 MR. REPPY: Yes.  
 23 MR. FLORINA: Okay. I'm just trying to  
 24 get the math straight. I don't want to belabor the

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1 whole discussion.  
 2 MR. REPPY: Okay.  
 3 MR. FLORINA: The second to last number  
 4 in the top box says number of beds needed at 90  
 5 percent occupancy.  
 6 MR. REPPY: If you have -- okay. It's  
 7 very simple. You have total licensed beds in the  
 8 state occupied in 2013 was 76,420. So, those are  
 9 76,420 people that need care. All right? So, if  
 10 you divide that number by 90 percent, you get  
 11 84,911. Which means you need approximately 84,911  
 12 beds to serve 76,000 people because nursing homes  
 13 -- the occupancy is going to go up and down. You  
 14 know, patients can't be admitted. When a patient  
 15 leaves on Monday, maybe you can't admit a patient  
 16 to that bed until Tuesday. So, it's just a 90 --  
 17 it assumes 90 percent occupancy of all of the beds.  
 18 MR. FLORINA: Can I just back up and  
 19 make sure I'm clear? Because the second number you  
 20 have on the box says total licensed beds in the  
 21 state of 99,422.  
 22 MR. REPPY: Correct.  
 23 MR. FLORINA: Are you talking about 90  
 24 percent of the licensed beds being this number?

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<p>1 MR. REPPY: No. I'm talking about --</p> <p>2 I'm talking about the 99,422 is how many beds are</p> <p>3 licensed in the state right now. I'm saying you</p> <p>4 only need 84,911. You're overbedded by that many</p> <p>5 beds. You're overbedded by 15,000 beds. Because</p> <p>6 your total licensed beds in -- you only have 76,000</p> <p>7 patients. So why do you need 99,000 beds? You</p> <p>8 only need 84,000 beds.</p> <p>9 MR. FLORINA: Yeah, I'm not disagreeing</p> <p>10 with that. I'm just trying to make sure the</p> <p>11 numbers jibe. And I was trying to figure out how</p> <p>12 you got the 90 percent. You explained that. I</p> <p>13 just wanted to make sure I have it correct.</p> <p>14 MR. REPPY: Okay.</p> <p>15 MR. FLORINA: Thank you.</p> <p>16 MS. CREDILLE: And John and the group,</p> <p>17 this is Cece Credille. You know, IHCA is looking</p> <p>18 at this. We've had so many discussions about</p> <p>19 unused beds, dead beds, whatever you want to call</p> <p>20 it. This type of formula like this takes that off</p> <p>21 the table. It doesn't matter that we have 99,000</p> <p>22 licensed beds and what are we doing with them</p> <p>23 because this formula speaks to usage. And then Don</p> <p>24 has built this formula around what our usage is and</p>	<p>1 because every year you're adding 10 percent,</p> <p>2 assuming that if people go over their capacity that</p> <p>3 they have 10 percent beds to use that aren't being</p> <p>4 used.</p> <p>5 So, if we want to solve the overbedding</p> <p>6 issue -- my understanding, when you are planning,</p> <p>7 you don't want to underproject. You always want to</p> <p>8 overproject because you don't know what will happen</p> <p>9 in the future. So, for me, that 90 percent</p> <p>10 discussion should be off of the table because it's</p> <p>11 not actually hurting the process.</p> <p>12 Now, you know, if we can maybe come</p> <p>13 back to some of this that I made in my</p> <p>14 presentation, I think some of the -- some of the</p> <p>15 statements was -- might not be well understood.</p> <p>16 MS. AVERY: Hey, Nelson, let's stop and</p> <p>17 see if there are any comments on your first point.</p> <p>18 MR. AGBODO: Oh, okay.</p> <p>19 MS. AVERY: If that's okay.</p> <p>20 MR. AGBODO: That's fine.</p> <p>21 MR. KNIERY: John Kniery.</p> <p>22 CHAIRMAN LAVENDA: Any comments?</p> <p>23 MR. KNIERY: If I may, John Kniery. I</p> <p>24 don't see -- just observation. I don't see a big</p>
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<p>1 then bumped that up to our current standard of 90</p> <p>2 percent. I mean, we could do 85. You could do 88.</p> <p>3 You don't have to pick 90, but 90's been the number</p> <p>4 that the Health Facilities Planning Board has</p> <p>5 looked at. So, we're taking 90 percent of what we</p> <p>6 are actually utilizing in the state. So, it takes</p> <p>7 the other issue off the table.</p> <p>8 MR. REPPY: And 90 percent is also what</p> <p>9 Ohio uses as well.</p> <p>10 MR. AGBODO: Nelson. I would like to</p> <p>11 make a quick comment about the 90 percent occupancy</p> <p>12 rule.</p> <p>13 The way 90 percent is used in our</p> <p>14 current formula suggests that we actually add 10</p> <p>15 percent more beds to the first need that we</p> <p>16 calculate. Because actually, we divide first need</p> <p>17 calculation by 90 percent. If we were multiplying</p> <p>18 that number by 90 -- 0.9, it will mean that we are</p> <p>19 reducing down to 90 percent of the needed beds.</p> <p>20 The way to use it is actually add in 10 percent</p> <p>21 extra beds, so -- and I looked at the Ohio process.</p> <p>22 It is doing at the same thing. And like some</p> <p>23 people already explained, doing that over so many</p> <p>24 years might contribute to build unoccupied beds</p>	<p>1 difference between what Illinois currently uses and</p> <p>2 what's being proposed here. You're replacing the</p> <p>3 HSA level with the statewide level. Both are using</p> <p>4 a 90 percent utilization. One just takes it</p> <p>5 through a beds per thousand. The state's need</p> <p>6 methodology is really more comprehensive, defining</p> <p>7 the different levels of care.</p> <p>8 I don't know that it matters one way or</p> <p>9 another. I really think you're ending up at the</p> <p>10 same point. I mean, we're still -- we're still</p> <p>11 talking about, you know, a finite number of beds.</p> <p>12 There's a -- either methodology you still have</p> <p>13 76,420 beds in use. I think we're coming to the</p> <p>14 same conclusion, just going about it two different</p> <p>15 ways.</p> <p>16 The issue with using the statewide</p> <p>17 utilization versus an HSA, I think we should -- I</p> <p>18 mean, that could be some good discussion. But I</p> <p>19 don't know that we're -- you know, you could do</p> <p>20 that with the existing methodology.</p> <p>21 MR. REPPY: The question sort of</p> <p>22 becomes --</p> <p>23 COURT REPORTER: I'm sorry. Who's</p> <p>24 speaking please?</p>

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1 MR. REPPY: I'm sorry. This is Don.  
 2 Just as a comment on that, the current  
 3 methodology does use -- it is more comprehensive  
 4 and is more really accurate on a community by  
 5 community basis. It accurately reflects what's  
 6 going on in that community.  
 7 But I'm not sure that accuracy is as  
 8 important here as result. And what you're looking  
 9 for is -- I'm hoping you're looking for an  
 10 equitable result. And that's why I think the Ohio  
 11 approach gives you a more statewide equitable  
 12 result.  
 13 MR. KNIERY: One more comment, Don, if  
 14 I may, just to add to that. I think I -- this is  
 15 John Kniery. If -- your earlier comment that the  
 16 current methodology -- and I might add even the  
 17 Ohio methodology, if it was adopted, is only as  
 18 good as how often it's updated. You know, the more  
 19 -- the more current it can be, the better the  
 20 results are going to be, regardless.  
 21 MR. REPPY: Absolutely. Absolutely.  
 22 And that's -- and Ohio updates their methodology  
 23 every -- they do every two years. They do it every  
 24 other year. I think their methodology is probably

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1 a little easier to update because it's basically  
 2 bed population ratio. So, it's less cumbersome to  
 3 prepare, publish, and distribute.  
 4 MR. MITCHELL: This is Mike Mitchell  
 5 with IDPH. And I think we're all in agreement that  
 6 we have more beds than are needed and that there's  
 7 probably some redistribution which is needed.  
 8 But when I look at the Ohio formula and  
 9 the way that you've applied it, it appears that  
 10 you're allocating all of the long-term care  
 11 utilization to the population 65 and over, and  
 12 that's not the case in Illinois. It may be in  
 13 Ohio, but it's not really accurate in Illinois.  
 14 Each year we do a questionnaire. We  
 15 send it out to all the long-term care facilities.  
 16 And over the past five years, between 23 and 24  
 17 percent of the patients are under 65.  
 18 MR. REPPY: That is true. However, the  
 19 formula does account for those people because we're  
 20 just taking patient days over 65-plus.  
 21 MR. MITCHELL: No, you're not, not the  
 22 way you applied the formula here. You did not take  
 23 patient days 65-plus. You took the total long-term  
 24 care patient days.

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1 MR. REPPY: Right. We took the total  
 2 long-term care patient days and we divided it by  
 3 the 65-plus population. So, it's just a ratio.  
 4 MR. MITCHELL: But it's attributing the  
 5 entirety of long-term care utilization to people 65  
 6 and over and that's -- and 65 and over population  
 7 in long-term care facilities is not a hundred  
 8 percent. It's only 77 percent. So, what you're  
 9 doing is you're overallocating utilization to 65  
 10 and over. So, you're going to be overestimating,  
 11 overprojecting because you're giving it all to 65  
 12 and over.  
 13 MR. REPPY: But -- but -- so it -- and  
 14 by the amount that we're over -- wouldn't the  
 15 amount that we're overestimating the 65-plus serve  
 16 the 65 and under? That's the key here.  
 17 MR. MITCHELL: But it doesn't --  
 18 MR. REPPY: Correct, we are  
 19 overestimating the 65-plus. But if we overestimate  
 20 the 65-plus by let's say two beds per thousand,  
 21 wouldn't those two beds per thousand then meet the  
 22 needs of the under 65? So, it's just a ratio.  
 23 MR. MITCHELL: It would, if the  
 24 distribution of patients between under 65 and 65

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1 and over were constant over all of the planning  
 2 areas, but it's not. It's much higher --  
 3 MR. REPPY: Correct.  
 4 MR. MITCHELL: -- in the Chicago and  
 5 Cook County areas than it is throughout the rest of  
 6 the state. So, you're still getting a  
 7 maldistribution.  
 8 MR. REPPY: And I believe that -- okay.  
 9 All right. Fair enough. But could you not --  
 10 could we not figure out a way to alter this formula  
 11 a little to account for that? So, instead of it  
 12 being 50 beds per thousand, instead of it being 50  
 13 beds per thousand, we look statewide and we say,  
 14 okay, we're serving the under 65-plus population  
 15 and that's three beds per thousand, so we'll change  
 16 our standard and we'll make it 53 beds per  
 17 thousand. I mean, there are ways to artfully solve  
 18 that problem I think.  
 19 MR. KNIERY: You know, I think -- this  
 20 is John Kniery. To me, it almost appears that you  
 21 can modify -- instead of using the Ohio model, you  
 22 can modify the existing model and go with a  
 23 statewide utilization instead of the HSAs and get  
 24 the same result that you're looking for and both

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1 would be happy. Because then you're still -- the  
 2 existing model uses all the different age cohorts,  
 3 but I think you're getting a better equitable  
 4 utilization if you're using the state number versus  
 5 the HSA number. I think that was your argument  
 6 earlier, Don.  
 7 MR. REPPY: Correct. You do get -- you  
 8 get a fairer result if you use the statewide  
 9 number. I haven't actually -- I haven't used the  
 10 state method -- applied the state methodology  
 11 statewide and then applied it back to the various  
 12 areas, but that's possible. That's certainly --  
 13 that's certainly something you probably want to  
 14 look at because it's possible that that would work.  
 15 You're currently -- the thing is,  
 16 though, you're currently -- statewide you are  
 17 currently at -- let's see -- you've got 99,000  
 18 beds. I don't know how that would work out, but  
 19 it's certainly something you want to explore.  
 20 That's certainly something that you should look at,  
 21 I agree.  
 22 MR. KNIERY: And I had a question, if I  
 23 can pick on you, Don. I hope you -- this is John  
 24 Kniery again. I'm not trying to.

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1 MR. REPPY: No problem.  
 2 MR. KNIERY: Can you educate me a  
 3 little bit on Ohio? Do they have -- what's their  
 4 -- what kind of assisted living do they have? How  
 5 robust is it? Do they have a waiver program for  
 6 reimbursement or a straight Medicaid reimbursement?  
 7 Do you know?  
 8 MR. REPPY: There's no -- to my  
 9 knowledge, there is no waiver program for assisted  
 10 living in Ohio. Assisted living is a privately --  
 11 it's in the private-pay business in Ohio.  
 12 MR. KNIERY: Okay.  
 13 MR. REPPY: But they do have -- they  
 14 have a very -- there is a lot of development in  
 15 assisted living in Ohio. I certainly visited the  
 16 Cleveland area not too long ago and we decided not  
 17 to further develop there because there was so much  
 18 competition in assisted living. So, there's very  
 19 robust assisted living going on in Ohio.  
 20 MR. KNIERY: I just liked your comment,  
 21 you know, that health planning should include  
 22 proposing the lowest level of care possible. And I  
 23 don't know if we could take it a step further and  
 24 -- I mean, I've always been for bringing it under

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1 CON to help further that.  
 2 MR. REPPY: There are only --  
 3 MR. KNIERY: I know my clients are  
 4 probably cringing.  
 5 MR. REPPY: Two states I think do that.  
 6 Missouri and North Carolina are the only two states  
 7 that I know of that now have a CON. Everyplace  
 8 else it's a free market to operate, free market to  
 9 develop whatever you choose. But clearly in  
 10 communities where there's a lot of nursing home  
 11 beds, assisted living providers aren't going to go  
 12 there because there's too much nursing home  
 13 competition in those communities.  
 14 MR. FLORINA: This is Florina again.  
 15 John, just to clarify, is the point you're making  
 16 or the question you're bringing up have to deal  
 17 with what impact does a non-nursing-home providing  
 18 services have on the nursing home bed need process  
 19 in that home health care or assisted living is not  
 20 regulated or part of that bed need calculation that  
 21 the results we have for the nursing home side would  
 22 give us skewed results? Is that where you're going  
 23 with what you're asking?  
 24 MR. KNIERY: No, I was -- I think that

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1 they are reflective because we're using an existing  
 2 use rate. So, it is reflective of current assisted  
 3 living in a marketplace that I think is a  
 4 historical effect, so it's already factored in.  
 5 I guess I was looking to push the  
 6 equitable development of more long-term care in  
 7 general, the full spectrum of long-term care. I  
 8 think that's where it's going. Everything is  
 9 moving downstream, as we've all seen. That was  
 10 more my point than -- I think there is some of that  
 11 in future when you project it forward.  
 12 The only issue I really have is we're  
 13 not looking forward if we're just using the 2013  
 14 projections. I mean, what are we planning for?  
 15 So, some of that, you know, would have to be worked  
 16 out and we'd have to talk that through, whatever --  
 17 you know, whatever methodology we'd use.  
 18 You know, we have the same problem with  
 19 our current methodology where the projected -- the  
 20 five-year projection is -- we're already at 2015.  
 21 So, there's some of that issue.  
 22 MR. REPPY: Projecting every other year  
 23 is probably -- as they do in Ohio and a couple  
 24 other states, is probably a good idea. But if you

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1 continue on the path that you're on with the  
 2 current formula, you should not expect robust  
 3 assisted living to develop in communities where you  
 4 continue to project a need for more nursing home  
 5 beds because the utilization is high, because  
 6 that's -- if you want -- if you want a strong  
 7 long-term care -- strong long-term care services  
 8 with the home health piece and the assisted living  
 9 piece and the Alzheimer's assisted living piece and  
 10 the nursing home piece, if you want all of those  
 11 things, you need to make sure that they're  
 12 appropriately utilized and that there's not an  
 13 excess. An excess of nursing home beds is going to  
 14 essentially reduce the likelihood that other  
 15 services will develop.  
 16 MR. FLORINA: This is Florina again. I  
 17 don't want to dwell on this outside type services  
 18 from nursing homes. Are we making -- we don't want  
 19 to have a continuum that is coordinated and not  
 20 overuse in any one particular component of the  
 21 continuum and that people are properly placed. Are  
 22 we making the assumption that based on market  
 23 factors and the actual use rates in the end that  
 24 placements in a non-nursing-home beds are the most

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1 appropriate for those clients? Is that a big  
 2 assumption we're making that's driving what the  
 3 correct nursing home need is, even though the  
 4 process of the market doesn't have any control over  
 5 what's happening with the non-regulated assisted  
 6 living side of things? Does that question make  
 7 sense?  
 8 MR. REPPY: I'm -- I'm not sure I  
 9 understand what you're saying. I'm not sure I  
 10 quite understand your question. Could you repeat  
 11 it for me, please?  
 12 MR. FLORINA: I'll see if I can  
 13 simplify it for myself as well.  
 14 The people that are going into  
 15 non-nursing-home settings, such as assisted living,  
 16 supportive living, are going there based upon  
 17 factors that aren't necessarily controlled through  
 18 the bed planning process for nursing homes. They  
 19 are going there and receiving services. And we're  
 20 making the assumption, I believe, that all those  
 21 placements are correct, meaning the people that are  
 22 there are only receiving the amount of services  
 23 that that type of setting is qualified to provide,  
 24 that they're not just taking people that have funds

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1 that can be in an assisted living setting when they  
 2 really should be in a licensed nursing home bed.  
 3 It seems to me like an important point of directing  
 4 this, and just relying on the market factors to  
 5 accomplish it doesn't necessarily mean it's the  
 6 best distribution of type of care providers.  
 7 MR. REPPY: I'm thinking that a family  
 8 and their physician and -- a family and their  
 9 physician is going to -- you have to assume that a  
 10 family and that family's position is going to make  
 11 the right choice for a patient. I think you have  
 12 to assume that. If you can't assume that, then the  
 13 whole -- the system collapses here. A family will  
 14 make the right choice for their loved one based on  
 15 what is available in the community. And our job --  
 16 our job is to make sure that those things are  
 17 available.  
 18 We can't -- we can't be in a position  
 19 of -- unless we're paying for it and if we're the  
 20 Medicaid agency and we want to go through the  
 21 nursing home and say this guy belongs in assisted  
 22 living and this guy belongs in home health or  
 23 whatever. Medicaid agencies do that in some  
 24 states. And if we're -- if the taxpayers are

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1 paying for it, that's appropriate.  
 2 But as a health planner, all -- in  
 3 health planning, all we can do is provide the  
 4 options for every family in every community. Our  
 5 goal is to make sure that the people in rural  
 6 counties have the same access to every level of  
 7 care that you do in Chicago, DuPage, and Peoria.  
 8 That's all we can do. And that's what the health  
 9 planning process should be about. We can't control  
 10 what families and physicians choose to do.  
 11 MR. KNIERY: This is John Kniery. I  
 12 think you hit it on the head for what's available.  
 13 MR. FOLEY: Yeah.  
 14 MR. KNIERY: That seems to be -- and  
 15 that was my -- that was why I made the comment  
 16 earlier about, you know, do we want to take a  
 17 practice step as this group to make sure those  
 18 levels of care are available. Because I don't -- I  
 19 mean, right now I think supportive living the  
 20 utilization is well -- it's as close to a hundred  
 21 percent as you can probably get, 97 -- 96-97  
 22 percent. So, as far as I'm concerned, there's no  
 23 availability there. And we have no oversight in  
 24 terms of -- assisted living is market rate and

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1 there's no oversight on it. A lot of areas have an  
 2 abundance of that. But I don't see that we have an  
 3 abundance of supportive living for accessibility  
 4 purposes.  
 5 MR. REPPY: I'm certain that's the  
 6 case. That's a -- supportive living is a -- that's  
 7 tough.  
 8 MR. KNIERY: Yeah.  
 9 MR. REPPY: That's a tough market for  
 10 an entrepreneur to be in and it's tough to make it  
 11 available. But our goal should be to control what  
 12 we can to make sure that that kind of service would  
 13 flourish, if possible.  
 14 CHAIRMAN LAVENDA: Alan, do you want to  
 15 say something?  
 16 MR. GAFFNER: Alan Gaffner. Thank you,  
 17 Mr. Chairman.  
 18 Mr. Reppy, thank you for the  
 19 side-by-side that you put forth with looking at  
 20 Illinois and Ohio and some of the pros and cons of  
 21 that.  
 22 I want to get back to a couple things  
 23 that we talked about most recently at our June  
 24 Long-Term Care Subcommittee that I think even

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1 Nelson acknowledged, which was if that 90 percent  
 2 occupancy rate was adjusted, which those of us  
 3 providers know is high, if that became a 75 percent  
 4 occupancy rate, that would immediately make beds  
 5 available. And it seems that there is a concern  
 6 that or belief that beds have not been available or  
 7 awarded by the planning board because of the  
 8 formula. Well, just simply changing that occupancy  
 9 percentage would immediately make beds available.  
 10 The timeliness of the data again is  
 11 significant. And I tip my hat to Nelson, Courtney,  
 12 and her staff with trying to achieve timeliness of  
 13 data based on budget limitations. But I think we  
 14 as the full Long-Term Care Subcommittee need to do  
 15 all we can in going to bat for them to have the  
 16 timely tools that they need to make any formula  
 17 work.  
 18 And then, Mr. Reppy, I just want to  
 19 make sure I'm understanding. When you're talking  
 20 about the Ohio methodology that uses county  
 21 numbers, are you saying that those county numbers  
 22 would vary based on the data in or are you saying  
 23 that the bed availability in every county would be  
 24 the same?

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1 MR. REPPY: Each county has certain --  
 2 I guess I'm not quite certain I understand the  
 3 question. But each county has a certain number of  
 4 beds. There is a statewide -- there is a statewide  
 5 standard, which I believe in Ohio now is 45 beds  
 6 per thousand I think, and then that standard is  
 7 applied to each county. That statewide standard is  
 8 applied to every county. If you have more beds  
 9 than 45 per thousand, then you sell beds. You can  
 10 sell beds every two, three, four years, something  
 11 like that. And if you have fewer, that county can  
 12 buy beds. And if you're like in between or right  
 13 on the number, you can't do either. There can be  
 14 no additions or subtractions from the county. But  
 15 it's all based on equalizing access statewide.  
 16 And I want to go back to -- I want to  
 17 go back to something you said earlier. And that  
 18 is, if you change the formula so that you're now  
 19 looking at 75 percent as opposed to 90, all's well  
 20 and good, but will those beds go to the right  
 21 places? Won't those beds just end up in Ford  
 22 County? Because now -- now the formula's been  
 23 changed, the utilization is high, and you're only  
 24 requiring 75 percent occupancy. So, if you just

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1 take the current formula, apply it on a  
 2 county-by-county basis, then put in 75 percent,  
 3 it's going to create a lot of bed need in places  
 4 that perhaps as health planners you might feel  
 5 that's maybe not the right place.  
 6 MR. GAFFNER: Well, that's a fair  
 7 question. I guess I don't know as any of us in  
 8 either location or on the phone know the answer to  
 9 that today. And if someone does, you know, that  
 10 would be helpful. But I think that would have to  
 11 be something that is looked at.  
 12 I'll close with this: The analogy of  
 13 the equal population in congressional districts,  
 14 I'm struggling to understand how a voter equality  
 15 number equates to a care delivery equality based on  
 16 differences in population. And now I'm thinking  
 17 primarily of rural downstate in Illinois where  
 18 there are beds that are needed regardless of the  
 19 population. I think a vote equality issue is  
 20 different. And I just respectfully disagree with  
 21 that being a driving function as to why an Ohio  
 22 model is better. I think any formula, whether it  
 23 be in Illinois or Montana, works best to do what  
 24 John Florina said in providing the best for

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1 Illinois residents if it takes into account local  
 2 needs and differences. And my years in both acute  
 3 care and long-term care bring me to that.  
 4 As an acute care provider for many  
 5 years, one of the worst things that was ever ruled  
 6 out was a DRG rate. Because my heart attack and  
 7 how I recovered is not going to fit Steve and it's  
 8 not going to fit Courtney. But yet, someone  
 9 somewhere used some data to come up with a flat  
 10 rate. And that's what gives me a little concern  
 11 when we talk about some of these things that pull  
 12 back on the planning board's ability to consider  
 13 the unique factors that are location driven.  
 14 Thank you.  
 15 MR. REPPY: I see where you're coming  
 16 from. I'm coming from the -- a little more from  
 17 the consumer's perspective. I'm -- my mom needs  
 18 nursing home care and I live in county -- I live in  
 19 one county and there are ten choices because there  
 20 are ten empty beds. And I live in another county  
 21 and everything is full. There are no choices.  
 22 I've got to drive to the next county to get care  
 23 because all of the beds in my county are full. So  
 24 to me, it's an issue of equal -- equal

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1 representation and equal access to the same thing.  
 2 I want to be able -- if I can get access to a  
 3 nursing home bed for my mom in county A, I should  
 4 be -- I should have the same access if I lived in  
 5 county B, C, D, or E. And right now I would  
 6 maintain that that's not the case. That's not the  
 7 case in Illinois.  
 8 MR. GAFFNER: And you'll get absolutely  
 9 no argument from me on that, because my family went  
 10 through that in the last year, just what -- just  
 11 what you described.  
 12 But I would go back to the discussion  
 13 that was underway -- and I think maybe John Florina  
 14 touched on that -- unfortunately, I don't believe  
 15 when you described that triangle of a family  
 16 physician making a best decision for the loved one  
 17 being the third corner. I think sometimes the  
 18 physician is not part of that, and a family and the  
 19 provider -- and I'll go back to AL and SL -- make a  
 20 decision that the loved one can be there when  
 21 really that is not the appropriate placement. So,  
 22 I believe we perhaps provide too much faith and  
 23 trust in the family's ability to decide that  
 24 because they may be aided in the facility

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1 indicating that they can appropriately care for  
 2 that resident when they cannot, and the family  
 3 welcomes that because that AL or SL setting is a  
 4 lower cost situation.  
 5 MR. REPPY: Understood.  
 6 MR. GAFFNER: Thank you.  
 7 CHAIRMAN LAVENDA: Charles, do you have  
 8 a comment?  
 9 MR. FOLEY: Yes, if I may. This is  
 10 Charles Foley.  
 11 Hi, Don, how you doing?  
 12 MR. REPPY: I'm doing fine, Charlie.  
 13 How are you?  
 14 MR. FOLEY: I want to thank you for  
 15 your presentation. I think you made some excellent  
 16 points.  
 17 By the way, by means of introduction,  
 18 Mr. Kniery is also my son-in-law. I just wanted  
 19 you to know that relationship.  
 20 MR. REPPY: I'm aware of that, Charlie.  
 21 MR. FOLEY: Okay. So he had a good  
 22 teacher in all of this, Don.  
 23 Don, I've been involved with this  
 24 planning board for a great number of years and I've

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1 seen this board do a lot of interesting  
 2 decision-making, if I may say. I've seen this  
 3 board approve projects where probably they should  
 4 not be approved and, obviously, I've seen them  
 5 approve a lot of projects that should have been  
 6 approved.  
 7 The one fair thing about this process  
 8 and about this board is that they do look at each  
 9 and every single project independently. Everybody  
 10 is different, as we said in this conversation, that  
 11 every planning area, every county is different and  
 12 has its own unique situations. I think that if we  
 13 brought an application to the planning board in a  
 14 county where the facilities are all full, I think  
 15 that within itself and we find patients are going  
 16 outside the county, I think we're going to find  
 17 that this board would probably be very, very  
 18 sympathetic and would approve a project for  
 19 additional beds or for a new facility in that  
 20 planning area.  
 21 But it's also important to look at the  
 22 population in that planning area and in terms of  
 23 their future, the future population, making sure  
 24 that the bodies are still going to be there

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1 tomorrow. Just because there may be a need and  
 2 demand today, there may not be an actual need and  
 3 demand tomorrow. So, this is where the board has a  
 4 very difficult time when they address a project,  
 5 when they review an application. Yes, it could be  
 6 -- you know, I've seen them vote just merely out of  
 7 sympathy. That has happened on several occasions.  
 8 But I really think that maybe, just  
 9 maybe what we need here is -- there could be some  
 10 tweaking in the methodology. I'm not going to  
 11 disagree with that. I also agree that we need to  
 12 get data on a more timely manner in order for it to  
 13 be more accurate. But I think also that if we  
 14 create some additional variances to our existing  
 15 rules, such as one could create an access variance,  
 16 which would mean that if there is such a planning  
 17 area where all the beds are in fact full, one could  
 18 apply for a variance to add additional beds or to  
 19 build a new facility.  
 20 At the same time, I think if we even  
 21 looked at the possibility of adding another  
 22 variance which would be called a buy/sell/, you  
 23 know, transfer variance, if there is not a need for  
 24 beds in a particular planning area and if there's a

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1 possibility that one could buy beds, I think that  
 2 could be simply accomplished through a variance to  
 3 our state's, you know, computed bed need that's  
 4 already in existence.  
 5 I think we're trying to get off track a  
 6 little bit that the purpose of this planning board  
 7 is to not look and to sympathize as what's going on  
 8 today or what happened yesterday, but what do we  
 9 need and where are we going tomorrow. This is  
 10 supposed to be a planning board and so we have to  
 11 put on our forward-thinking cap, so to speak, and  
 12 plan for tomorrow.  
 13 Other than that, I'll just --  
 14 MR. REPPY: I think --  
 15 MR. FOLEY: Go ahead, Don.  
 16 MR. REPPY: I agree with you, Charlie.  
 17 I do believe that -- for example, in this example  
 18 that I've given today we've used the 2013  
 19 population because we happened to have it. But  
 20 certainly if you're going to do any type of future  
 21 planning, you need to be using the state's  
 22 population information for -- this is 2015, so you  
 23 probably want to use it for five years down the  
 24 road, 2020. I would agree with that.

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1 I think you and I have a disagreement.  
 2 I believe, and I think IHCA believes, that a  
 3 simpler methodology is more likely to be updated on  
 4 a regular basis and is more -- and is less likely  
 5 to place applicants in jeopardy of subjective  
 6 judgment. And so that it's very -- so, rather than  
 7 have all the variances, we have a simple  
 8 methodology, there is a need or there isn't a need,  
 9 and this is the application. And if the applicant  
 10 can meet the requirements of providing a quality  
 11 product or can demonstrate that they'll meet the  
 12 requirements of providing a quality product, they  
 13 should be approved.  
 14 I tend to have a bias against more  
 15 variances and more rules because it makes it much  
 16 more complex and much more difficult to update on a  
 17 regular basis. So, we just have a disagreement on  
 18 that issue.  
 19 MR. KNIERY: Can I expand on -- this is  
 20 John Kniery. Can I ask you a couple different  
 21 things? Actually, one.  
 22 MR. REPPY: Sure.  
 23 MR. KNIERY: Item E, which is after --  
 24 in the Ohio rules, page 3, item E.

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1 MR. REPPY: Okay. Let me get to those.  
 2 Ohio rules item E. Okay.  
 3 MR. KNIERY: I'm sorry. It's D. Item  
 4 D, just before that. If you apply that -- for  
 5 instance, on your chart, like Champaign you came  
 6 out having a need, but yet the HSA utilization is  
 7 77 -- it's actually the PSA utilization is 77.1.  
 8 So, then would that need then be negated via the  
 9 Ohio rules?  
 10 MR. REPPY: Under the Ohio rules, yes.  
 11 Ohio has an occupancy standard that says that if --  
 12 if the county is below a certain occupancy -- and I  
 13 believe -- this one says 90 percent. I believe in  
 14 the 2010 one they used 85 percent. If a county has  
 15 an overall occupancy of less than 85 percent, then  
 16 that county cannot participate in the transfer of  
 17 beds from one part of the state to the other.  
 18 Now, if you choose to adopt this  
 19 approach, you would have to have a -- you would  
 20 have to start out with a lower rate and do as Ohio  
 21 has done. I think it was 85 percent in 2010 and  
 22 then I think this is the 2012 example. On there  
 23 they went to 90, I believe.  
 24 So, yes, you're exactly right. A

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1 county whose occupancy is less than 90 percent  
 2 would not be eligible.  
 3 MR. KNIERY: And the same would hold  
 4 true for McHenry County and Sangamon County if my  
 5 numbers are correct.  
 6 MR. REPPY: If the occupancy --  
 7 MR. KNIERY: So, the occupancies were  
 8 not of 85 percent or higher. So, all those needs  
 9 would be negated.  
 10 MR. REPPY: Those needs -- those needs  
 11 would be negated. However, if you want to adopt an  
 12 approach of transferring beds across the state in  
 13 order -- without adding additional beds, Illinois's  
 14 going to have adopt a lower occupancy standard in  
 15 the beginning. Because if you adopt a 90 percent  
 16 standard, you'll never build anything anywhere.  
 17 MR. KNIERY: Right. That was my  
 18 concern.  
 19 MR. REPPY: No project, by the way, no  
 20 project in Illinois between 2008 and 2012 met -- no  
 21 new application for a nursing home in Illinois  
 22 between 2008 and 2012 met that 90 percent  
 23 requirement within the 30 and 45 days or whatever  
 24 -- 30 and 45 minutes or whatever. So, your

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1 facilities are not already meeting that standard.  
 2 MR. FOLEY: Yeah. And, Don, that's  
 3 absolutely correct. This is Charles. That's  
 4 absolutely correct. And that's my point in that  
 5 this board has in fact looked at each and every  
 6 application independently because each county, each  
 7 planning area does have its own set of unique  
 8 circumstances. And so what you said is in fact  
 9 correct. And I don't see -- I just don't  
 10 understand where we're going to go, you know, with  
 11 all of this in terms of the Ohio methodology.  
 12 Because this board has in fact been somewhat  
 13 lenient. They have turned down projects in the  
 14 past as well. And they have approved a lot of  
 15 projects. I just don't understand what everybody's  
 16 concern is.  
 17 MS. CREDILLE: This is Cece Credille.  
 18 We've spent a lot of time talking about more of the  
 19 nuts and bolts part related to licensed and  
 20 unlicensed beds, which has gotten us boxed into a  
 21 corner, you know, staff discussion of buy/sell, and  
 22 I'm going to bring us back to the nuts and bolts of  
 23 the formula.  
 24 And, Nelson, I will call upon your

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1 expertise because I'm looking at your document  
 2 again and on slide number 9 bed need methodology.  
 3 Now, I'm back to the nuts and bolts, not on what  
 4 we've been discussing in the last few minutes here.  
 5 The current bed need methodology uses licensed  
 6 beds. That has been a discussion that we go round  
 7 and round on. When you use the licensed beds in  
 8 the formula, then that causes all of us heartburn,  
 9 and I believe it even causes Nelson some of that  
 10 heartburn. Because then on slide for sure 11 and  
 11 12 when Nelson made his presentation, then they  
 12 utilized data from the formula at slide 9 and then  
 13 they set up maximum and minimum usage based on a  
 14 formula that doesn't work. And if I recall, Nelson  
 15 was worried about why we were still using maximum  
 16 and minimum usage data.  
 17 And this subcommittee is charged with  
 18 looking at what we need to do with the current bed  
 19 need formula. So, we have all these issues of  
 20 access that we've been talking about. We've been  
 21 having discussion about should we utilize the whole  
 22 state, should we utilize counties. But we also  
 23 have this issue of the current formula and how  
 24 cumbersome it is and that it's using a piece of

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1 data that's not accurate.  
 2 And what Don has presented is a very  
 3 simplified, straightforward formula that we're  
 4 already talking about that we could make some and  
 5 could and should make some changes potentially to  
 6 that, given over 65, under 65, and that discussion.  
 7 But it certainly simplifies the formula and the  
 8 process and then would negate the -- sort of the  
 9 exceptions that are made by the board because of  
 10 the existing formula and we can't hit the  
 11 occupancy. So, everything that's been approved, as  
 12 just has been discussed, was negated because of  
 13 what's happening in Illinois.  
 14 MR. AGBODO: If I can make a brief  
 15 comment.  
 16 CHAIRMAN LAVENDA: Yes.  
 17 MR. AGBODO: Actually, in this minute I  
 18 was also hoping to come back on some of the things  
 19 we covered in my presentation that might not be  
 20 clearly stated about the licensed beds. The  
 21 licensed beds is only used at the end of the  
 22 formula. It's just to find the excess or  
 23 deficiency of beds. But in projecting for the  
 24 need, that process does not use licensed beds.

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1 I know I did make a mistake in the previous  
 2 presentation saying that we do use that.  
 3 Actually, I was referring to another  
 4 table that was based under licensed beds.  
 5 Actually, that's where we are trying to find out of  
 6 the total licensed beds how many or what's the  
 7 percentage of use. That's a different aspect of  
 8 the presentation.  
 9 But truly, the bed need formula does  
 10 not use licensed beds until the end where we are  
 11 trying to find excess or deficient beds. And  
 12 actually, Mike corrected that statement. And if  
 13 you look through again, you know, on slide 6 to 9,  
 14 you will realize that, you know, licensed beds are  
 15 not used in finding projected patient days,  
 16 projected bed needs. That's one thing.  
 17 And the other comment I would like to  
 18 make is that for this workgroup I would suggest  
 19 that we go first from a goal and measure our goal.  
 20 And I already heard that, you know, it might be how  
 21 do we provide appropriate allocation of beds --  
 22 allocate beds to each health planning area. I  
 23 think it's a good goal, measurable goal.  
 24 And then we can run another model, run

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1 Ohio models, run our current model, and run another  
 2 model where we actually change things that I  
 3 suggested that we might change under the  
 4 assumptions, and see what are the final results,  
 5 see which results actually get close to the goal or  
 6 help us to meet the goal.  
 7 Because Ohio majority of -- I see  
 8 trying to understand the basis of that, but just  
 9 running that on a few counties might not help us to  
 10 see the whole picture. We need to run that for the  
 11 95 planning areas and evaluate the final result and  
 12 see if that helps to allocate beds better for the  
 13 health planning areas. That would be my suggestion  
 14 for, you know, this group to move forward and get  
 15 to a final result that can go back to the  
 16 subcommittee.  
 17 MR. KNIERY: If I may, this is John  
 18 Kniery. I think, Cece, you did a great job  
 19 delineating out what some of those issues were.  
 20 The 160 percent and the 60 percent, if  
 21 I heard correctly, statewide versus the health  
 22 service area utilization rates being applied to the  
 23 target -- to the planning service areas, the PSAs,  
 24 I think was one area of potential concern.

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1 I think if I heard Nelson right, do we  
 2 use a 90 percent or Alan said an 80 percent  
 3 utilization -- target utilization rate. But should  
 4 that be used on the front end or the back end?  
 5 I think the Ohio model uses it on both. It's not  
 6 the same necessarily. They have on the front end a  
 7 90 percent, but on the back end they have a target  
 8 utilization for the PSA, in our case. In the model  
 9 it's a county. So, that would be an issue.  
 10 I think those were the main three  
 11 concerns between the two. I just wanted to try to  
 12 identify those. Does anyone else see -- am I  
 13 missing any?  
 14 MR. AGBODO: Yeah. So, about the 60 to  
 15 160 patient rule, that's the rule actually that  
 16 allocated beds to the health planning area. I  
 17 would say the 90 percent rule is applied at the  
 18 health planning area. It's kind of, you know,  
 19 finding, you know, how big the pie should be. And  
 20 then when you want to distribute that pie to the  
 21 area is the 60 to 160 patient rule. And what that  
 22 rule does is it takes people that are overusing  
 23 beds, I would say, you know, over 160 percent use  
 24 rate to bring them down to the middle, you know,

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1 within 60 and 160. And the areas that are using  
 2 very low rates, you know, the formula brings them  
 3 up to the middle. So, by doing that, it's kind of  
 4 adjusting everybody has to come to the middle. And  
 5 I believe that is trying to correct what Don is  
 6 seeing as a problem. But how much discouraging is  
 7 done is not clearly evaluated. So, that's the work  
 8 I would suggest that we might do when we are  
 9 revising the assumptions.  
 10 And once we put those presentations  
 11 back to -- you know, to variabilities and we run  
 12 them and see which have the value that maximize the  
 13 location of beds, we can now go back and run the  
 14 projection again and see if the issue we are seeing  
 15 has been corrected. So, that was, you know, one of  
 16 -- a way to improve this.  
 17 But now going back to Ohio, one flat  
 18 rate for everybody, it just doesn't sound right to  
 19 me. That's me. And I'm trying to respectfully say  
 20 this, you know, that this type of issue is well  
 21 known as, you know, encouraging copycats. I mean  
 22 that you are actually trying to, you know, force  
 23 everyone to have the same value. What if, you  
 24 know, in the group some of the areas are very low

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1 -- are using like 10 percent of the beds and some  
 2 of them are, you know, way -- 90 percent, and now  
 3 you are making everybody to come to the middle  
 4 somewhere, maybe 45 percent. It's just, you know,  
 5 statistically not correct.

6 But now I'm trying to understand, you  
 7 know, how this can be seen as a best way to  
 8 allocate where we go in the market in the field of  
 9 long-term care, which I'm new to. That's really  
 10 what I'm struggling with. But statistically, when  
 11 you produce a study using a high aggregated liberal  
 12 value, you have to say that it's a limitation to  
 13 that study. Because -- and that can be done in the  
 14 first time while you are doing that type of work  
 15 and the only values that are variable are at that  
 16 high level. But once you start collecting data  
 17 over years -- now, you know, for this program it's  
 18 40 years. And we do have data at the individual  
 19 level. Why don't we use that and we want to go  
 20 back to that high level aggregated number.

21 So that's my struggle actually. I  
 22 really want to understand, you know, why Ohio is  
 23 doing this. I also want to know, you know, when  
 24 was the last time Ohio have evaluated this

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1 methodology. Because for me, if they started with  
 2 that and then nobody reviews that, now that they  
 3 have data at the county level and they're not even  
 4 using that, maybe somebody just forgot to go back  
 5 and review what was done the first time. I'm just  
 6 trying to understand. You see what I mean? Well,  
 7 that's one of my concerns about the Ohio formula.

8 MR. REPPY: Nelson, this is Don. The  
 9 Ohio formula was developed and distributed in 2009,  
 10 implemented in 2010, and it's been used in 2012,  
 11 2014, and it will be used in '16, and then I think  
 12 it skips 2018 and they go to 2020. So they're  
 13 fully on board, and this is a -- for them this is a  
 14 new methodology, a new approach that they are  
 15 completely comfortable with and will continue to  
 16 use.

17 I like your idea, though -- I do like  
 18 your idea of going back and taking the current  
 19 methodology and running it for all the counties,  
 20 and then taking the Ohio approach and running it  
 21 for all of the counties, and then taking the  
 22 Illinois approach using the statewide use rate and  
 23 applying it to every county, and then also taking  
 24 the current formula but tweaking the 60 and 160

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1 maximum/minimum and maybe get that down to 90, 110,  
 2 or something that you're comfortable with. And if  
 3 you bring those four back to the committee and we  
 4 see the -- and everybody sees the results, that  
 5 might be a better indication of which way you want  
 6 to go. Because then you can begin to see whether  
 7 the transfer of beds or selling of beds or whatever  
 8 will work with one of those methodologies or if it  
 9 won't work with this one or if it will work with  
 10 that one or whatsoever. I think it'll make things  
 11 a lot clearer. So, I think that's a -- I think  
 12 that's a -- on your agenda here you have next  
 13 steps. I think that's a -- that's a very good next  
 14 step.

15 I also think, though, that somewhere  
 16 along the line someplace sometime the feds are  
 17 going to come along in the Medicaid area and start  
 18 controlling the patients that can get Medicaid  
 19 services in a nursing home. So that high  
 20 utilization -- we're providing beds for high  
 21 utilization in a community, but we don't know if  
 22 five years from now that the feds are going to  
 23 require all the states to do what Washington state  
 24 does, which is walk through the nursing home every

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1 month and evaluate every one of their patients and  
 2 decide who needs to go to another level of care.  
 3 So, that's something we need to think about, too.  
 4 That could be in our future as well. So that the  
 5 -- and the feds are going to be trying -- they're  
 6 going to be trying to get utilization at  
 7 approximately the same level everywhere because  
 8 they're paying for it. So, that's something we  
 9 need to think about as well, I think. But I like  
 10 your whole idea, Nelson. That's great.

11 MR. AGBODO: Thank you.

12 CHAIRMAN LAVENDA: This is Steve  
 13 Lavenda. I think that's a great step what Nelson  
 14 has suggested. Just out of curiosity, Nelson, how  
 15 long do you think it would take you to, you know,  
 16 calculate all that data?

17 MR. KNIERY: Tomorrow?

18 MR. FOLEY: It's on a computer, Nelson,  
 19 you know.

20 MR. AGBODO: Yeah. Well, about the  
 21 Illinois current methodology, there's no current  
 22 concern about that. We can get it done, you know,  
 23 like tomorrow. Yes.

24 Now, Ohio, it's a new methodology. I

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1 already understood their process. I'll have to  
 2 check with my mentor, Mike, to see if we have the  
 3 data exactly the way they define the data to see if  
 4 we have that to be able to run that method for  
 5 Illinois. I don't know for sure. Because I was  
 6 looking at some of the definitions, it's like, you  
 7 know, we don't collect them. I already discussed  
 8 with Mike. But I think we can have approximately  
 9 to those type of data. And once we evaluate that,  
 10 the answers should be in the computer doing the  
 11 work, so it should be quick.

12 MR. KNIERY: It looks like Mr. Mitchell  
 13 already has it figured out in his head.

14 MR. FLORINA: This is Florina, if I can  
 15 chime in here. I'm all for the modeling. I think  
 16 it will help us make some decisions.

17 But just for clarification again on the  
 18 Ohio system, from what I surmise from the  
 19 discussion starting with where Cece began, it  
 20 doesn't really matter what we're doing with the  
 21 inventory of beds in Illinois as far as them being  
 22 unused or the impact that assisted living or  
 23 alternative care locations would have on the Ohio  
 24 system bed need calculation because the Ohio system

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1 is based off of actual occupancy. I do think,  
 2 however, that we will get into some fairly detailed  
 3 discussion as to how it impacts the specific  
 4 planning areas or what we want to recognize as a  
 5 planning area and how those beds are distributed.

6 But could one of you, whether it's Don  
 7 or Cece, could you confirm that that's a fair  
 8 understanding that the actual bed inventory and the  
 9 alternative care sources, care locations really  
 10 have no impact on the Ohio outcome as far as  
 11 calculating the need?

12 MR. REPPY: Right. That's correct.  
 13 It's a need for skilled nursing beds, period. No  
 14 -- and that, by the way, part of that is, you know,  
 15 in Ohio nursing home beds are really the only thing  
 16 that are CON regulated. Hospital beds and home  
 17 health care and all that other -- all those other  
 18 services are not. So, there's -- no, it's just  
 19 nursing home beds.

20 MR. FLORINA: Are there any unintended  
 21 consequences by not recognizing those two factors  
 22 in this process?

23 MR. REPPY: I -- I frankly -- my --  
 24 having done this for a number of years, I frankly

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1 think you're making it too complicated. Now,  
 2 that's my -- that's my -- my head tells me that.  
 3 That it's not -- that it's -- we're -- we try to  
 4 make sure that we've got the appropriate number of  
 5 nursing home beds in every community so that  
 6 everybody has access. And we hope that in doing so  
 7 we can somehow -- that will encourage the  
 8 development of other levels of care, but we  
 9 recognize that some of those levels of care,  
 10 because of the reimbursement system are probably  
 11 not going to get to some rural communities. That's  
 12 just the way life in America is.

13 MR. FLORINA: Okay. Then I have a  
 14 question for our chairman.

15 Steve, one of the issues we've dealt  
 16 with all along was the actual beds that are  
 17 available for use in the State of Illinois and how  
 18 it plays into how our current methodology is set  
 19 up. Obviously, Nelson can use a number of  
 20 different variables in any models in changing it  
 21 around to see what the outcomes would be. But is  
 22 there any way from an accounting standpoint or a  
 23 numbers standpoint of convincing facilities that  
 24 they don't want or need these beds sitting out

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1 there that are not being used? Is there any  
 2 capital calculation or other reason from an  
 3 accounting standpoint to not have these beds still  
 4 in the inventory?

5 CHAIRMAN LAVENDA: Okay. That's a lot  
 6 there. What we've discussed before is some homes  
 7 have leases and financing based on the licensed  
 8 beds. So, that would mean redoing leases, and the  
 9 landlords may not want them to redo them. And then  
 10 also, again, there may be mortgage documents out  
 11 there that are based on licensed beds. And I think  
 12 one of my colleagues made a presentation here about  
 13 HUD requirements. I, unfortunately, couldn't be  
 14 here, but he presented what some complications  
 15 could be from that.

16 As far as the capital rate formula for  
 17 Medicaid, if anything, that might help a nursing  
 18 home's capital rate if you take away some beds. As  
 19 long as you can prove to HFS that you're still  
 20 using that part of the building, there wouldn't be  
 21 any reduction in cost. So, therefore, you'd be  
 22 providing the same cost by having fewer number of  
 23 beds and that could potentially increase the  
 24 capital rate for some homes.

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1 MR. REPPY: This is Don. A nursing  
 2 home bed is an asset.  
 3 CHAIRMAN LAVENDA: Yes, in some way,  
 4 shape, or form, it's an asset. I think there is  
 5 always this discussion back and forth as to what  
 6 the value of that asset is, you know, how you put a  
 7 dollar amount on it, and that's going to be another  
 8 problem we'll have to tackle.  
 9 And then also, I want to point out,  
 10 you're saying if you make beds available in a rural  
 11 area or just even any area of the state, the  
 12 current Medicaid methodology for reimbursing the  
 13 capital cost is over 15 years old at this point.  
 14 And even at that time probably didn't cover what it  
 15 cost you to build a nursing home. So, now it's not  
 16 even close. So, even though you're making this  
 17 access, I'm not sure beds will be built unless that  
 18 formula is updated somewhat. I just wanted to  
 19 throw that out there.  
 20 MR. REPPY: I guess I would -- this is  
 21 Don. I would say I agree, but we have to do what  
 22 we can.  
 23 CHAIRMAN LAVENDA: I understand.  
 24 Yes, Alan.

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1 MR. GAFFNER: This is Alan Gaffner.  
 2 Mr. Reppy, you mentioned each year depending on the  
 3 county-specific bed need then either transferring  
 4 or buying or selling beds. So, that bed  
 5 buy/sell/transfer component is the corollary to  
 6 this Ohio bed need formula. Am I accurate in that  
 7 assessment?  
 8 MR. REPPY: Correct. There are no new  
 9 beds in Ohio. No new beds. 45 beds per thousand.  
 10 They will approve no new beds in Ohio. The only  
 11 way to -- the only way to get beds in Ohio for a  
 12 new building or to do an addition on your building  
 13 is to either transfer them or buy them from another  
 14 provider in another part of the state. That's the  
 15 way it works.  
 16 And then the -- and also, an additional  
 17 -- an additional incentive there is that in Ohio  
 18 beginning I think in 2016 they're going to require  
 19 if you want to buy beds, you can buy them but you  
 20 have to buy 20 percent more than you need and give  
 21 the 20 percent or maybe 10 percent back to the  
 22 state. So, their goal is ultimately to use this  
 23 system to reduce their licensed capacity down to  
 24 something that is more reasonable. So, if you need

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1 120 beds to build a new building, you buy 132, and  
 2 then the state -- then the state takes back 12 and  
 3 you get your 120. That's another -- but that's --  
 4 that's like later in the process. So, they passed  
 5 the law but really didn't implement that system. I  
 6 think that comes into effect in 2016. This is a  
 7 long process for Ohio.  
 8 MR. GAFFNER: So, in essence, then -- I  
 9 know you were commenting to Charles about variances  
 10 or exceptions. In Ohio the bed buy/sell/transfer  
 11 is really a variance or an exception process that  
 12 the free market controls rather than the planning  
 13 board.  
 14 MR. REPPY: No. You have to get  
 15 approved. If you want -- if I -- if you have  
 16 nursing home beds for sale because your building  
 17 has, you know, 150 beds and you're only operating  
 18 110, and I have a -- and I want to add 10 beds  
 19 because I'm in Columbus where the population is  
 20 growing, I buy 10 beds from you, but I have to go  
 21 through the CON process. I have to prove that my  
 22 building is full. I have to prove that I've got a  
 23 quality record. I've got to prove that I've got  
 24 the financing. I have to prove all of those things

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1 in the normal CON process. Now, in Ohio there's no  
 2 board. It's a state staff decision. But  
 3 nevertheless, I have to prove all of those things,  
 4 that I'm a qualified applicant to get those beds.  
 5 CHAIRMAN LAVENDA: I have two  
 6 questions. What's -- this is Steve Lavenda.  
 7 Sorry. What's the turnaround time on that?  
 8 MR. FOLEY: Yes.  
 9 CHAIRMAN LAVENDA: Does anyone know  
 10 what the turnaround time has been for Ohio?  
 11 MR. REPPY: Well, they've built in a  
 12 turnaround time of -- they've built in a turnaround  
 13 time which I don't think is enough. They've built  
 14 in a turnaround time of two years. So, they  
 15 approved beds in 2010. They assumed those beds  
 16 will come online in 2012 and that they can -- and  
 17 that they can then produce bed need based on those  
 18 approvals. I'm thinking that's a little short, but  
 19 that's their decision. But it's basically two  
 20 years. So, they only do bed need every other year.  
 21 MR. FOLEY: Hey, Don, this is Charles  
 22 Foley.  
 23 MR. KNIERY: He had a second question.  
 24 MR. FOLEY: I'm sorry. Go ahead.

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1 CHAIRMAN LAVENDA: My other question  
 2 is: What have the prices have -- what have --  
 3 what's like the average price per bed that's been  
 4 sold of the ones that have been sold?  
 5 MR. REPPY: I believe \$17,000 a bed or  
 6 18,000 maybe. But that's -- it depends on the  
 7 year. If it's a year when there's bed need and  
 8 everybody is transferring beds, then the -- you  
 9 know, then there's a lot of demand and the price  
 10 goes up. And then if it's a year where there is,  
 11 you know, no statewide transfer or whatever, maybe  
 12 the price is down a little bit. But the prices run  
 13 -- I seem to remember that Christine Kenney in her  
 14 last -- and she's the former CON director in Ohio.  
 15 I think the last time she published something for  
 16 us it was like somewhere between 17 and \$19,000 a  
 17 bed.  
 18 CHAIRMAN LAVENDA: Charles, you had  
 19 something?  
 20 MR. FOLEY: Yeah. Don, just a question  
 21 out of curiosity. As a -- looking at this on the  
 22 planning side, how long does it take -- if you want  
 23 to add 50 beds to an existing facility and you have  
 24 to go out and buy beds, and I have to go out and

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1 buy beds, let's just say for the sake of  
 2 conversation five different facilities, what is the  
 3 average length of time will it take me to actually  
 4 go through the process of contacting, you know, all  
 5 the various providers? I'm sure that there's a  
 6 listing out of there who have beds available. You  
 7 contact them, negotiate a price, get everybody to  
 8 agree on the specific terms, five different people.  
 9 You may have five different prices per bed. And  
 10 then to file your CON application. What is that  
 11 timeline? How long does it take before you're able  
 12 to file an application?  
 13 MR. REPPY: Usually it's the same  
 14 timeline -- it takes approximately the same  
 15 timeline as it would take to get a piece of  
 16 property -- to get a piece of land under contract  
 17 if it was a new building. So, you know, four or  
 18 five months, four months maybe, and then you file  
 19 your application.  
 20 And usually what happens, Charlie, is  
 21 that guys like you and Dave Kostinas in New Jersey  
 22 and Christine Kenny in Ohio, the consultants in the  
 23 community, health care consultants become  
 24 essentially bed brokers. So, I call you, Charlie,

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1 and I say I need eight beds in such and such  
 2 county. And you say, Don, Bill has -- Bill has 20  
 3 beds for sale. I will call him and see if he's  
 4 willing to sell eight. And that's sort of the way  
 5 it works. So, there -- what happens is it tends to  
 6 coalesce around a few -- a few consultants or  
 7 attorneys or whatever in the state who specialize  
 8 in health care. And once you've talked to all of  
 9 them, you've kind of figured it out. You have  
 10 somebody working on it for you. So, it really  
 11 doesn't take that long. I'm surprised at how  
 12 quickly -- how quickly you can identify beds in  
 13 Ohio. It doesn't really take that long.  
 14 And then the CON process in Ohio is  
 15 five months, four maybe. But it's not the lengthy  
 16 process that you have in Illinois because there's  
 17 no board. So, there's no intent to deny and all  
 18 that stuff. So, it's a lot simpler.  
 19 CHAIRMAN LAVENDA: Alan.  
 20 MR. GAFFNER: Alan Gaffner. Just a  
 21 general observation. And we've got a long way to  
 22 go on this as well as, you know, Cece and I have  
 23 served on the ad hoc bed buy/sell/transfer program.  
 24 But it seems as if this Ohio model and various data

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1 points that relate to Nelson, this overall  
 2 discussion is more than just formula revision and  
 3 data points, because it seems to me that the  
 4 parallel track with this if you move to an Ohio  
 5 model is almost an immediate adoption of a bed  
 6 buy/sell/transfer. So, I think we don't quite  
 7 accurately describe the conversation today as being  
 8 only formula-driven issues. It has the companion  
 9 of bed buy/sell at the same time.  
 10 MS. CREDILLE: Don, can you comment?  
 11 Because the bed need formula existed before the  
 12 buy/sell. So, this is not some like underhanded  
 13 thing to try and look at the formula. Because the  
 14 buy/sell -- it does fit with buy/sell, but that was  
 15 not the intention of the formula in Ohio.  
 16 MR. REPPY: No, no, no. The formula in  
 17 Ohio was set in advance and then in 2009 is when  
 18 they -- it was all -- there's been a 45 beds per  
 19 thousand standard in Ohio for a long, long time,  
 20 and no new beds were built at all. So, they had a  
 21 -- that formula was long ago. And then when they  
 22 decided that they needed to -- that the best way to  
 23 bring beds -- frankly, I think the reason was to  
 24 bring beds to Columbus. Because that city grew and

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1 Cleveland and Cincinnati got smaller, the best way  
 2 to bring beds to Columbus was to add a buy/sell  
 3 component and that's when things kicked off. But  
 4 the 45 beds per thousand or 50 or whatever was a  
 5 standard they had for a long time.  
 6 MR. GAFFNER: Well, Mr. Reppy, do you  
 7 think the Ohio model works in Illinois if it  
 8 doesn't have bed buy/sell/transfer as a companion?  
 9 MR. REPPY: I don't see why it  
 10 wouldn't. I don't see why it wouldn't. What it  
 11 would do, it would significantly add to the number  
 12 of beds you're approving. So, you would be -- you  
 13 would be -- without that component, you would  
 14 continually overbed. But it would equalize -- it  
 15 would equalize access to care. It would do that.  
 16 Because it would bring beds -- it would bring beds  
 17 to Kendall and Will and some of the other counties  
 18 that are currently underbedded.  
 19 CHAIRMAN LAVENDA: (Inaudible) relieve  
 20 underbedding in some places and there's the  
 21 potential for overbedding in the places you're  
 22 adding.  
 23 MR. FOLEY: Steve, we can't hear you.  
 24 I'm sorry.

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1 CHAIRMAN LAVENDA: No, I was just  
 2 commenting to Alan. I say if you don't have the  
 3 buy/sell, it would seem that even in the areas that  
 4 are currently underserved you have the potential to  
 5 make them overserved, just like you have in other  
 6 parts of the state unless you have that buy/sell in  
 7 there.  
 8 MR. GAFFNER: Then I guess I'm not  
 9 certain how the Ohio formula is better if it still  
 10 creates too many beds in one place and too few in  
 11 another.  
 12 MR. REPPY: Well, it wouldn't because  
 13 its goal is to create -- its goal is to create 45  
 14 beds per thousand everywhere. So, I don't -- I  
 15 guess I don't -- I don't understand why one would  
 16 think that it's going to create too many beds in a  
 17 community because it would be equal -- all it does  
 18 is equalize -- it equalizes access. 45 beds per  
 19 thousand in Cuyahoga County and 45 beds in Hamilton  
 20 and 45 in Darke and 45 in Lucas, it creates the  
 21 same everywhere, every county.  
 22 CHAIRMAN LAVENDA: This is Steve again.  
 23 I just wanted to say, but if population shifts, you  
 24 know, in the future, then that's when you can have

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1 the overbedding in the areas that are -- you know,  
 2 that we are adding beds. Is there some type of  
 3 adjustment?  
 4 MR. REPPY: That's true. And that's  
 5 why Ohio has the buy/sell situation because they  
 6 had some significant adjustment that they needed to  
 7 do because there are too many -- there were too  
 8 many beds in Cleveland and too many beds in  
 9 Cincinnati. Those cities were shrinking and  
 10 Columbus was growing. And so consequently, they  
 11 created this buy/sell approach that allows beds to  
 12 be moved across the state so that as population  
 13 moves the beds can move as well. Which to me makes  
 14 perfect sense.  
 15 MR. FOLEY: I don't understand. This  
 16 is Charles again. If a community's population is  
 17 decreasing, why would anybody want to build there  
 18 in the first place?  
 19 MR. REPPY: If the community population  
 20 is decreasing, the provider is no longer full, and  
 21 he's selling -- he will sell his beds to a  
 22 community where the population is growing. That's  
 23 the gist of the Ohio approach. Communities where  
 24 the population -- in Illinois, when in the

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1 population of a county decreases, those beds stay  
 2 there and they're just unused and unstaffed. And  
 3 in Ohio, when the population decreases, those beds  
 4 get moved to the community where they're needed and  
 5 not only do they create services but they create  
 6 jobs in that community. And so you're not -- you  
 7 don't have an empty -- you don't have an empty  
 8 room, an empty wing in Cleveland. Maybe that wing  
 9 is now all private rooms.  
 10 MR. FOLEY: Well then, Don, another  
 11 question on the same line if I may, please.  
 12 You know, we've heard many times in the past and  
 13 Steve has just reiterated the comment that when you  
 14 try to change a licensed number of beds from your  
 15 lending institution, that could -- not necessarily,  
 16 but that could present some problems. Aren't you  
 17 going to have the same situation here where, if the  
 18 state arbitrarily says, okay, we've got all these  
 19 unused beds, so therefore, based on the actual beds  
 20 in use, we're going to de-license X number of beds?  
 21 Everybody says, no, you can't do that because it's  
 22 going to affect my mortgage. But we're doing the  
 23 same thing and it's still going to affect their  
 24 mortgage one way or another. So, either the state

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1 will get --

2 MR. REPPY: No, in this case it's not

3 true because in Ohio they're selling the beds.

4 They're selling an asset. And if you have a

5 relationship with your mortgagee -- with your

6 mortgagor, I guess, and they're not interested in

7 participating in that process and they want to hold

8 you to that mortgage, then there's not much you can

9 do. You can't participate. But some providers'

10 mortgagors will see the opportunity for the

11 provider to get something for that asset and

12 perhaps improve the building or whatever. So,

13 you're not forcing -- no, it's a totally voluntary

14 situation. You're not forcing anybody to do

15 anything. If a provider can participate, they

16 participate. But if that provider and his

17 mortgagor can't get on the same page, that's the

18 way it is.

19 MR. FOLEY: So what happens to the

20 money that is received under this buy/sell

21 agreement? Can a facility that receives let's say

22 for sake of conversation \$17,000 a bed, can he just

23 keep that money and walk away or must it go towards

24 reducing the mortgage or putting money back into

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1 the facility? What happens to that money?

2 MR. REPPY: Well, you know, he's an

3 individual entrepreneur, so he can keep the money.

4 If I were you -- if I were you, when I wrote this

5 up, I would force him to describe in his -- in the

6 CON application the applicant -- the buyer of the

7 beds should be the applicant. But still, if I were

8 you and I was writing the rule, I would force the

9 provider to tell the board what he's going to do

10 with that money.

11 Now, he may not -- there's no

12 requirement. They can't condition the CON. But

13 nevertheless, if you've got it on paper that he

14 says he's going to create -- he's going to take out

15 -- he's going to take 20 rooms and create that to

16 all -- sell 20 beds in semiprivate rooms and make

17 them all private and build a therapy space, if he's

18 got to tell the board that, you know, then let's

19 make him -- make him tell the board that. And when

20 he comes back three years later and wants to do

21 something else before the board, somebody can go

22 back and say, well, wait a minute, you know, four

23 years ago you told us you were going to create all

24 private rooms there. You didn't do that. What's

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1 going on with that?

2 So, you have a number of alternatives

3 here to get what you want. You can tell the buyer

4 he's got to build 60 percent private rooms if you

5 want. That's the way I'd write the rules.

6 CHAIRMAN LAVENDA: Nelson, go ahead.

7 MR. AGBODO: Yes. The current formula

8 actually reduces available beds after populations

9 decrease. Because the first step in the

10 calculation is the bed use rates, which divides --

11 the way we figure that out, we divide the patient

12 days by the base population. So if the base

13 population goes down, it means that the use rates

14 is going down, and that reduces the final bed need

15 that we calculate for the area. That's one of the

16 comments I'd like to make.

17 But the other one is that perhaps we

18 are making a confusion between geriatric population

19 for a specific area and the target population.

20 What I call target population is the population

21 that need nursing care in a general population.

22 So, if we want to project to meet the need of the

23 population, I think that population should be the

24 target population.

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1 And I'm trying to assemble this

2 information by using patient discharge information

3 collected by the patient safety office within IDPH.

4 I already made the request. I would like to do

5 this because a population can decrease but the

6 target population might not decrease at the same

7 rates. So, that can be one of the limitations of

8 our formula. And instead of using the general

9 population, we might also look at the target

10 population, which is the population that needs

11 nursing home or nursing care, and see how, you

12 know, they go together. So, at the end of the day,

13 if we want to evaluate the best methodology, we can

14 also use that information. So, the formula that

15 provides beds, you know, in proportion reflect the

16 proportion of the target population might be the

17 best.

18 Thank you.

19 CHAIRMAN LAVENDA: All right. We have

20 to be out of the room here in the next ten minutes,

21 so we probably should wind things up.

22 We have to pick out some future meeting

23 dates. Let's give Nelson some time to work up the

24 numbers and all. Can we say three weeks? How does

MEETING HELD 7/27/2015

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<p>1 three weeks sound? 2 MS. CREDILLE: Are we going to stay 3 with Monday? 4 CHAIRMAN LAVENDA: I don't know if 5 we're tied to Mondays. 6 MS. AVERY: We have a board meeting 7 that week before. It's usually kind of hectic. 8 So, if we can look after the holiday. 9 CHAIRMAN LAVENDA: After which holiday? 10 MS. AVERY: Labor Day. 11 CHAIRMAN LAVENDA: After Labor Day, 12 okay. How does Wednesday, September 9th, look? 13 MS. CREDILLE: That looks good for me. 14 CHAIRMAN LAVENDA: Okay. Well, check 15 your e-mail. Courtney will coordinate, make sure 16 we get the conference room here and everything. 17 And I think that we'll shoot for that. 18 Let's pick one other day just to be on 19 the safe side. Maybe the 11th. 20 MS. AVERY: The 9th or the 11th? 21 CHAIRMAN LAVENDA: Yeah. 22 MS. AVERY: Okay. 23 CHAIRMAN LAVENDA: Anyone else have any 24 other comments or questions?</p>	<p>1 the other associations or any other person 2 individually that Ohio is not the only one that we 3 can look at. If you have suggestions or 4 recommendations for anything that pertains to the 5 methodology or looking at other states, please pass 6 that information on to Nelson. 7 CHAIRMAN LAVENDA: (Inaudible) 8 COURT REPORTER: I'm sorry, can you 9 repeat that? 10 CHAIRMAN LAVENDA: What Courtney said 11 was if anyone else has any other states they want 12 to look at, you know, any other suggestions to look 13 at other methodologies across the country for a 14 similar type thing that they should pass it on to 15 Nelson and myself. 16 MR. FLORINA: And again Florina. I 17 would ask backwards, does the staff have any states 18 that they think we should consider? 19 MR. CONSTANTINO: Illinois. 20 MR. AGBODO: Illinois. 21 MS. AVERY: No, but we'll keep our eyes 22 out -- open. 23 CHAIRMAN LAVENDA: Okay. Thank you, 24 everyone, for taking the time to attend. And I</p>
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<p>1 (No response) 2 CHAIRMAN LAVENDA: I think this was a 3 good meeting, good first step and good discussion, 4 and we look forward to discussing the data next 5 time. 6 MR. FLORINA: Did you pick a second 7 alternative date? 8 CHAIRMAN LAVENDA: The 11th. 9 MR. FLORINA: The 11th? 10 CHAIRMAN LAVENDA: Yes. 11 MR. FLORIN: I have a conflict with 12 that. This is Florina. 13 CHAIRMAN LAVENDA: The 9th is no good 14 for you? 15 MR. FLORINA: The 9th is fine, the 10th 16 is nine, the 8th is fine, but I can't do it the 17 11th. 18 CHAIRMAN LAVENDA: Let's make it the 19 8th. 20 MS. AVERY: The 8th or the 9th? 21 CHAIRMAN LAVENDA: Yeah, the 8th or the 22 9th. How's that? 23 MR. FLORINA: That sounds good. 24 MS. AVERY: I wanted to make clear to</p>	<p>1 want to thank Courtney for organizing everything. 2 MS. AVERY: Was there anyone else that 3 joined the call after the roll call? 4 MS. HANDLER Just Carolyn. 5 MS. AVERY: Cece and Carolyn we have. 6 MS. HANDLER: Okay. 7 CHAIRMAN LAVENDA: All right. Thank 8 you, everybody. 9 (The meeting adjourned at 11:52 a.m.) 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24</p>

1 CERTIFICATE OF REPORTER  
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3 COUNTY OF SANGAMON )  
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