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TASK FORCE ON
HEALTH PLANNING REFORM

REPORT OF PROCEEDINGS had of the above-entitled matter before the Task Force on Health Planning Reform at the Thompson Center, 100 West Randolph, Chicago, Illinois, on the 14th day of July, A.D. 2008, at the hour of 9:04 o'clock a.m.

MEMBERS PRESENT:
SENATOR SUSAN GARRETT, Co-Chair;
REPRESENTATIVE LISA DUGAN, Co-Chair;
SENATOR PAMELA ALTHOFF, Member;
MR. GARY BARNETT, Member;
SENATOR BILL BRADY, Member;
MR. PAUL GAYNOR, Member;
REPRESENTATIVE RENEE KOSEL, Member;
SISTER SHEILA LYNE, Member;
MS. HEATHER O'DONNELL, Member;
MR. KENNETH ROBBINS, Member;
MR. HAL RUDDICK, Member; and
MS. MARGIE SCHAPS, Member.

EX-OFFICIO MEMBERS PRESENT:
MR. DAVID CARVALHO, and
MR. JEFFREY MARK.

ALSO PRESENT:

MR. GREG COX,

MS. MELISSA BLACK,

MR. KURT DeWEESE, and

MR. MIKE JONES.

CO-CHAIR GARRETT: I'd like to open up the meeting of the task force.

We'll just have everybody introduce themselves.

MEMBER BARNETT: Gary Barnett, Sara Bush Lincoln Health Center.

MR. ROBBINS: Ken Robbins, Illinois Hospital Association.

MEMBER RUDDICK: Hal Ruddick, SEIU, Healthcare Illinois.

MR. MARK: Jeffrey Mark, Health Facilities Planning Board.

CO-CHAIR DUGAN: Representative Lisa Dugan.

CO-CHAIR GARRETT: Senator Susan Garrett.

MEMBER GAYNOR: Paul Gaynor, Illinois Attorney General's Office.

MEMBER O'DONNELL: Heather O'Donnell, Center for Tax and Budget Accountability.

MEMBER SCHAPS: Margie Schaps, Health and Medicine Policy Research Group.

MR. DEVLIN: Patrick Keenan Devlin from Citizen Action.

MEMBER BRADY: Senator Bill Brady.
CO-CHAIR GARRETT: Do we have anybody on our phone lines who would like to chime in?
(No response.)
CO-CHAIR GARRETT: How about over in Springfield? I see we have a couple people. Do you want to introduce yourselves?
MR. DeWEESE: Kurt DeWeese, speaker staff.
MS. BLACK: Melissa Black, Senate staff.
CO-CHAIR GARRETT: We have minutes that we need to approve. Do we have any changes based on -- they're fairly comprehensive minutes. We've come a long way since we first started, 16 pages of minutes.
CO-CHAIR DUGAN: Yeah.
CO-CHAIR GARRETT: Do we have any changes to the minutes?
MR. DEWEESE: I have one change from Springfield. There is a listing there for staff present via phone, Susanne Hack. I believe she is public, not staff.
CO-CHAIR GARRETT: You believe what?

MR. DeWEESE: She is public, not staff.

CO-CHAIR GARRETT: Yes, she would be. Is Susanne, is she staff or public?

MS. HACK: This is Susanne Hack. I represent Barnes Jewish Hospital.

CO-CHAIR GARRETT: Thank you. Is there any motion to accept the minutes?

CO-CHAIR DUGAN: With that correction.

CO-CHAIR GARRETT: With that clarification, change, Representative Dugan makes the motion, second by Senator Brady.

There is a motion to approve the minutes. The minutes are approved.

I think we're ready for testimony. Have we got everybody here?

We have SEIU and Sumanta Ray, introduction by Keith Kelleher, president of SEIU Healthcare Illinois and Indiana; and then following that, we have Dr. David Dranove from Northwestern University.

So let's start with SEIU.

MR. KELLEHER: Good morning. My name is Keith Kelleher, and I am the president of the

Service Employees International Union Healthcare Illinois and Indiana. Joining me today are Suman Ray, director of public finance for SEIU's capital stewardship program, and Andrew Hamilton is a senior researcher and attorney with SEIU's hospital division.

SEIU Healthcare is the largest union of health care workers across the country as well as in Illinois. In Illinois and Indiana, we are 85,000 health care providers who include hospital care, nursing home care, home care, and child care providers. Our members are working every day to provide vital care for our children, our parents, our seniors in our communities.

Many of our members work in facilities that come under the review of the Illinois Health Facilities Planning Board. SEIU-HCII shares the steadfast belief that every human being deserves access to a quality care system.

While our members are tireless in their efforts to provide quality care, they cannot do it alone. They depend on the support of the facilities where they work, from the elected officials and representatives that promote

responsible health care policies, and from the certificate of need process and the Board.

The CON process and the Board play an integral role in supporting not only the health care system, but the workers, patients, and communities they represent.

As a representative of health care workers in every legislative district in Illinois, SEIU-HCII asserts the following about the CON process:

One, the CON process plays an important role in our health care system; and therefore, the permanent continuation of the Illinois Health Facilities Planning Board's review of services and institutions and the CON process is necessary.

While the Board and the CON process are important, we propose some changes that would improve the general effectiveness of the CON process and of the Board.

The CON process plays an important role in protecting safety net services, particularly safety net hospitals that are critical to Illinois communities.

We'll use part of this presentation today to

show the great disparity in access to capital between the richest and poorest private, nonprofit hospitals in Illinois. While the CON process plays an important role in helping to combat this disparity, other intervention from public entities is also necessary.

SEIU-HCII is submitting a position paper to the Board -- on the CON process to the task force, but I'd like to outline some of our specific recommendations here. As we mentioned, we believe the CON process should be kept permanently because of the vital role it plays in the health care system.

First, the CON process limits the duplication of services from hospitals to nursing homes, dialysis centers, and ASTCs. By limiting the duplication of services, we have the opportunity to limit the medical arms race that endangers the vulnerable safety net hospitals where many of our members work.

SEIU-HCII recognizes that poor safety net hospitals have reached a crisis in access to capital and that by limiting this arms race, the CON process protects the safety net services.

The CON process also preserves critical, less profitable services for communities by ensuring that the discontinuation of services does not leave a disproportionate burden on the remaining providers.

Finally, and most importantly, the CON process creates one of the only places where the public can weigh in on public health care decisions. These decisions have significant impacts on patients, workers in the community, as well as the health care systems. It is critical that the CON process provide a venue for the public to express their perspectives about significant changes to the health care system.

Administrative recommendations -- this will be outlined in our PowerPoint here.

So the administrative recommendations -- while we believe strongly that the CON process plays a critical role in the health care delivery system, we agree that there are opportunities to improve the effectiveness and the efficiency of the Board.

With that in mind, SEIU-HCII makes the following six recommendations to improve the

administrative functioning of the Board.

One, the Board's sunset should be eliminated, thereby making the CON process permanent.

Two, the Board should continue to review services provided by hospitals, nursing homes, ASTCs, and dialysis providers, and should once again have the power to review nursing home changes of ownership.

Three, we believe the current five-member Board creates the necessary public forum for the Board members to review and discuss CON applications.

Four, we are opposed to categorical appointments to the Board.

Five, SEIU-HCII believes strongly that the current ex-parte communication rules create important protections for both the staff and the Board.

We also urge that the process could be streamlined better to prepare applicants and the public for the CON review. In particular, we believe that any communication between staff, Board, applicants, and the public should be

available for public review within 24 hours of receipt.

Six, finally, we believe that every Board meeting should include a period for public participation.

Application criteria recommendations -- while these administrative recommendations are important to improving the effectiveness of the Board, we also believe there are opportunities to improve the functioning of the CON process itself. Importantly, the addition of the following application criteria are designed to improve health care planning by improving public input and furthering other important policy goals with the CON process.

We believe institutions coming before the Board need to continue to be reviewed as entire systems of services and facilities given that the system tends to operate as a system. For example, by taking up debt obligations as a system, using individual facilities of the applicants does not provide an accurate picture of the operating reality and distorts the health care planning process.

SEIU-HCII believes that the state lost an important regulatory function when nursing home change of ownership review was recently removed from the CON process. We would recommend that the CON review be reinstated for the nursing home change of ownership.

SEIU-HCII also recognizes that certain smaller transactions involving free or fewer facilities may not require every element of the CON review process as it existed prior to 2007.

We see the value of the CON process as an important public accountability and transparency tool and believe the public hearing review process should be maintained and expanded to include public participation at every Board meeting.

SEIU-HCII believes patient care evaluation tools, like the hospital report card, can make sure providers whose care processes and outcomes reflect the highest evidence-based medicine standards with reasonable resource utilization are favored.

The CON process needs to consider the levels of charity care when approving applications. All hospitals have a duty to provide charity care in

return for the tax exemptions they receive. While the individual situations of each hospital should be considered, overall, each hospital has an obligation to provide charity care to the citizens of Illinois.

SEIU-HCII supports the previous discussion about the use of an impact study in the review of CON applications. Such impact studies should include the impact that the project will have on patients, workers, the community, and other health care providers. Additionally, those impacted by the project should be given ample opportunity to review and respond to any impact study presented to the Board.

Recommendations to protect the safety net -- perhaps one of the most important functions of the CON process is to help protect the health care safety net, particularly safety net hospitals.

Many of the hospitals where our members work are part of vital safety net -- the vital safety net of hospitals, including: Roseland, Mt. Sinai, Michael Reese, St. Bernard's, Loretto, and the Cook County health care system. These safety net hospitals have made a commitment to serve

Illinois' most vulnerable populations and communities.

Sharing that same commitment are the caregivers themselves. Every hour, 365 days a year, our members keep these safety net hospitals going.

Despite the tireless efforts of our members, there continues to be a growing burden on the safety net of hospitals. To put it bluntly, the safety net is fraying, and the patients and the workers are falling through.

By limiting the medical arms race, the CON process helps protect the safety net hospitals, but we think there are some important facts that the task force should know about the capital disparity within the hospital industry.

Suman Ray, director of public finance of SEIU's capital stewardship division, is going to spend the remaining time outlining a study that addresses this disparity in safety net hospitals.

Suman.

MR. RAY: Thank you, Keith.

Good morning, members of the task force. Thank you very much for giving me and us the

opportunity to speak to you today.

My name is Suman Ray, and I'm the director of public finance of the SEIU capital stewardship program. The capital stewardship program is a program that has been created by the national union to engage in the capital markets as it relates to the various sectors that SEIU is in. As director of the public finance program, we engage in the tax-exempt bond market, particularly as it relates to the non-for-profit private health care industry.

And just taking a step back, you know, we're going to -- I believe our plan is to provide you a copy of this white paper report at the end of this meeting, and, you know, the slides that I'm going to go over draw from this report, and there's more details in the report, so later on, you can go ahead and take a look.

There has been a lot of attention given here to, you know, the disparities between the have and have-not hospitals. There have been a lot of press reports about it. I know Crain's has published many stories on this subject matter.

What we wanted to do was add some numerical

rigor to that and take a look at some data sets to see to what extent is this true, how systematic is it, and who are the affected parties. So that's what the paper is intended to do.

So, you know, Keith outlined some of the importance that safety net hospitals play in the communities they serve here in Illinois. When we look at the poorest hospitals -- I'm going to keep referring to the poorest and richest hospitals, and I can go back later on and give you the specific definition, but the way we define it is the poorest -- we look at the cash and investments they have in their portfolio on their balance sheets to determine if they're rich or poor.

When I say the "poorest," it's the top 25 bottom quartile in Illinois. When I say the "richest," I'm really referring to the top 25, the top quartile, the top 25 hospitals that have the most cash and investments.

So when we look at the poorest hospitals, we see that they have 7 percent of the setup beds in Illinois. Despite having 7 percent of the beds, they serve 8 percent of the Medicare patients in the state -- Medicaid patients in the state, and

12 percent of the charity care and self-pay patients.

So safety net hospitals treat nearly twice the number of self-pay and charity care patients than expected given their capacity, and like I said, the press has continued to document how safety net hospitals continue to get squeezed.

The need for capital for safety net hospitals is fairly clear, and it's fairly startling compared the richest hospitals. These are the three areas that we have identified where we believe the need for capital is the strongest.

One is the renovation of aging buildings. This is a most urgent funding need for safety net hospitals -- capital needs from regulated upgrades like fire sprinkler systems, such as building a new emergency room. When we looked at the poorest 25, the poorest hospitals, we saw that the average age of their facilities was 60 years versus 10 years for the richest hospitals in the state.

Modernization of equipment and health it, lack of capital prevents safety net hospitals from fully investing in the highest grade technology that can enhance health care delivery. For

example, safety net hospitals face extreme difficulty investing in advanced health information technology, such as electronic medical records and computerized physician order entry. Studies have linked the implementation of these technologies to improved delivery of health care services.

And finally, the expansion of services: without the state-of-the-art facilities and equipment, these hospitals cannot expand the services they offer. The health affairs studies concludes newer facilities might more easily attract qualified physician staff.

Without physicians, they cannot increase the number of surgeries and other profitable lines of service performed in their hospitals. Without these services, they cannot attract better paying, well-insured patients.

So this kind of speaks to a vicious cycle there in which I'm going to start outlining the three prongs of that vicious cycle and come back to describing it in detail.

The lack of access to capital -- typically, hospitals -- private, non-for-profit hospitals

have three sources of capital. One is based on the profits they can generate and retain and put towards capital improvements through operations, operating cash flows and profits; second is fund-raising; and the third is access to capital through borrowing. What we see is safety net hospitals are challenged in all three prongs, particularly compared to the richest hospitals.

So in terms of the first one, internally-generated operating cash flows, this is largely a function of the communities they operate in. As a result, they have a less favorable payor mix than wealthier hospitals.

For example, the poorest hospitals in the state have a payor mix of charity care, self-pay, and Medicaid that's 38 percent of their payors, versus 20 percent for the richest hospitals; and typically, the reimbursement for these payors is below cost.

To give another example of sort of the poor or the weaker payor mix that safety net hospitals face, in terms of private insurance payors, which are typically wealthier payors, they pay above the cost, safety net hospitals have only

14 percent of their payors in that category, whereas the wealthiest have about 40 percent.

In terms of the low fund-raising, I'm going to quote here, safety net hospitals -- again, this is from a Crain's article where they address this issue. "Safety net hospitals have to sell potential donors into contributing to a facility they'll never use in a part of the city they never visit."

As Crain's Chicago Business puts it, significant donors do not generally live in neighborhoods where safety net hospitals are located, so safety net hospitals are often overlooked, and they're at a severe competitive disadvantage when it comes to fund-raising.

The final point, the final source of capital would be external capital which primarily is through borrowing for non-for-profit hospitals, and here, as I'll show you later in slides, the safety net hospitals are completely locked out of this industry, and they are not able to access this capital market which is a -- you know, it's a federally subsidized form of capital.

So this slide -- what we did was we took a

look at capital in the state, and this is really two forms of capital, if you will. One is debt capital, which is taxes and bonds, which is a form of capital that's widely used in the industry overall; and then cash and investments, equity capital, if you will.

What we've observed is that there's a huge disparity in both categories between the wealthiest hospitals and the poorest hospitals. So if you look at the numbers here, the poorest, the bottom 25 percent of hospitals had .4 percent of the total outstanding taxes and bonds that -- outstanding in the state, where the richest, the top 25 had almost 80 percent.

It's the same pattern when you take a look at the cash and investments. The poorest hospitals had only half a percent of the cash and investments in the state, whereas the richest hospitals, the top 25 percent, had 82 percent.

So there's a similar pattern, and it really speaks strongly to the disparity in the industry.

On the next slide, it takes a look at it adjusted for scale. We thought it would make sense to take a look at this on a per-bed basis to

see how it plays out, so then you can sort of compare -- it's more of an apples-apples comparison.

Again, it's a start. I think this slide is powerful in showing the discrepancy. Again, if you will, the yellow bars are the debt -- is the cash and investments capital, equity capital, if you will; and tax exempt bonds, the blue column is the debt capital.

Again, if you take a look, the poorest hospitals have little over $40,000 per bed, capital supported per bed, whereas the richest hospitals have about $833,000 capital supporting each bed.

In addition, if you look at the debt, it's even more stark in the sense that these are the medians here in every quartile. If you look, the median in the bottom quartile, in the lower-middle quartile, the median is zero. So half the industry in Illinois doesn't have access to tax-exempt debt, and this is, you know, part of their whole problem.

Therefore, you know, their balance sheets are weak because they have a weak operating cash

flow, a weak payor mix, weakened fund-raising; and as a result, you know, it's a vicious cycle. They cannot -- they don't have strong balance sheets, so they can't access the tax-exempt market.

So if you add it all up, it's even more stark. When you look at the poorest hospitals, the total capital they have access to per bed is 40,000; where the richest hospitals, you've got to really add them up, and so you're over 1.2 million there in the capital supporting each bed.

This takes us to the vicious cycle. The weak operating cash flows, the low fund-raising and limited access to borrowing, and the weak cash flows also translate into, you know, weaker balance sheets and very little cash and investments held.

Because of that they're unable to implement their capital plans, and because of that they're unable to attract better paying patients to offset the poor paying patients, so they can't improve their payor mix.

This also affects their ability to attract good doctors and physicians, which is critical to the success of any hospital. So this is a vicious

cycle in which we see the safety net hospitals just kind of spiraling downward.

So we believe, you know, the certificate of need process can play an active role in easing this disparity, and some of the points that Keith made, and public intervention from a variety of other entities can also work to strengthen the health care system and start bridging the capital stronghold in the industry.

Thank you.

CO-CHAIR GARRETT: Do we have questions from committee members?

CO-CHAIR DUGAN: Why can't -- I don't know if this is a stupid question, but why can't poorer hospitals which are exempt, tax-exempt, why can you not access more?

MR. RAY: They typically, you know, don't have the -- it's kind of a self-fulfilling prophecy. You have to have a fairly strong income statement and balance sheet to be able to access the tax-exempt bond industry because you need to get rated. You need to go to a rating agency to get a rating.

If you don't have a good rating, then you

have to purchase what's called a credit enhancement. That's more expensive. And as a result -- and also in some cases, the scale of their needs are smaller. Typically, the bonds we see are very large, you know, they come out up above 50 million, though you can have much smaller ones, too.

So it's kind of -- because they're weak to begin with -- it's the vicious cycle. Because they're weak to begin with, they can't ever work to improve their payor mix to get a better income statement. They can't get the operating cash flows to build up enough cash and investments to where their balance sheets are stronger to get a good rating to be able to come to market.

CO-CHAIR DUGAN: Okay. You also made a statement that the safety net hospitals are locked out of federal subsidies. Why is that?

MR. RAY: I was alluding to the tax-exempt bonds in general, that it is a federal subsidy. It's a federal -- primarily a federal taxpayer subsidy. So, you know, being able to borrow in the tax-exempt bond industry, you're borrowing at lower rates than you would in the

commercial market typically.

CO-CHAIR GARRETT: To follow up on that, don't some of these safety net hospitals get DSH funding, you know, federal funds that the more wealthier hospitals don't have access to?

MR. RAY: I believe they do, but I do not believe that it's the case that the wealthier hospitals don't get any access at all to the DSH funding. This is not my area of expertise, but I think one of my colleagues --

MR. KELLEHER: I believe that also reflects that in those figures, right, the DSH funding is reflected in the per-bed costs. Do you know what I mean? So, yes, they do.

CO-CHAIR GARRETT: Does it? I mean, do you know that for a fact?

MR. KELLEHER: I believe it is.

MS. MIRANI: Yeah, because it would flow through that.

MR. KELLEHER: It would flow through their income statement. So you can see, even though they do get DSH money, they're still at 40,000 per bed compared to, you know, what, 30 times more per bed than the other hospitals, the

richer hospitals.

MR. RAY: It would appear it's not significant enough to offset that.

CO-CHAIR GARRETT: And then the hospital assessment that the State of Illinois has been participating in, is that factored into those hospitals as well?

MR. KELLEHER: Yes.

MS. MIRANI: It would all flow in.

MR. KELLEHER: It would all flow in, I mean, so, you know --

CO-CHAIR GARRETT: When you did your analysis, you factored all of those in?

MR. KELLEHER: Yes.

CO-CHAIR DUGAN: You figured --

MR. RAY: I should add that all the data is for fiscal year 2005, which was the last full set of data we were able to get our hands on from the state.

CO-CHAIR GARRETT: And that includes the hospital assessment?

MR. RAY: The hospital assessment was in effect for 2005.

MR. KELLEHER: It was a four-year

assessment, and the last year just hit, so it would have been in effect in 2005.

CO-CHAIR GARRETT: But didn't they receive -- I mean, maybe I'm not clear on it, but I thought the funds really didn't start coming until 2006.

MR. KELLEHER: I thought they had gotten them the previous year. I could be wrong, but I know that the one they just got was actually for a prior year.

CO-CHAIR GARRETT: Right.

MR. KELLEHER: They just got the one in March for '07, I believe.

MEMBER ROBBINS: My understanding is that -- I don't know that it makes a great difference --

MR. KELLEHER: Right.

MEMBER ROBBINS: -- for your analysis to use that data, but if you're using 2005 data, it probably did not include the beneficial effect.

MR. KELLEHER: Okay.

MEMBER ROBBINS: Because it took CMS a very long time to improve it, and eventually it was retroactive, but it would have showed up in

the next year's data, I think.

MEMBER GAYNOR: My understanding also is that even though -- even if you include the assessment money, that hasn't really materially changed the outlook of the safety net hospitals.

I don't know if -- I know we have Sister Sheila who is in charge of one of those hospitals, and I don't know whether she or others can shed light on the fact that the hospital assessment is solving these problems that you're talking about.

CO-CHAIR GARRETT: I'm just wondering -- I agree with you, but if we didn't have that, there would be even more disparity.

MEMBER GAYNOR: Right.

MEMBER LYNE: Right.

CO-CHAIR GARRETT: Maybe you could comment on that.

MEMBER LYNE: I agree thoroughly with you.

CO-CHAIR GARRETT: Yeah.

MEMBER LYNE: It's a big help, but we still don't have more money to spend.

CO-CHAIR GARRETT: You still can't invest in capital.

MEMBER LYNE: It's a factor. Right.

MR. CARVALHO: Sister Sheila didn't hear the early part of the conversation when we were talking about the disparities in capital availability for the lower quartile of hospitals versus the capital availability of the top quartile.

So the assessment gave the safety net hospitals more money, but the assessment wasn't particularly skewed to them. In other words, a lot of hospitals benefited from that assessment, not just the safety net.

CO-CHAIR GARRETT: Right.

MR. CARVALHO: Then the question that Representative Dugan had about why can't lower quartile hospitals access, it's not just that their rating isn't good. Fundamentally, you have to remember that tax-exempt bonds still have to be repaid from something. They have to have a cash flow over operations to cover it.

So if they're just living from hand-to-mouth and keeping up with operations both with the assessment, with the DSH payments, and with the regular payments, if they aren't generating excess

cash, they cannot support the payments on the bond, and it really doesn't -- the bond really isn't available to them because it's not a gift. It has to be repaid.

CO-CHAIR DUGAN: I just have a -- if you can answer it simply. So the CON process, if I understand the importance to the safety net hospitals, I guess my question then is, if you could summarize, then the CON process of whether or not a hospital receives expansion, what then needs to be or what can be done in the CON process to address the issue?

Can we address in the CON process the issue of there's not enough cash flow, and you can't get tax-exempt bonds? I mean, does the CON process address that type of thing or can it?

I'm just trying to figure out what the CON has to do with the -- other than maybe not letting another hospital go in so it doesn't take services away from the services that you may provide.

MR. KELLEHER: Just an example, one of the hospitals that we were talking about the other day gave the example that when Bethany, for instance, reevaluated and came in to become more

of a long-term care facility than an actual hospital, our hospital next-door to it has suffered a $2 million loss because then everybody went over to Loretto. Loretto was the hospital. Everyone went to Loretto who had been going to Bethany. So they lost 2 million more dollars.

So I believe they had to come here to actually get that permission to scale down or convert into a long-term care facility as opposed to a primary care facility. So that directly affected the safety net hospitals in that area, and they suffered a $2 million loss.

That was just one of the hospitals that we talked to. That would probably include Cook County and some of the other ones, too, because Cook County is even closer than Loretto, but Loretto itself suffered a $2 million loss.

I don't know if Mercy may have suffered some too, I don't know, but I know on the west side, the other safety net hospitals were affected directly, and that's how that CON process affects it, and we have some recommendations in here regarding that.

CO-CHAIR DUGAN: Okay. Thank you.

MEMBER ROBBINS: I appreciate the recognition you gave to the capital needs, unmet capital needs of a class of hospitals. I think that's a serious concern.

But maybe to tag on to Representative Dugan's question, other than the example you gave with Bethany, is it your view that CON is largely responsible for that capital shortfall, or is it more likely that inadequate payment systems and the failure to come to grips with how we pay for the care of the uninsured is more likely a contributor to that?

MR. KELLEHER: I think it's a combination of factors. You know, I think the CON has a very critical role in it, but you're also -- I wouldn't disagree with you that the reimbursement rate system and the way they're skewed across the state also affects it a lot.

MEMBER ROBBINS: So even if we kept CON, which I'm in favor of, and the impact of CON decision making were taken into account, do you think it's likely that that class of hospitals would have greater access to capital without payment changes?

MR. KELLEHER: I think that it could be a factor in getting those hospitals to be able to get that access to capital. You're right, it's not the only -- we would prefer rate increase reimbursement, too; but I think it is a key factor in it, too, because it is equivalent to other industries where if there's too much in the market, it's going to affect some of these poorer hospitals. So that was one of our concerns also.

MEMBER ROBBINS: By and large, it has been my observation that there are very few hospitals who wish to compete with safety net facilities or the geography that they serve; and so while you may have the occasional decision, to use Bethany as an example, there may be others as well, I think that -- it's my impression that that is, while it may be important, literally at the edge of the core concerns that affect those hospitals.

Most of those hospitals' concerns have to do with either inadequate reimbursement under the existing programs like Medicaid, or an almost total failure to do anything about the large population of uninsured patients, uncovered

patients that hospitals in those geographic areas must serve, and I wonder if we're really trying to open access to capital markets, or if we're more focused on giving those elements, without necessarily ignoring this element.

MR. KELLEHER: I also think one of the things -- if you read the recommendation also, is that not having the capital to offer the other services, right, that other people go to those hospitals for, and these are low income, moderate income, or upper income, is a real key thing, too.

I mean, a lot of our hospitals -- a lot of the safety net hospitals, a big issue is they don't even have sprinklers, you know, or not to mention MRIs, you know, some of the other diagnostic equipment that you need to compete in the marketplace with the better funded hospitals.

So like I said, I think it -- yes, you're right. The reimbursement rate, those issues you mentioned are key, but also the access to capital is also a big predictor if you're a success or a failure.

MEMBER ROBBINS: I would assume that included in SEIU's position is you do not stand

for the proposition that no hospital should ever close or that all hospitals are sort of equal in the eyes of the community.

Michael Reese, for example, has announced that it's going to close.

MR. KELLEHER: Right.

MEMBER ROBBINS: I'm guessing that when they come before the Planning Board for approval for that, that probably will be approved given their sort of declining record of performance, financial performance that brings them to that. Perhaps also I would say it's other public needs that might be applied to the property over there.

So, I think, the question of access to capital and the continuation of certain hospitals is not necessarily the only consideration as opposed to when it comes to whether or not a hospital can continue to function.

MR. KELLEHER: Right.

CO-CHAIR GARRETT: But you did have the hospital report card in your consideration.

MR. KELLEHER: Right, and charity care, charity care should be one of the

considerations.

CO-CHAIR GARRETT: One of the things that we've talked about as a task force is that it's not just about the money and the insurance and all that, it's about factoring in how high-performing hospitals should be sort of looked at and the low-performing hospitals should be looked at as well in the CON process.

MEMBER RUDDICK: I just wanted to mention, when Ken was talking about the CON process and the safety net hospitals, you were focused exclusively on hospitals; and we had testimony from the safety net hospitals themselves that there were other -- principally ASTCs and other types of providers as well competing with their patients.

It does tie into that whole cycle because if they don't have the equipment to introduce some of these services, and an ASTC comes in, gets in and makes that investment, then they take that revenue away and so on. So I just wanted to clarify that.

CO-CHAIR GARRETT: Go ahead.

MEMBER SCHAPS: You mentioned, Keith, earlier that you thought the CON group should

maintain five members. I'm curious to why you said that because we have had a fair amount of discussion about should it be expanded or kept at five. I'm curious about that.

MR. KELLEHER: We just believe that, you know, right now at least we have been able to adequately represent our positions before the five currently. So we just believe in the future that would be a good mix for us.

Also what's important -- what's also important is that the -- and you've heard my testimony on this -- that they keep it as permanent because some of the problems you see is staff turnover or whatever. We also see that as critical to the operation of the Board is its staff and still be able to, you know, advise and assist on all the questions that come before the Board. So that was our thinking on that.

CO-CHAIR GARRETT: Before we go on a little bit more, I notice we have some new additions in Springfield. I just wondered if you guys could introduce yourselves.

MR. JONES: Mike Jones for HFS.

CO-CHAIR GARRETT: What about the back

row?

MR. REBA: Yes, Curt Reba with Life Services Network.

MR. FOLEY: Charles Foley, consultant.

MR. COX: Greg Cox, Senate republican staff.

Madame Chair, when all the task force wrap up their questioning, I would have a couple of quick questions at the end at your indulgence.

CO-CHAIR GARRETT: Okay. Sounds great. I have a couple of questions, too.

MEMBER KOSEL: Renee Kosel on the phone.

CO-CHAIR GARRETT: Oh, sorry, go ahead.

CO-CHAIR DUGAN: Renee Kosel is on the phone.

CO-CHAIR GARRETT: Hi, Renee. Thank you for participating.

On the no public participation at the Board meetings, you know, we focused a little bit on the hearings, that the Board members don't have to go, they don't go, so they don't get all of the sometimes backlash or, you know, comments pro or

con on any type of an expansion of a hospital; and I guess I'm a little bit surprised to hear that there is no opportunity for public participation.

So maybe I should talk to Jeff about this. So that is the case and why?

MR. MARK: It's my understanding that the way this process evolved over time, we have statutory restrictions on ex-parte communication. So I believe what the Board has done over time in its rules is defined it such that all comments, pro, con, neutral must be made part of the public written record. So they've defined a process whereby there is a public hearing opportunity.

CO-CHAIR GARRETT: But the Board members don't go to that.

MR. MARK: Well, everything is transcribed, and all Board members get a copy of the transcription as well as SEIU and others, again, pro or con may submit written comment.

So the entirety of the record considered by the Board is a written public record.

CO-CHAIR GARRETT: But I have never heard, and I don't mean to be argumentative, of any public body that doesn't allow for comments

from the public. It's almost like an oxymoron to have a public meeting and then not let the public participate.

I'm not sure I understand the ex-parte, you know, at some point you can't shield yourself from the realities of how people are interpreting the process.

MR. MARK: Well, again, I would just say that the Board does allow for public comment, but through a prescribed mechanism that results in a written record.

CO-CHAIR DUGAN: And I think we've talked about this before, but if there's a question or something is not, you know, that they don't understand or maybe there's a question from a Board member, there's nobody there to ask because we don't actually have people there that can say, Well, no, that's not what we meant by that, or you're misunderstanding what we say.

MR. MARK: Understood.

CO-CHAIR DUGAN: I think we do think that that's an issue.

CO-CHAIR GARRETT: And then the other question -- I had a couple more.

Keith, you had mentioned and you had put it on your slide the nursing home change of ownership, you want to renew that, but you never said why.

MR. KELLEHER: Well, we recently had an example where in Illinois a large nursing home for-profit chain came in and bought up a whole bunch of homes, I believe it was 40 homes, 30 or 40 homes.

CO-CHAIR GARRETT: So is that a percentage of the overall homes? Is that like a third?

MR. KELLEHER: Probably like -- no, probably about 7, 5 to 7 percent.

CO-CHAIR GARRETT: Okay.

MR. KELLEHER: It depends on how you count them, there's about 700 to 800 homes in the state. That's the number that we work with, so 5 to 7 percent. So that's huge, and we're -- I think in my testimony, we're saying only -- we're exempting like 3 or less homes.

This is more to provide these -- Manor Care is owned by the Carlisle Group, which is one of the largest private equity companies in the world;

and these are companies that they don't have -- don't even have to have the regular corporate accountability that corporations have to have that actually file SCC statements and things like that.

So they just come in, you know, and many times it's what they call "pump and dump." You know, they come in and pump some money in, they make the facilities better, and then they try to dump them to somebody else, or they come in and suck them, and then they try to dump them to somebody else.

CO-CHAIR GARRETT: So wasn't it Representative Lang, who is not here by the way, wasn't he the legislator who introduced legislation to --

MR. KELLEHER: I think it was Representative Harris, I believe had a bill to limit --

CO-CHAIR GARRETT: Okay.

MR. KELLEHER: Oh, was it Lang? It was Lang.

MEMBER RUDDICK: It was Representative Lang who had written a bill to remove them from the CON process, yeah.

CO-CHAIR GARRETT: All right. And I'm just wondering -- I guess I've always had that question in my mind. I'm just wondering if anybody knows why that happened.

MR. KELLEHER: I do not know.

MR. CARVALHO: They will be testifying later.

CO-CHAIR GARRETT: All right.

MR. KELLEHER: Well, we think they should.

CO-CHAIR GARRETT: Going back to the tax exemptions, do all hospitals receive tax exemptions or just the not-for-profit hospitals?

MR. KELLEHER: I believe all of them; right. Oh, I'm sorry.

MEMBER ROBBINS: Only not-for-profit -- you have to be a non-for-profit hospital as sort of an entry level for consideration for tax exemption.

CO-CHAIR GARRETT: Because you talked about the hospitals being tax exempt or being under the umbrella that all hospitals get those tax exemptions.

So can somebody explain to me, given there

is the difference between the two, but if you're a hospital that is for-profit, then how does this relate to everything that we're talking about?

MR. KELLEHER: I'm batting zero for two on these questions.

CO-CHAIR GARRETT: Well, they're the wealthy hospitals, but they're still -- they're paying taxes. Some of them, I don't know what the --

MEMBER GAYNOR: Some of them are not wealthy hospitals, in fact.

CO-CHAIR GARRETT: They're for-profit?

MEMBER GAYNOR: Yeah, because they're -- Sacred Heart is a for-profit and a poor hospital.

MEMBER O'DONNELL: Michael Reese.

MR. HAMILTON: Michael Reese, and I believe Lincoln Park also.

MR. KELLEHER: Yeah.

MR. HAMILTON: They're all for-profit.

MEMBER O'DONNELL: Most hospitals in the state and across the country are non-profit hospitals. Ken, you can probably --

MEMBER ROBBINS: Actually, in Illinois

there are about 25 for-profit -- 25 for-profit licensed hospitals out of a total of about 211, so roughly 10 percent.

CO-CHAIR GARRETT: I just have one more question on that.

Then if I were a hospital, why would I want to be for-profit? What is the benefit to being for-profit when I can get this not-for-profit tax exemption?

MEMBER BRADY: Profit.

CO-CHAIR GARRETT: Explain that to me. I get the profit, and so they put that in like this separate little deal, and then they can invest it, but the non-for-profits can't do that?

MEMBER BRADY: They don't have stock.

CO-CHAIR GARRETT: Okay.

MEMBER ROBBINS: The principal -- I know it can be very complicated, but let me try to simplify it.

Investor-owned hospitals are just that, they are owned by investors who expect to get a reasonable rate of return on their investment. They have shareholders, and they expect that the hospital will generate enough profit to justify a

return.

Non-for-profit hospitals do not have shareholders of any sort at all. The community, if you will, is the shareholder.

CO-CHAIR DUGAN: 25?

MEMBER ROBBINS: 25.

MEMBER O'DONNELL: So 90 percent --

CO-CHAIR DUGAN: Correct.

MEMBER O'DONNELL: -- receive non-for-profit status.

CO-CHAIR GARRETT: I'm just wondering, can I just take this a step further, what type of tax exemptions do the not-for-profits get?

MEMBER O'DONNELL: They get --

MR. KELLEHER: Bonds.

MR. RAY: Bonds and property tax.

MR. KELLEHER: Water.

MEMBER GAYNOR: Sales tax.

MEMBER O'DONNELL: They're exempt from federal income tax, the state income tax, the state sales tax, the local property taxes.

CO-CHAIR GARRETT: And the for-profits are not exempt from any of those?

MEMBER O'DONNELL: No.

CO-CHAIR DUGAN: Correct.
MEMBER BRADY: They can still get tax-exempt financing, can't they?
MS. MIRANI: No, no.
MEMBER BRADY: I thought a city could issue a bond.
MR. RAY: There are a certain type of bonds called private activity bonds. They don't apply to what we're talking about. Some manufacturers, they're offered in special economic zones, development zones can get access to this capital, but that's a totally separate issue.
CO-CHAIR GARRETT: So are the biggest -- I'm just not as, you know, well informed as many other committee members perhaps, but, for instance, is Northwestern a for-profit or not-for-profit?
MR. RAY: Non-for-profit.
CO-CHAIR GARRETT: So are the bigger hospitals generally not-for-profit?
MR. RAY: Yes.
CO-CHAIR GARRETT: Okay.
MR. RAY: The big systems you see in the state that are part of the --

CO-CHAIR GARRETT: So they get all these exemptions.

MEMBER GAYNOR: Then obviously, depending on your location, for example, the real estate taxes might be a little -- exemption, might be a little more favorable to certain institutions. For example, if you're on the lake, one would think that the land might be worth more.

MEMBER O'DONNELL: The property tax benefit is likely to be a bigger bang for the buck in the city than in downstate.

MEMBER GAYNOR: Right.

MR. KELLEHER: They also get free water and things. Some of the hospitals get free water from the city.

MEMBER GAYNOR: For example, if you have private rooms and you put flat screen televisions in each room, you don't pay the sales tax for that when you get the televisions in the room.

CO-CHAIR GARRETT: So there are huge tax advantages.

MEMBER O'DONNELL: Our CTA study illustrated the value of the tax benefit of the

hospitals for Cook County, for some of the hospitals in Cook County. It was over $300 million that we estimated for the total tax benefits, not including tax-exempt bond money. It includes just federal, state, sales tax, local property tax money for 21 hospitals in Cook County.

CO-CHAIR GARRETT: And this is across the country you've got the separation of the not-for-profits and the for-profits -- profitable hospitals. This is not something that's --

MR. KELLEHER: Right.

MR. RAY: It's roughly, if you look at nationally, the statistics are about 70 percent of the hospitals are private, non-for-profit, 15 percent are public hospitals, which is another category, and then 15 percent is private.

MEMBER SCHAPS: So in Illinois, we actually have more non-for-profits --

MR. RAY: Yes.

MEMBER SCHAPS: -- than most states.

MR. RAY: A lot more.

CO-CHAIR DUGAN: Where is the 25 poorest that you said you were using as an example

for your data? Do you happen to know? Where is the 25, you don't have to name them all off, but where is the -- I mean, is it pretty much throughout the state, or is it pretty much located, the 25, in a geographical area?

MR. RAY: I think it's concentrated in Cook County.

MS. MIRANI: Yeah.

MR. RAY: Yeah, I believe.

MEMBER ROBBINS: Just a question, it may not be relevant.

Is it the poorest 45 hospitals that account for that and the staff at all those hospitals, and within the 25th percentile, how many hospitals are there? 50?

MR. RAY: Yeah, I believe our universe was -- first of all, it's a quartile. It's not the 25 poorest hospitals. It's the 25 poorest percent measured by cash and investments. Our universe included 147 hospitals.

MEMBER ROBBINS: Out of 211 hospitals.

MR. RAY: Yeah. Well, the data set we could get our hands on was 147 hospitals.

MR. HAMILTON: Like we said, that

didn't include the for-profits either, and it does not include the public hospitals either.

MEMBER ROBBINS: So you were only looking at not-for-profits?

MR. HAMILTON: Not-for-profits, right.

MEMBER ROBBINS: That wasn't clear.

MS. MIRANI: The details are in the paper, but the data sources, the IRS might not be --

MEMBER ROBBINS: The poorest quartile of hospitals are also only those hospitals that are non-for-profit, tax-exempt. So it wouldn't include Sacred Heart or Michael Reese.

MS. MIRANI: Correct.

MR. RAY: That's right.

MEMBER SCHAPS: You said it doesn't include public, so it doesn't include Stroger or --

MS. MIRANI: No.

MR. RAY: That's right.

CO-CHAIR GARRETT: Would that skew the numbers at all? I mean, I would think Stroger is a pretty major health care system.

MR. CARVALHO: Stroger wouldn't use

the Illinois Finance Authority for its financing. They get their own bonds, so they wouldn't be part of that mix.

CO-CHAIR GARRETT: I feel like this is a different, like a separate topic almost because it really does matter, though, how you look at the wealth of hospitals and how they're able to access more funds, and then on the opposite side, a lack of wealth and where they come from.

MS. MIRANI: Well, they don't have the sources of capital.

MEMBER LYNE: It is the haves and the have-nots.

CO-CHAIR GARRETT: Right.

MEMBER LYNE: And whether this is the body or not to deal with it, but it's got to be dealt with, or we'll continue to see hospitals closing. Unfortunately -- the challenge of Michael Reese, unfortunately for us, it went down gradually. It went down all at once which was much more of a shock to us. As it is, our emergency room is getting beyond our strength, and our patients are leaving without being seen.

Obviously, the Medicaid or self-pay

increases disproportionately, but that's what we accept as the reality of where one is in our community, that's how it is for hospitals. You know, it used to be early on we started looking at financing new hospitals, you know, people started saying, well, they're managed better. That's not the issue, right, Rob, you would agree with that?

MEMBER ROBBINS: Location, location, location, real estate.

MEMBER LYNE: So it's just -- and I go back to it being a public good, not a marketable commodity. It just doesn't behave that way, you know.

MR. CARVALHO: The important thing about the location-location item is also even if the location is improving as, for example, one might think that the location on the near south side is improving, if the community that lives there before uses the hospital and the new community bypasses the hospital because of all the capital deficiencies and the amenity deficiencies, the improvement in the neighborhood may not immediately happen, in fact, on the local hospital.

We were on a tour of Stroger Hospital last week and, in fact, the improvements around Stroger Hospital have a negative impact on their census because the people who are new to the community don't use that. They go to one of the hospitals where there's nicer amenities and the like.

MEMBER RUDDICK: I think in terms of looking at this and in terms of what we've been discussing over the five or six meetings of the task force, in the initial discussion about CON and the role of safety net hospitals, I think there was -- some people pointed out, Well, how much impact does CON really have on safety net hospitals because they're still economically in trouble? I think that's true; right?

So I think what some people on the task force may have been saying is that CON is necessary to protect the safety net hospitals, but as presently constituted, it's not enough.

I think that's kind of -- if you look at this presentation in that context and the mission of the task force which talks about specific recommendations to reform CON and the Health Facilities Planning Board, but also look at the

whole health planning process in the state, I think basically everybody on this task force has a shared goal that we've talked about; how do we preserve these vital hospitals? I don't think there has been anyone that has said, Well, let's just see them all close.

So I think that's the context in which to look at this. Here are some recommendations where CON can go further and through the CON process more actively help the safety net hospitals. Here are some other issues that we have to look at in our health planning process because CON by itself won't be enough.

CO-CHAIR GARRETT: I have one final question on this public participation. Jeffrey, has it always been this way with the Health Facilities Planning Board? Way back when, did the public have an opportunity?

MR. MARK: It's my understanding, and there may be better historians in the audience --

CO-CHAIR GARRETT: Billie?

MS. PAIGE: It's always been that way.

MR. MARK: I would point out that prior to the prohibition on ex-parte, there was

ongoing dialogue between members of the Board and the public that never made it to the record, one-on-one conversations that never made it to the record of the project.

MEMBER LYNE: If I may also add something, it seems to me way back when I had a need to go to a CON, that you could -- the Board member at the Board meeting would at times invite the person, but just by invitation, to speak or answer questions. I suppose that still exists.

CO-CHAIR GARRETT: I mean, I hate to bring this up, but it seems to me that if you have a one-on-one relationship, that kind of could get you back in trouble like what we --

MR. MARK: We don't have that anymore. We don't have that.

CO-CHAIR GARRETT: But now it's to the extreme where, you know, and I think Senator Brady has been trying to sort of, you know, figure out how we can open the process.

MR. MARK: Senator, I'm not saying it's good or bad, but the way it functions now is we have in recent times where there is a project of high profile and a lot of community interest --

we just had one in East St. Louis at Touchette Regional Hospital where we had literally hundreds of people testifying, and we had thousands of pages of public comment.

I will say that in response to that, the Chair and other Board members asked staff to pursue certain lines of research to confirm some of the allegations made in the comment. That is not uncommon. It happened on Bethany. That's the way it works now. Could it operate differently? Yes, it could.

CO-CHAIR DUGAN: Because if there's no questions, let's just say if the staff isn't instructed to investigate a certain thing because -- then it just wouldn't get investigated if the Board didn't say -- do you know what I mean?

MR. MARK: Once in a while we do have an allegation that the staff did not do something right or that the Board is not following its rules. Those we investigate in-house regardless.

CO-CHAIR GARRETT: But then it's hard to follow through on that. So the staff says, okay, investigate, and then you bring all that

stuff back to the meeting; and then those people that are unhappy with the process, are they made aware that's when they can come to hear what the final -- it seems like kind of a disjointed process.

MR. MARK: Everything is made public.

CO-CHAIR GARRETT: Okay.

MR. MARK: We don't inform the applicant one way and the rest of the public another way. We inform everybody.

But I will say that in the case of Touchette and the case of Bethany, after staff was asked to explore some of the impacts that weren't specifically covered in the rules, staff came back and in open public session made their report to the Board and the public. That's how it's working today.

CO-CHAIR GARRETT: Okay. So any other questions before we move on?

Oh, Springfield, sorry.

MR. COX: Thanks, Senator. This is Greg Cox, Senate republican staff.

I'm kind of slow, and you might have said this already, gentlemen, but what exactly is a

poorest hospital and a richest? What criteria do we use? Is that operating margin? Is it amount of foundation dollars they have? Is it who has the nicest cafeteria? What's the criteria?

MR. RAY: The criteria is cash and investments, and it's defined by quartile. When we talk about the poorest, the poorest hospitals, we're talking about the lower quartile, and we're defining it in terms of cash and investments on their balance sheet.

MR. COX: So a safety net hospital could conceivably have a higher operating margin than a nonsafety net hospital, and they can still be on this list as being one of the poorest hospitals?

MS. MIRANI: Yes.

MR. RAY: Yeah, sure.

MR. COX: Would you share the data that you used to compile this?

MS. MIRANI: It's publicly available data.

MR. RAY: The data is publicly available. It's IRS Form 990.

MR. COX: Given that it's publicly

available and that you've already done the leg work in compiling it, wouldn't it be easy to share that data with the task force?

MR. RAY: Yeah, I think we're willing to share it with the task force. I think we have the data.

MR. COX: Thank you.

CO-CHAIR GARRETT: Okay. So then you'll send us a copy? Thank you.

MR. RAY: Yeah.

CO-CHAIR GARRETT: Anybody else? Renee, do you have any questions on the phone line?

Renee?

All right. Thank you.

Five-minute break.

(Whereupon, a recess was had from 10:06-10:12 a.m., after which the hearing was resumed as follows:)

CO-CHAIR GARRETT: We now have Dr. David Dranove from Northwestern. I don't have your bio in front of me, but go ahead and give us just a brief background.

MEMBER ROBBINS: Just to distinguish you.

MR. DRANOVE: Ken, thank you very much.

CO-CHAIR GARRETT: I would like to have a brief summary of some of your credentials.

MR. DRANOVE: Sure. I am a Walter McNerney Distinguished Professor of Health Industry Management at Kellogg School of Management at Northwestern University.

I'm the director of the Center for Health Industry Market Economics and the new director of health at Kellogg, which is a new initiative to beef up both the research and teaching endeavors in the health industry at Kellogg.

I have been researching competition in the health care markets for the past 25 years and published extensively and written several books, and I have been working with members of the State Attorney General's office on some critical health care issues facing the State of Illinois. I'm here to present today on some of my ideas.

CO-CHAIR GARRETT: Thank you very much.

CO-CHAIR DUGAN: It's good to have you.

MR. DRANOVE: Thank you very much. It's a real pleasure to be here, and it's been a pleasure working with Paul and others on his staff and working with Lisa Madigan especially.

The title of my talk, "Healthcare on the Brink: An Integrated Solution to Illinois' Health Care Crises," I realize now in looking at it up on the big screen maybe is a bit presumptuous. I think there's a greater chance that the Cubs and White Sox will meet in the World Series than that this proposal will solve all of Illinois' health care problems, but hopefully, it can be an important step in the right direction.

So what are some of the problems that I hope to address through my solution? Well, first is safety net. The safety net, not just throughout the United States, but here in Illinois, is tattered. There are an estimated 1.75 million uninsured in Illinois. That comes from the Kaiser Family Foundation.

We all know that Medicaid is underfunded, and many providers feel, you know, somewhat ill at

ease about the decision as to whether to take Medicaid or not. There's a mission reason to do so, but maybe a financial reason not to do so.

At the same time, in some parts of the state, things are actually good. In the growing areas of the state, providers are looking to expand their prospering areas, the Chicago suburbs, many of those where new providers are needed to deliver care to growing populations, even as other communities are forsaken and providers are leaving them or are unable to grow and reinvest in their capital.

Finally, the system of regulating providers has been, in my opinion, ineffective. It is unnecessarily bureaucratic and cumbersome in the eyes of many providers who have had to go through the CON process over the course of months, years, and sometimes repeatedly in order to meet some of the local demand for growth; and let's face it, the regulatory process, the CON process in Illinois is politically challenged.

CO-CHAIR GARRETT: We like that. That's a nice way of putting it.

MR. DRANOVE: I was working hard on

that one.

So let me preview my solution, which really tries to pull together both of these strands into one integrated. The first is to remake the safety net -- I should have said reweave the safety net -- to what I call a "floor and trade" system of charity care that I'll spend a lot more time describing as I go along.

I would like to make it every institutional provider's responsibility to do their part, though there might be limits to how we can capture everybody in this process.

At the same time, we should give providers the freedom to determine how best to meet their responsibility and not add new layers of bureaucracy, but actually remove bureaucracy while helping providers and the government collectively meet their objectives, and in the process liberating providers from some onerous regulations. So I think there's something for everybody here, or at least I hope so.

Let me talk a bit more about the tattered safety net. A little bit of history actually is important here. There has always been uninsured

in the United States and in Illinois, but the numbers are rising in both absolute and percentage terms.

Nonprofit providers, community centers, and medical professionals more broadly have always provided charity care, but charity care as defined now represents less than 1 percent of hospital net revenues in Illinois, and less than 7-1/2 percent of overall community benefits as defined by hospitals.

So it's become just a small percentage of what the hospitals themselves say are their community benefits and less than 1 percent of their revenue. I do not have comparable statistics for other providers, such as ambulatory surgery centers or physicians in their offices.

At the same time that we're seeing this decline in charity care, we're seeing a growing number of uninsured, and what that means is that more uninsured are facing financial barriers to care. I like to say that a problem of the uninsured is that more people are one illness away from financial catastrophe.

At the same time, prosperous providers, if

you look at who is doing well financially, they tend not to be located where the need for charity care is the greatest. So it's kind of natural that a provider in a wealthy area is not providing a lot of charity care. There isn't much call to provide charity care where they're located. It's not necessarily that they're doing anything wrong under the current system, but it does mean that that need it not being met.

So the growing challenge is that on --

MEMBER ROBBINS: Just one second.

MR. DRANOVE: Okay.

MEMBER ROBBINS: What need is not being met?

MR. DRANOVE: The need to provide charity care in the system. Okay. The need to provide care for those who don't have health insurance is probably a better way of describing it.

The growing challenge is that limited Medicaid funding is squeezing safety net providers. It's squeezing all providers, of course, but mostly safety net providers; and now we see that Medicare reimbursements are starting

to slide down a slippery slope; and at the same time that funding from government sources is declining, new organizations -- ambulatory surgery centers, specialty hospitals, new community hospitals -- while meeting growing needs for care in their communities are not always doing their part to serve the uninsured, and as I'll talk about again later, sometimes siphoning off the highest paying patients to make it possible for the current providers to do their part.

It raises the question: Should we ask providers to meet this challenge? Is it the responsibility of providers to set aside resources to care for the uninsured? Here again, a little bit of history is important.

Nonprofit hospitals have always been the core of the safety net in the U.S. health care system. In fact, if you go back to the Hill-Burton Act of 1948, I believe it was, which provided just a substantial amount of capital to the growth of today's nonprofit hospital, that money was provided with an assurance and a responsibility to provide charity care. Those obligations have long since expired, but that has

always been the essence of the U.S. safety net, and that essence has been lost.

Even so, nonprofits that receive tax exemptions are -- do have obligations, and I would argue that to this day, one of those obligations remains to provide charity care or free discounted care to indigent patients. Again, many nonprofits are located far from the need for charity care.

I should point out that for-profit providers have no such obligations, but do pay income taxes, so that's a consideration that needs to be weighed. Other institutional providers such as ambulatory care centers, specialty hospitals that they develop, there has been no historical obligation. They certainly haven't felt the force of history for any obligation to provide charity care.

Yet, as I mentioned, they all compete for the same pool of insured patients. It's not just our community hospitals where we have always expected them to provide charity care that are trying to get these insured patients, it's all these new providers as well.

So that raises the interesting question,

should they all have a charity care obligation, and I would argue that the answer is yes.

Well, that's the charity care side. This is meant to be an integrated solution. So there's another problem that I want to talk about, and then I'll show you how to link the two.

There's a problem with certificate of need. It's costly. It's time-consuming. While it does eventually facilitate growth, and we've seen profound changes in the last few years in the certificate of need process, new hospitals finally getting approved and coming online rather quickly, but even then the growth is rarely in those areas where the safety net is the weakest. So new providers may contribute very little towards mending the safety net, and again, they may draw lucrative patients away from safety net providers.

I think, you know, CON is something that's valued by providers. Providers are looking to grow in markets where there are financial opportunities. It's very rare you see a CON application for somebody who wants to grow someplace where they're going to barely scrape by. They're looking to grow in areas where there's

financial opportunities and that CON grants them a license to successfully operate without the threat of unlimited and unfettered competition.

CON does limit competition, and I'm not here today to debate the merits of outright limits on competition. Some of you know where I stand on that, but the fact is that if you have CON, you are protecting incumbent firms to a certain extent.

So you are giving something of value every time you grant a CON, and I think it's reasonable to ask those who receive CON approval to give something back in exchange. So I think there's this quid pro quo. Reform the CON process, make it easier for providers to meet needs of growing communities, but in exchange expect those providers to do their part.

In that sense, I feel that CON reform and the safety net are inextricably linked. You are giving something to providers. What should they give back? Let them give back the thing that's needed the most, mending the safety net.

So the integrated solution -- first, ease CON restrictions. Make it easier for providers to

meet growing needs of all populations. I have some ideas on how that can be done. I'm not sure we want to get into the specifics here. I think that's something that one needs to sit down and really talk through in detail.

Tie certificate of need to aid for the safety net. All providers who obtain CON -- and I think this is regardless of hospital, ambulatory surgery center, diagnostic facility, for-profit and nonprofit, you are getting something of value from the state. In exchange, you should have an obligation to help mend the safety net.

At the same time, we should reaffirm the responsibility of all nonprofit providers, not just those seeking CON, but all nonprofit providers who are getting tax advantages, that they have to do their part. They have to do their part by helping to mend the safety net because that's where we are in a critical condition.

But we should allow providers the freedom to figure out how best to do this through what I'm going to describe next, a floor and trade system of charity care.

Actually, I guess I'm going to talk about

ease of CON first, and then I'll talk about floor and trade.

We should increase the dollar threshold for certificate of need review. Small projects are unlikely to cause grievous harm to the system. So if you believe in the theory that underlies certificate of need -- and as I say, I'm not a big believer in all those theories, but, you know, some people believe that those theories still have validity. Even if you believe in those theories, small projects are not what CON theory is meant to attack. So let's continue to raise the threshold.

At the same time, let's eliminate some of the burdensome aspects of the review process. Just to give you one example, people who are applying for certificate of need have to do financial projections. How much is it going to cost? How much revenue is it going to generate on a year-by-year basis?

Nobody goes back five years after the fact and says, you were wrong, give us back your certificate. Those projections are sticking your finger in the air, and not only that, all of these projects are funded by going to debt markets.

Let's put the burden where it belongs on those who are going to pony up the money and have financial responsibility. Why should we have the CON Board doing something that is more appropriately done by a financial oversight process?

I think there are other examples of how to make the process simpler for providers. We should reevaluate how utilization is computed and need is projected.

I think we should also eliminate the micromanagement of facility construction. I don't think anybody cares how many bathrooms you're going to have. Let's assume that they're going to get that right.

Let's let the cost of construction be the responsibility of the provider and the lender, and let's really focus on whether the facilities are meeting the need. With that, I think you really liberate a lot of what makes providers upset about the CON process, a lot of what delays the process, and a lot of what sometimes leads to a wrong decision.

But at the same time, let's remember that providers highly covet CON. It's a license to

prosper, and it's protection from excessive future competition, but ask the providers to give back to the community.

If you get a CON, you should have a one-time obligation based on the percentage of the capital cost of the project, and you should have an annual obligation based on total revenues, but you can get exemptions if you provide a certain level of Medicaid or charity care.

I would make this apply to all certificate of need applicants. This obligation to take care of Medicaid patients and provide charity care should not just be community hospitals. It should include, again, ambulatory surgery centers, outpatient diagnostic centers, whoever is getting this favor from the government should give something back.

And the obligations should be enforced through a floor and trade methodology. The benefits -- remove unnecessary oversight, reduce the time and expense of obtaining approval, allow providers to determine how best to meet the need of the neediest patients.

It will also protect providers currently

serving needy populations by exemptions from these contributions. So if you are serving these populations who seek CON, you won't have to make these payments. This is really for those who are in the prosperous communities.

How do you meet this obligation? I'm sorry, the second part, before I get into the floor and trade system.

We've talked about nonprofit providers and their historical role as our safety net providers. I feel that nonprofits have drifted away from this mission. I want to reaffirm this mission through the floor and trade system, the floor and trade system that CON beneficiaries would be obligated to meet.

How does that work? Nonprofit providers should meet a minimum standard of charity care based on percentage of net revenue. What should that standard be? That obviously is something that has to be discussed. It's something that has to be reasonable for the providers, but also something that is substantial in terms of moving us away from the status quo.

Providers can meet that obligation either by

offering direct patient care, so you meet that floor by doing it yourself; or instead by trade, by forming financial partnerships with designated safety net hospitals, directly sending money to them or working in partnerships to develop new services, having an outpatient cancer care center or a prenatal facility. Form real partnerships between the haves and the have-nots in the State of Illinois.

If you fail to meet this obligation, you decide I'm not going to get involved in providing charity care, you could simply give the money to the state, but you will have to give an elevated amount, an elevated percentage to the state. We really want to keep this in the private sector as much as possible. I don't want to encourage the formation of another state agency to supervise more state spending.

The benefits -- we could dramatically increase resources for charity care without overburdening our community hospitals. There's so little money going to charity care right now, you can get a substantial increase without it really taxing many community hospitals.

So keep funding in the private sector, encourage hospitals to form partnerships, and help -- and I should add, helping our safety net hospitals survive through these partnerships really does help all hospitals because we know every time a safety net hospital goes under, those patients are not lost to the system. They stay in the system, and they go somewhere else.

Any questions?

CO-CHAIR GARRETT: Okay. Where should we start?

Go ahead, Pat.

MR. DEVLIN: I'm sure you're going to get a lot of questioning --

MR. DRANOVE: Good.

MR. DEVLIN: -- but mine is very simple. On your slide "Ease CON" --

MR. DRANOVE: Yes.

MR. DEVLIN: Could you just explain one more time the bullet eliminating burdensome aspects of review process?

MR. DRANOVE: Sure. I've had an opportunity to work with, I guess, a couple of hospitals on CON applications over time, and some

of you know my work with Edward Hospital. And I've had a chance to see the certificate of need applications here, but I've also seen them in other states, which are considered to be even less burdensome than Illinois.

There are, you know, lots of financial analyses that have to be performed as part of the CON process. You have to spell out the size of the hospital and how big every ward is going to be, and that has to be reviewed by the task force. You have to get letters from every doctor under the sun saying, Yes, I'm going to send some patients to this hospital. Nobody ever goes back after the fact and says, Did you actually do any of that?

So this is just a lot of, in my opinion, busy work that avoids the real fundamental question; which is, does this community have a need and can that need be met by existing providers? If not, do you need a new provider to meet that need?

I think if the Board focuses on that, they can do 90 percent of their job with a very small percentage of the burden that they currently place

on hospitals.

MR. DEVLIN: I appreciate that. Thanks.

MEMBER SCHAPS: Are there any other states that use the type of formula you're laying out?

MR. DRANOVE: No. In fact, I had an opportunity at a conference three weeks ago, the American Society of Health Economists conference, to share these ideas with some of my colleagues, including people who have been involved in state health reform efforts in other states, and they were very excited. They thought that this was -- this is not the big kahuna, right, this is not the Massachusetts health plan covering a 100 percent of the population and totally restructuring how health insurance works in the state.

This is the small kahuna that might actually do a pretty -- a fair amount of good without massively changing the system.

CO-CHAIR GARRETT: Go ahead. We'll just take it down and keep going.

MR. DRANOVE: Sure.

MR. MARK: Just to follow up to the

question regarding the burdensome review process, you gave an example of the letters from doctors. This is one of the criteria the Board uses to establish need for a projected service, such as cardiac surgery, cardiac cath.

How else would one project need?

MR. DRANOVE: They've got models that have always been used to project need in the public health sector, and they don't use letters from doctors. So I know the models are out there.

But I don't want to get into specifics of what needs to be in. I know that if you were to ask Ken, Ken would have a laundry list of things that he thinks could be taken out of certificate of need, yet still keep the essence of the need -- of projections of need and making sure we meet need. I'd rather this be done in a conversation rather than me off the top of my head giving specific answers.

MR. MARK: And something else, what was your source for your charity care numbers?

MR. DRANOVE: The charity care was information given to me by David Buysse in the Illinois Attorney General's Office, and David is

here. I don't know if you remember the source.

MR. BUYSSE: It's information from the community benefit reports filed by hospitals under the Community Benefit Act.

MR. MARK: But that's just a limited number of hospitals in the state.

MR. BUYSSE: That's correct. There are some hospitals that are excluded from the requirement to file reports with our office under the statute.

MR. MARK: So that excludes all proprietary for-profit hospitals. It excludes public hospitals. It excludes, I think, hospitals under a certain size. Is that correct?

MR. BUYSSE: That's correct.

MR. MARK: Thank you.

MEMBER ROBBINS: Roughly about half of the hospitals?

MR. BUYSSE: I think it's about 147.

MR. DRANOVE: It's a substantial number.

CO-CHAIR DUGAN: Out of 211?

CO-CHAIR GARRETT: Is your point that the data isn't reflective of the entire --

MR. MARK: It's not the entire picture.

CO-CHAIR GARRETT: Right.

MR. DRANOVE: It's certainly the case, obviously, that, you know, government-owned hospitals such as Stroger will have a much higher percentage, but, again, I'm not sure if that means we're doing a good job of meeting the charity care mission. On the other end of the spectrum, I don't think the proprietary hospital numbers are going to be bigger than the ones that I saw.

MEMBER LYNE: I really appreciate your presentation and the thoughtfulness, and whether it's complete or not can always be made in a rationale for what's in and what's out.

But I think to suggest that -- I wondered about floor and trade, and I appreciate that. It gets at, I think, an issue that for many of us, probably more so in the safety net group, gets at what we think is fair and equitable, and it's out there to be dealt with now, I think, in a clearer way than just comments here and there.

MR. DRANOVE: Thank you.

CO-CHAIR GARRETT: Ken.

MEMBER ROBBINS: David, a variety of questions, I suppose. You use a couple of phrases. One is do their part, and the other is give back to the community.

While it is perhaps easy to see how those terms fit together in geographically cohesive environments, it is less clear to me how a hospital in Carbondale meeting the needs of its community, part of which is charity care and part of which is other things like capital investment in facilities and technology that wouldn't be there but for the hospital, can be held accountable for a tattered safety net several hundred miles away.

And so we actually do have some legal standards. Precisely how they're being defined is being tested in court right now. One of the legal standards is that a hospital should provide charity to all who need it and apply. Then it gets into definitions of what need is and what is the application process. I understand that.

But I'm having a hard time understanding the notion that my hypothetical hospital in Carbondale has any obligation to a safety net in Chicago as

long as it's, in fact, meeting the requirements of its community.

How does that fit into your framework?

MR. DRANOVE: That's a very valid point, and one may want to think about the geographic sphere in which responsibility lies.

The starting point, I would say, of what nonprofit hospitals, for example, receive in exchange is the tax benefits, and one of the things they don't pay is property taxes. That tends to be local, but there are other taxes that they don't pay. Those are state-wide.

So we can see how some of that obligation might extend beyond local boundaries, but many of those may remain local. I think that's an issue that's going to have to be discussed.

CO-CHAIR GARRETT: Do you have any other questions?

MEMBER ROBBINS: Let me come back.

MEMBER O'DONNELL: I'd like to make the point that while the standard is, you have to provide charity to those who need and apply and place no obstacles in the way of those seeking health care, that because hospitals often do bill,

there is an explicit barrier there that sometimes people in the community who are uninsured don't seek care because they are afraid of getting a hospital bill.

So certainly I think we need to look at the number of uninsured by region and by community, but I'm guessing that there are unmet needs in nearly every community across the state.

MEMBER ROBBINS: Let me go back and ask a bit of a follow-up.

David, in a book that you wrote, "Code Red," an economist explains how to revive the health care system without destroying it, you make the point, with CON, legislators can sustain the hidden cost subsidies of the preselective contractor, rather than raise the taxes necessary to properly fund Medicaid and cover the uninsured.

But doesn't your proposal continue to give legislators cover from that basic responsibility that I would argue that they shirk?

MR. DRANOVE: Either fortunately or unfortunately economists don't get to write the laws. The laws have to reflect a broad number of interest groups. While I personally might go

beyond what I proposed here today, what I tried to propose is something that might be realistic in terms of what can be accomplished.

I don't think it's realistic to expect the state legislature at this point in time to say let's add 25 percent to Medicaid payments. I think we need to find other workable solutions.

MEMBER ROBBINS: But this would still be your second-best solution, this new proposal of yours?

MR. DRANOVE: This is a positive step. There are other things that I would recommend other than the specific proposal in that book that are more pro-competitive than what I've suggested; but, again, I think it's important that we find something that works for everyone.

MEMBER ROBBINS: But it would still be your opinion --

MR. DRANOVE: I think this is an improvement and a dramatic improvement.

MEMBER ROBBINS: -- that CON particularly in the way that you are suggesting it would change, but would provide cover to legislators who don't have the political will to

increase Medicaid or do something about coverage for the uninsured.

MR. DRANOVE: It's no surprise to anybody who has read any of my books that I'm not a fan of CON.

CO-CHAIR GARRETT: I think Senator Brady was next.

CO-CHAIR DUGAN: Yes.

MEMBER BRADY: The charity care problem, how big have you quantified it to be? How many dollars?

MR. DRANOVE: Well, gosh, I know this has been done. I don't have it at my fingertips. There are, what, 47 million uninsured, 1.75 million uninsured in the State of Illinois.

On average --

MEMBER ALTHOFF: Can you repeat the question about that, sorry?

MR. DRANOVE: Do you want to repeat the question or ask a question?

MEMBER ALTHOFF: I'm sorry. This is Senator Althoff on the telephone.

When you say that there are that many uninsured, does that include people who are

electing not to purchase insurance because it's too expensive, or is that people who cannot get insurance because they're uninsurable?

MR. DRANOVE: It is both. It is everybody that reports to a survey taken at a given point in time in response to the question, Do you have health insurance coverage, and the answer is no.

So that includes, as you're suggesting, a large number of categories. Research by Mark Pauly at the Wharton School suggests that a substantial fraction of those individuals have the financial wherewithal to buy insurance, but have chosen not to do so, plus a substantial fraction that do not.

MEMBER ALTHOFF: Do we have any idea what that breakdown is?

MR. DRANOVE: Perhaps half-and-half.

MR. CARVALHO: We've got information from the adequate health care task force last year, I'll get that for you, but it's nowhere near half-and-half in Illinois.

CO-CHAIR GARRETT: What is it near?

MR. CARVALHO: More people cannot

afford it.

MEMBER O'DONNELL: I thought -- I'm not sure this is correct, but I thought it was around 20 percent.

MR. DRANOVE: I suspect that a lot of this is going to have to do with how you define affordability. That's certainly an issue that a lot of people have taken with Mark Pauly's work, probably with any study.

But no matter how you slice and dice it, there's probably tens of millions of Americans who are financial -- they're at risk of financial catastrophe through no fault of their own, and whether it's 1.75 million in Illinois or 1 million or .75 million, it's a substantial number of individuals.

How many of those are receiving free care, how many of those are getting bills and pay, I have researched, partly by the Robert Wood Johnson Foundation, and the results are finally on the printed page suggesting that a typical uninsured person who falls ill in the United States loses roughly half of their accumulated life savings.

MEMBER SCHAPS: You said about the

question of how much --

CO-CHAIR GARRETT: Wait, wait.

CO-CHAIR DUGAN: Let's get back to Senator Brady.

MR. DRANOVE: So how big -- I don't know how many people are sitting out there saying I need free care. What I do know is there's a substantial number of people who would have financial piece of mind if more charity care was made available to them. I don't have --

MEMBER BRADY: So you don't have a --

MR. DRANOVE: I don't have an exact number.

MEMBER BRADY: You don't know how much money we're talking about.

MEMBER SCHAPS: We're talking about 1.75 times $6,500 per person, which is what we're spending per person nationally.

MR. DRANOVE: Well, it would be lower than that because the typical uninsured person tends to be younger and healthier. Those are the folks who voluntarily choose to go without insurance.

MEMBER BRADY: Would you include in

that equation payments for Medicaid?

MR. DRANOVE: No, I don't include that, and that's --

MEMBER BRADY: I think it's irresponsible of the legislature to have something that might not be adequate, but yet the only charity care you want to talk about is free care.

MR. DRANOVE: I'd love to talk about more. You remember the old Chicago Bulls in the old days when we had -- you know, before Michael Jordan, we were at Point A and ultimately got to Point C. I'm trying to get us to Point B.

MEMBER BRADY: Would you advocate a tax over and above the tax benefit that these hospitals receive?

In other words, would you give the CON process a license to tax at any rate they wanted to to cover up whatever your definition of charity care is --

MR. DRANOVE: Yeah, I'm suggesting that --

MEMBER BRADY: -- or would you limit it simply to the tax benefit they receive from the state?

MR. DRANOVE: I'm suggesting that those who receive a certificate of need, those tend to be prosperous organizations going into prosperous areas, and for a limited period of time, if they are not providing charity care, and if they're not providing Medicaid --

MEMBER BRADY: To what level?

MR. DRANOVE: That's the --

MEMBER BRADY: To the level of their tax benefit from the state?

MR. DRANOVE: That's a number that needs to be discussed.

MEMBER BRADY: So you're not even saying it should be limited to that. You might give the CON process the ability to tax them beyond their tax benefit to cover whatever they arrive at this problem?

MR. DRANOVE: Personally, I wouldn't go that far, but this is not going to be something that I'm going to negotiate. This is going to be your task, but I personally would not go that far. I would be much happier getting something that works and moves us in the right direction than blowing up the system.

MEMBER BRADY: Why would you only pick on CON, why not medical licenses?

MR. DRANOVE: Very interesting question about what to do about physicians, and that was discussed at length. The feeling right now might be one step at a time, or perhaps we make the tent bigger and bring that in. I'd be comfortable making the tent bigger and bringing that in.

MEMBER BRADY: Did you hear the earlier testimony on the safety net areas and so forth?

MR. DRANOVE: Sorry, I did not.

MEMBER BRADY: Earlier, it was indicated by SEIU that one of the concerns is capital in safety net regions and so forth. You're obviously an observer of the Health Facilities Planning Board, and you obviously think the safety net issue is important.

Recently the Board allowed, under my interpretation, the movement of two hospitals, one from Joliet and one from St. Louis, away from poorer areas into wealthier areas.

What's your opinion on that?

CO-CHAIR GARRETT: Is that relevant, though, to the discussion?

MEMBER BRADY: Well, look at the resolution which we were created under. Everything is relevant.

CO-CHAIR GARRETT: Yeah, but he didn't have anything to do with that decision of the --

MR. DRANOVE: I would say that if you're granted a license to move to a prosperous area and now be defended from future competition in that area, it is fair for the state to expect something in return.

I was somewhat disappointed. The move is a good move in the sense that it's serving a needy community, not needy in the financial sense, but needy no matter how much wealth you have, you should have access to care; but now you have a hospital, if it's managed well, that will prosper, and I believe that it should give something back. Not everybody will agree.

MEMBER BRADY: What kind of controls would you put on charity care? I mean, I'll give you a case in point. I can't believe this happened, but one midnight I had to take my

daughter to Broward County Hospital. I offered to pay. No, we won't take any money. They won't do anything.

How do you regulate these hospitals? If you're in a poorer system, how do you regulate to make sure that they're charging when they can?

MR. DRANOVE: Well, that's a terrific question, and it's always a frustration for me to read about that happening and to hear now firsthand from you that it's happened.

That's a really thorny issue, but I don't think it's impossible to solve. I think one can define what charity care is and tell whether a hospital has met its obligation to provide it. I have been in conversations with the Illinois Hospital Association, the Catholic Hospital Association, and the State Attorney General's office. These are thoughtful people. They have --

MEMBER ROBBINS: Only one of us has paid you for that conversation, though; right?

MR. DRANOVE: I should point out that subsequent to that meeting, all the work I've done in the past year has been pro bono. This has all

been pro bono work. After taking a little bit of that money, I realized how can you work on a charity care issue and do something --

MEMBER GAYNOR: But I would hope that you're not implying that if we had paid him, that that would somehow impact somehow his recommendation.

MR. DRANOVE: Right. In all five, I've been paid --

MEMBER ROBBINS: No, I'm sure the consultants always continue to give --

CO-CHAIR GARRETT: All right. I'm going to step in.

CO-CHAIR DUGAN: Okay. Okay.

MR. DRANOVE: That's funny.

CO-CHAIR GARRETT: Let me ask some questions.

MR. DRANOVE: Yes, please.

CO-CHAIR GARRETT: David, I think you've got -- you know, it's intriguing, this concept. Whether you're for it or against it, it's definitely intriguing.

So in my way, let me explain to you how I am interpreting this. So if you're a not-for-profit

hospital and you're going into a prosperous area, and you have a certain amount of revenue, and whatever that formula would be, you would then give back a certain percentage of that revenue based on criteria that we haven't defined yet to a -- and here's where I'm a little bit lost -- would it be a state-wide charity care foundation, or would it be to Carbondale, a regional safety net hospital that doesn't have access to those types of funds? Is that --

MR. DRANOVE: Yes, that's correct.

CO-CHAIR GARRETT: -- floor and trade?

MR. DRANOVE: That's floor and trade. My personal preference is that it doesn't go to a state agency, that there is an incentive to keep it within the private sector.

CO-CHAIR GARRETT: That's my next question.

MR. DRANOVE: Yes.

CO-CHAIR GARRETT: So I'm Hospital A -- well, there's two questions I have. So let's go to the for-profit hospitals. Are they excluded from this?

MR. DRANOVE: That's an age-old

question in the health economics literature as to whether for-profit hospitals by paying income taxes are doing their share.

CO-CHAIR GARRETT: So could there be a formula where based on their income taxes and based on their Medicaid population or based on the under and uninsured population, there's like a threshold; and if they don't meet that threshold, then they too would be part of this process?

Because it seems to me that -- and somebody reminded me when I was on my cell phone. I live in the suburbs. I live in Lake Forest in Lake County, and somebody said that's the second largest area for the non-for-profits. That's why I was asking all these questions. I'm used to dealing --

MR. DRANOVE: For-profits.

CO-CHAIR GARRETT: -- I'm sorry, second largest area for for-profits. So I'm used to working with for-profit, profitable hospitals. In my area everybody wants to come in, you know, from around the world because there are so many -- the population has insurance.

So if your concept works, it ought to work

for those types of areas, too, and maybe all those factors of how much they pay in taxes and --

MR. DRANOVE: Sure.

CO-CHAIR GARRETT: -- all the other stuff should be taken into consideration.

MR. DRANOVE: The bigger the tent, the more we can accomplish without affecting any one provider to a large extent, but the more complex it becomes. That's one tradeoff.

Another, you have to bear in mind, we don't want to get to the point where we frighten the providers out of the state.

CO-CHAIR GARRETT: Right. So to your point to the value, you're decreasing competition with the CON process, and you're allowing an entity to prosper. But what you're saying is you can't prosper so much that the safety net hospitals, the guys who are in the poorest areas of the state, don't have the ability to buy MRIs. So give something back to them, and how that would be worked out would be --

MR. DRANOVE: Yes.

CO-CHAIR GARRETT: -- determined by factors --

MR. DRANOVE: And I should say, if you were to put down numbers that would completely solve the problem of the uninsured, you have to give back this percentage, you would drive every hospital out of the state.

CO-CHAIR GARRETT: Right.

MR. DRANOVE: So this is not the solution. This is a step in the right direction.

CO-CHAIR GARRETT: Okay. So let me ask you then about the ambulatory service --

MR. DRANOVE: Yes.

CO-CHAIR GARRETT: Okay. So they come into profitable areas also, and they don't do that unless there is a hospital there that they can sort of suck some juice out of because they don't get into a rural area with no hospital because they couldn't survive.

So the formula that you're vaguely, informally putting out there, how would those guys be able to participate, or should they then give back to the local hospital that they're basically sucking some juice out of?

MR. DRANOVE: Yes.

CO-CHAIR GARRETT: I hate to -- I'm

not going to read these minutes.

MR. DRANOVE: That's also a terrific question, and it's true that ambulatory surgery centers do siphon patients away from traditional community hospitals. While I haven't seen the data, it would not surprise me if they were not doing as much in terms of charity care or Medicaid as the community hospitals that they were competing with. That wouldn't surprise me.

CO-CHAIR GARRETT: It's difficult for them to do it because their hours are very different, and they're not open on weekends --

MR. DRANOVE: Sure.

CO-CHAIR GARRETT: -- as an example, generally speaking.

MR. DRANOVE: Some of the -- any new ambulatory surgery center is going to need a certificate of need. This process would find a way to get revenues from them, and the nonprofit ambulatory surgery center, the same thing, if it's a for-profit or if it's a doctor-owned.

CO-CHAIR GARRETT: But what I'm saying, I guess -- so we're looking at the hospitals in general giving back either regionally

or to a state charity care foundation, but the ambulatory centers are really dependent on their local hospital.

MR. DRANOVE: Yes.

CO-CHAIR GARRETT: So I think in my opinion, we're looking at a different formula, so the local hospital doesn't lose twice.

MR. DRANOVE: Yes, you know, that could be tricky, though, because as you say, they have been siphoning patients away, and that's the polite way of putting it, from a hospital, and I'm not sure if it's going to work if the only partner that they can work with is that local hospital.

CO-CHAIR GARRETT: But if you put a value on the hospital, and that value is translated into dollars for the ambulatory, you know, service center or whatever it is, then maybe that could work because I think the hospitals have -- I mean, at some point in time, I, you know, understand the notion of total competition. I think most of you are probably free market, but the investments are so great into health care, I think we have to be careful that we don't get taken over by these specialty diagnostic service

centers.

MR. DRANOVE: Sure.

CO-CHAIR GARRETT: Again, I just don't think that they would be, you know, trying to open up their doors if there wasn't a local hospital that they could siphon from.

MR. DRANOVE: Of course.

CO-CHAIR GARRETT: That's a different formula.

MR. DRANOVE: Cream skimming is a valid concern, and one way to address cream skimming, which the federal government had, was a moratorium on specialty hospitals. The moratorium has been lifted, but specialty hospitals or ambulatory surgery centers still pose this threat, and I think we have to think very carefully --

CO-CHAIR GARRETT: Right.

MR. DRANOVE: -- about how to apply the formula to those entities which are some of the entities that I'm most concerned about.

Some of them are doing their share, but the reality is that many of them see the fact that mission-bound community hospitals are going to continue to take the Medicaid patients, and they

don't have to be bound by that mission; and that's made an unequal playing field, and some of this proposal is meant to address that.

CO-CHAIR GARRETT: And then the other question I have is, we talk about limiting some of the requests for the CON stuff, and I couldn't agree with you more on some of these capital expenses. Like for an MRI or something that they would have to spend money to come to the Board to get permission to add value to their hospital. So I'm in total agreement.

But you also say that if some type of process is adopted in the State of Illinois, who oversees the process of the finances? You don't want any more bureaucracy; but on the other hand, if all the hospitals are participating, there's got to be somebody that oversees that. Who would that be in Illinois?

MR. DRANOVE: Well, if it's simply to assure that this is a financially -- likely to be a financially viable enterprise, whoever you are going to to raise the capital for that, the funding agencies, they're going to have to do that, and they are professionals at doing that.

MEMBER ROBBINS: Investor-owned hospitals don't go to the debt market, they go to the capital market, the shareholders.

MR. DRANOVE: That's fine. If somebody wants to invest in a for-profit organization, they're taking that risk.

CO-CHAIR GARRETT: That's not what I'm talking about, though.

So it's the transaction. So Hospital A moves in to Lillyville, Illinois, and -- I'm sorry. So the hospitals that have to pay into this charity care foundation, if we use that as an example, who oversees those transactions, the money coming into the foundation and then disseminating it to either local or state-wide safety net hospitals.

MR. DRANOVE: That's something that I have not sorted out with Paul and David and Attorney General Madigan.

I'm hoping to make that as small as possible by giving this financial incentive through the trade so that hospitals keep the money in the private sector, and then something like the Health Facilities Planning Board is in place to assure

that they're actually partnering with other facilities rather than having to be the one to spend the money.

CO-CHAIR GARRETT: Okay. That's it. Oh, one thing -- no, go ahead.

CO-CHAIR DUGAN: No, go ahead.

CO-CHAIR GARRETT: I'm okay.

CO-CHAIR DUGAN: Go ahead.

MEMBER BARNETT: You talk about the safety net as being tattered and really needs to be repaired. I appreciate your bringing forward one proposal for doing it.

When you suggest that this might get us from A to B, suggesting perhaps that's 50 percent of the way, realistically, you're an economist, if we had an uninsured problem, if we had a Medicaid system that doesn't cover the cost, if this was implemented, what percent of the problem would be solved?

MR. DRANOVE: It depends on what percentage levy you're willing to impose, and it's going to be a tradeoff. I think the higher the levy, the more you solve that problem; but the more you expose providers to risk, the more you

run the risk of slowing down reinvestment in capital and growth in growing areas.

I'm coming down on the point of view that we've gone too far in terms of prospering in growing areas and we've moved away from the traditional mission, but where you're going to go on that line is completely up to you -- up to the legislators here.

MEMBER BARNETT: I think that, and I've shared this opinion before, to add the whole charity care and we're going to somehow make a major impact on improving a lot of safety net hospitals or providing more care to the needy through this certificate of need process, if we're going to go through that effort, then that's going to contribute a great deal to the debate, whether anything gets passed, if we try to solve charity care.

I think it's only fair for you, who is bringing a proposal, to express an opinion on if it's balanced, are we doing 5 percent or 35 percent of the solution?

MR. DRANOVE: I'll give you an example. If we were to take the amount that

hospitals currently say -- this is the hospitals that are in the data that I've seen -- giving a community benefit, and we were to take that from their current numbers, which is 7-1/2 percent of community benefit being charity care and raise it up to 30 percent of community benefit being charity care, we would pump close to a billion dollars into the state in terms of providing charity care.

MEMBER BARNETT: But you've reduced by a billion dollars the other programs that are being supported in the local communities by the hospitals.

MR. DRANOVE: No, we would reduce what the hospitals are defining as community benefit, and that debate as to how to define community benefit, as I mentioned, is a vigorous debate. The IHA, the CHA, the State Attorney General, there are lots of different opinions as to what constitutes community benefit.

But, yes, if you're going to ask hospitals to pay money to do something, that money is going to come from somewhere else. There's no free lunch.

MEMBER ROBBINS: I have just one question, just so I understand this proposal.

Several times now you've talked about prosperous hospitals moving to prosperous areas or something to that effect. So would this obligation, this new obligation that you're talking about only apply to a hospital when it was being created or moving to a prosperous area so that it could be prosperous, or would it apply to all hospitals even where they presently exist even if they aren't especially prosperous?

MR. DRANOVE: That is a good question. There would be an exemption for hospitals that are already meeting certain criteria for charity care and Medicaid; but if you're not doing that -- if you're the only hospital in Lake Forest, and you're not making money, I've got no sympathy for you, and you should still be meeting that obligation.

If you're not providing charity care -- you should be meeting it, and if you're now losing money, you should replace the management and find somebody who can figure out how to run a monopoly in Lake Forest.

But to answer the first part of your question, if you get a CON in exchange for that, no matter who you are, there is an obligation, and all nonprofits at all times have an obligation, an obligation that has been lost over time.

MEMBER ROBBINS: And that obligation would be enforced through the CON mechanism?

MR. DRANOVE: No.

MEMBER ROBBINS: No.

MR. DRANOVE: That obligation is enforced through whatever legislation is written by the state.

CO-CHAIR DUGAN: I just have -- of course, a lot of my questions have already been answered, and I just -- it's more I think really as a state, we are trying to figure out, especially with our safety net hospitals, whether we -- as you know, some have said that, you know, one place we have a real problem is raising taxes to pay for Medicaid.

I don't believe that we pay for Medicaid in the system, and Illinois is not working as far as Medicaid. So whether we in some way do legislation to raise taxes for that, we can pay

Medicaid and raise the rates, or we can figure out a way to do partnerships with local health care centers and local hospitals to figure it out, either way the taxpayers of this state are going to pay.

Now, I kind of look at it that whether it be we raise the taxes just for Medicaid or we look to a partnership, I don't know, and certainly I have a community, two community nonprofit hospitals, but also fortunately are not in positions of where we have some other hospitals that have more -- safety net hospitals that have much more of a need.

But as we go forward and certainly as a legislator and on this task force, we have to find a way in order to help save our safety nets; and I've got to look at it kind of like I do education in the State of Illinois. You know, some areas in the State of Illinois, their schools are much better than the ones that I might represent.

But it's the responsibility of the entire state education system to make sure that everyone has access to health care, whether it's by for-profit or not-for-profit, just like every

child has the right to have an education whether they live in a poor area or in a wealthy area.

So as much as I appreciate the fact of some of the concerns of a hospital or a regional hospital who would take the CON away, why is it my responsibility to worry about a poorer area of the State of Illinois and those children and people needing health care? I think it's the responsibility of the state.

So as we look forward and try to figure out how to solve this issue, it may -- we're always going to have the conversation, and I think we'll continue to.

MR. DRANOVE: Absolutely.

CO-CHAIR DUGAN: But you're already there. What should the percentage be because I wasn't involved in those conversations. It's a very difficult decision to make, but I think as we move forward, we have to move forward with the understanding that the state is responsible. We as people, not the State of Illinois, but we as the people in the state are responsible.

So as we go forward, I think we'll continue to have a lot of conversations as to how we

partner to make it work, but I think we all know that we have to do something, or we're going to continue to lose hospitals that serve those people that sooner or later will just end up coming to other areas of the state. Somebody is going to have to take care of them, and if we close down hospitals in the poorer areas, they're going to have to come somewhere else. So we're all going to pay in the end anyway.

But I have -- of course, I think the CON process -- as far as burdensome and bureaucratic, I have problems with it anyway and some of the things, but I wanted to question just one part on the easing of the CON.

The micromanagement of facilities when we construct, is there -- maybe you can answer this. Do we actually, what, we have someone that goes out to the hospitals and looks to make sure they're building them right?

MR. DRANOVE: No, no,

CO-CHAIR DUGAN: What is this eliminating micro, cost of construction thing?

MR. DRANOVE: Just in the planning process, you have to submit documents to the

Board, the design, the costs, how many people you've going to have to staff it. You're going to basically --

MR. MARK: Doctor, that's not quite correct. What we have is we have criteria that look at cost per square foot per national standards as a test of the cost of the project.

We do have, as you have alluded to, we have standards in the major departments on square footage per bed or square footage per CT. You're absolutely right on that.

MR. DRANOVE: Okay.

MR. MARK: We're reviewing those standards as we speak.

CO-CHAIR GARRETT: Do you have standards -- does your criteria include charity care questions to hospitals trying to obtain a license?

MR. MARK: We do not currently have any rules along those lines. There are some charity care criteria being considered --

CO-CHAIR GARRETT: But right now.

MR. MARK: Today, we do not.

CO-CHAIR GARRETT: So if you're going

into a wealthy area, again, and that's -- I mean, there's truth in what he's saying about that. I mean, just economically, it makes sense.

So we don't ask any questions to those hospitals, what their Medicaid population may be or what their, you know, charity care forecast might be. That's something that we don't ask.

MR. MARK: We don't ask as a formal part of the rules, but what the Board has been doing fairly consistently over the year or so is asking what their level of charity care is. We provide for each applicant who is an existing health care facility, we provide their profile, which gives the percent of patients by payor source, and the new profile will include the level of charity care.

CO-CHAIR GARRETT: But it's not a criteria.

MR. MARK: It's not a criteria.

CO-CHAIR GARRETT: So all of these per-square-foot costs and all of that seems to be more of a priority and more of a focus, which I've got to say, if you're a hospital, you're going to know what's going to make money for you and what's

not going to make money.

But when it comes to understanding the real population and allowing for a hospital to move into an area based on, you know, the Medicaid or charity care, none of that is taken, right now, into consideration.

MR. DRANOVE: Jeff.

MR. MARK: I just want to point out that that's exactly as responsive to the legislation as written.

CO-CHAIR GARRETT: I know.

MR. DRANOVE: Jeff, can I say that, when I saw the committee, the Board actually making inquiries about existing charity care effort, then I first started to think about this.

What I'm proposing is going from -- that is a standard, unless you are already providing it, and you can't get CON to -- well, you know, there's many providers who just because of where they're located won't be able to meet that standard, but it's still an important thing for providers to do, so let's give them this alternative way to meet the standard.

CO-CHAIR GARRETT: So in a way what

you're saying is, let the square footage, the cost of all that, put that aside --

MR. DRANOVE: Yes.

CO-CHAIR GARRETT: -- and maybe include in the criteria something to do with the Medicaid or the charity care from, you know, population and stuff like that as a factor.

MR. DRANOVE: Yes. That they either meet through what they're currently doing or through the floor and trade system.

MEMBER ROBBINS: If I could ask for, again, a clarification.

The standard that you refer to would be a standard that would be state-wide or a standard in some geographic area or a standard --

CO-CHAIR GARRETT: That would be determined by us.

MEMBER ROBBINS: -- based on whatever particular community? What is it you're thinking about?

MR. DRANOVE: You know, I'm so Chicago-centric, that I just think the metropolitan area. What goes on downstate is what goes on downstate. You don't want to ask me what

it should be.

MEMBER BRADY: We have that problem with a lot of people up here.

MR. DRANOVE: Right.

CO-CHAIR GARRETT: But to your point, I think that's a really important point.

MR. DRANOVE: Of course, it is, yes.

CO-CHAIR GARRETT: And I think that, you know, my area in Lake County, for instance, there's a safety net system, Vista Health Care, that probably would benefit if it was a regional approach, but there are other ways to look at it. So maybe there would be an option, a way to sort of take both into consideration.

MEMBER BRADY: We all agree that it would be best if everyone can afford to buy their health care insurance, make it affordable.

How do you view the argument against your theory that goes along this line: The hospitals just aren't going to take the hit, they're going to increase their cost of insurance or what they charge insurance companies, and insurance companies then are going to increase their premiums, and health care therefore is going to be

less affordable to fewer people?

What you're in essence doing in an economic model, some would argue, is you're taxing a responsible behavior to the point it won't be afforded by them, and you're going to create a bigger problem.

MR. DRANOVE: What you're describing is cost shifting, and Ken read my book. Thank you, by the way. The dollar in royalties is going to help offset my PowerPoint presentation.

MEMBER ROBBINS: I got it from the library.

MR. DRANOVE: Don't say that.

In fact, I wrote what -- I have a handful of a papers that have been well received over the years. My paper studying cost shifting in Illinois in the 1980s is certainly one of those. One of the observations that I made in that paper was that with the looming growth of selective contracting and the tilting of power away from hospitals towards a level playing field that's tilted too far in favor of payors, but that's a debate for another time.

If you see my recent affidavit in a legal

case in Nevada, you know that I am now leaning in that direction, that maybe it's gone too far in the way of payors. But whether it's a level playing field or it's gone too far in some markets, it is certainly the case that cost shifting is no longer what it used to be.

The ability of hospitals to pass along the cost of doing business is not what it used to be, and this is not really increasing the cost of doing business. A tax on profits is not the same as an increase in cost.

MEMBER BRADY: This isn't a tax on profits. If you eliminate their sales tax and their property tax, which is all you have advocated, it's just like a gross receipt. It's a tax before profits, and if they don't have anywhere to go, they've got to get it from the payor. I mean, unless you're presuming they're all fat and making more money than they deserve.

MR. DRANOVE: I don't know the average profit margin for nonprofit hospitals in the state, but it was more than sufficient that those that have a fairly high percentage of privately insured patients have rates of failure that are

minuscule compared to the rates of failure of other businesses in the economy. So they are protected. They are sheltered from competition.

They do have responsibilities to provide community benefit defined in a particular way, and they are scarcely meeting that responsibility through charity care. They are meeting it in other ways. Some of those ways, I think, are blatantly not community benefits. Some of those ways are blatantly loss leaders that are provided in equal quantity by for-profit providers.

MEMBER BRADY: What are those, in your opinion?

MR. DRANOVE: I'll give you one example, and we've had this debate, money spent on academic research. Academic research institutions command the highest prices of any hospitals in negotiations with insurers.

MEMBER BRADY: Do we give universities property tax breaks for academic research?

MR. DRANOVE: No, the university gets property tax breaks for being a nonprofit institution.

MEMBER BRADY: What community benefit

are you providing? Is one of your benefits not research?

MR. DRANOVE: The benefits we are providing is not something I studied. I'm not --

CO-CHAIR GARRETT: Yeah, I don't want --

MR. DRANOVE: My bailiwick is not university --

MEMBER BRADY: You brought it up.

CO-CHAIR GARRETT: Okay.

MEMBER BRADY: Let me go to another issue.

MR. DRANOVE: No. I mentioned university hospitals. I didn't mention universities. University hospitals is an -- you asked for an example. I gave you an example. Okay. I can give you more.

MEMBER BRADY: Are you arguing that the cost shift -- you're arguing that the cost shift wouldn't take place?

MR. DRANOVE: The prices that insurers pay for hospital care are largely a function of the value that those hospitals bring to them, and they won't pay a penny more than those hospitals

are valued.

After research -- and I should say, Senator Brady, the research evidence, there's a wonderful book by Mike Morrisey at the University of Alabama, Birmingham, that covers the research evidence. The research evidence strongly suggests that cost shifting is either minimal or nonexistent in the area of selective contracting.

MEMBER BRADY: On another issue, you suggested, I think, that the only value the CON has really in your mind is a value to tax for that license and that tax to be used for charity care.

MR. DRANOVE: No. I said anybody who knows my work knows that I don't think certificate of need is a good thing. I would do --

MEMBER BRADY: I think that's fairly consistent with what I said.

Do you find that it is harmful?

MR. DRANOVE: Yes, in my personal opinion.

MEMBER BRADY: Leaving the cost aside, tell us how you think it's harmful.

MR. DRANOVE: It stands in the way of the market. So instead of market forces deciding

which providers get to grow and prosper and meet the needs of their communities, it gives incumbent providers a license to continue operating free from traditional market forces.

It allows incumbent providers to decide how much innovation, what services they're going to offer, what doctors they're going to deal with and all of those things; and if those incumbent providers don't make the decisions that are best for their community, they do not get -- they do not bear the full brunt of market forces. I personally think that's a bad thing.

MEMBER BRADY: Have you ever put a value on that?

MR. DRANOVE: No, nor do I think has Milton Freeman ever put a value on what he thinks is the value of the market.

MEMBER BRADY: No, I'm not being argumentative. I just wondered if you've quantified it. Any anecdotal situations you think we should know about?

MR. DRANOVE: I'm trying to think. There is a lot of research on certificate of need. Off the top of my head, I know there's research

that at a minimum shows that certificate of need has not led to any cost savings, but I'll tell you that some of the research showing what has happened with certificate of need has shown that it has led to benefits to the community, but I don't have that research off the top of my head.

CO-CHAIR GARRETT: Okay.

MR. DEVLIN: The certificate of need process, is it necessary to keep it in place in order to implement the floor and trade system you're advocating?

MR. DRANOVE: No. In fact, you can separate the two. You can just have the nonprofit obligation through floor and trade.

MR. DEVLIN: Would that, in your professional opinion, be the ideal maybe result of this task force, that we maybe do away with the CON process since you don't believe that it's meritorious?

MR. DRANOVE: My ideal reform -- you've given me a table here -- would be No. 1, to try to do something along the lines of the Massachusetts health plan. That would be a dramatic upheaval for the state, but I think

doable, and it would require lots of new dollars.

No. 2 would be to perhaps, not just what you suggested, which is get rid of CON, increase the nonprofit obligation, but also pump money into Medicaid. Rationalize Medicaid so that those are not second-class patients.

I think that that package, which would require dollars, and I would have to pay some of them, and I would be glad to do so, would really move us towards a system that would make I think everybody comfortable.

MEMBER LYNE: Would you still be talking about the hospitals getting the tax-exempt privilege?

MR. DRANOVE: The nonprofit hospitals that have the tax exemption would still have this obligation, absolutely.

MEMBER LYNE: Well, the obligation, but should they even be tax-exempt?

MR. DRANOVE: Oh, should nonprofits be tax-exempt?

MEMBER LYNE: I mean, if you're not doing the charity care and obvious repayment back into the system. So the more I'm hearing where

you're going now, I think --

CO-CHAIR GARRETT: It's his personal opinion right now.

MEMBER LYNE: Yeah, but it's part of the record here, and that concerns me.

MR. DRANOVE: Under the Dranove health care system --

MEMBER LYNE: Is this a public good?

MR. DRANOVE: Yes.

MEMBER LYNE: Is this a public good? Somebody already referred to, the Co-Chair, about schools, making a comparison with schools, which I clearly agree with, but it operates totally different, health care does, and it gets the benefit of being tax-exempt as well as make as much as you want and get, you know, favoritism if you're large in terms of bargaining powers.

MR. DRANOVE: I know -- I guess I'm getting a few of the details wrong. So I may have gotten some of the details wrong here as well, so forgive me again.

It's my understanding that nonprofits in the state do have certain obligations that they have to meet that the State Attorney General's office

is responsible for making sure they have met them; and perhaps in the opinions of some, there are some institutions that continue to get tax-exempt status that have not met those obligations. That's not for me to judge.

Clearly, if we move in the direction I have been suggesting, which is this floor and trade system, if you don't meet that obligation, the law supposedly is written so that you lose something, and what you might lose is the tax-exempt status.

MEMBER LYNE: I guess this all goes to the implementation and enforcement of those things.

MR. DRANOVE: Yes.

MEMBER LYNE: But we haven't seen a lot of that up to this point, and so the rich get richer, and the poor try to survive. That doesn't seem right to me in a public good arena.

CO-CHAIR GARRETT: Can you tell us what some of the benefits to the hospitals might be if we pursue this?

MR. DRANOVE: Sure.

CO-CHAIR GARRETT: I'm sure getting this feeling that the people that lean towards,

you know, the hospitals and, you know, all the good work they do, that they feel like if we pursue this, that they would get shorted. I don't see it that way, but let's talk about that.

MR. DRANOVE: By making the tent bigger, by bringing in ambulatory surgery centers, freestanding diagnostic facilities, specialty hospitals, and maybe even more, I think we would have more --

CO-CHAIR GARRETT: And maybe decreasing the process, the paperwork, and the bureaucratic --

MR. DRANOVE: Yes. Well, streamlining CON is a clear, I think, plus for hospitals.

Expanding the tent I hope will bring more into the system in terms of helping the safety net; and also make some of those providers who said, I'm going to open an ambulatory surgery center because I can skim the cream realize that maybe that's not going to be such a good option anymore; and those hospitals that are on the knife's edge, they're surviving only because they are fulfilling their mission and will get further protection.

CO-CHAIR GARRETT: There was somebody who actually testified, a hospital who testified here, and we had talked about this concept in a very vague way.

He called me up, and he said, you know, we do a lot of good. We, in fact, donated X number of -- well, we donated land to another hospital free of charge. How would that compute into this formula?

I said, that's exactly where I think -- what this is about, forging partnerships. It's not about writing a check every month to a group of people to disseminate the money, but it's about this sort of -- in a way, it's about forging partnerships and bringing more health care into the process without an additional charge.

MR. DRANOVE: And I'd love for a nonprofit provider, let's say that this is a hospital in -- say, Lake Forest Hospital, and it looks to the north and realizes those hospitals to the north have a disproportionate share of Medicaid and uninsured patients.

If those hospitals fail, those patients are going to come down to us, and either we're going

to get bad publicity by sending them away, or we're going to take the financial -- it's just not going to be good for us.

I'd love for there to be a way that Lake Forest Hospital could form a partnership with the hospital to the north, so they can keep financially viable those that are serving the same communities from the standpoint of what the geographic bounds should be. I think we need to think about that.

CO-CHAIR GARRETT: If something like this happens, don't you think that they will sort of come together and say, well, we can give you this if you can give us that, and it might meet the criteria for this charity care issue that we've been talking about for years.

MR. DRANOVE: In fact, one issue that's been raised that I worry a little bit about is the antitrust. That's something that would have to be dealt with, but I don't see how -- this would be such small potatoes compared to other antitrust concerns on the payor and provider side, that I don't think this would be an issue.

CO-CHAIR GARRETT: I guess what I'm

saying is, I would like to pursue this. I don't want the hospitals to think that they're getting pushed aside and this is negative. I see it as a potential positive, a really -- a potential positive and a whole new way of looking at how we deal with health care in the State of Illinois.

MEMBER ROBBINS: Does this theory apply to, let's say, long-term care as well?

MR. DRANOVE: Absolutely.

MEMBER ROBBINS: Any entity regulated by the state?

MR. DRANOVE: Absolutely.

And I do want to, again, though -- there is a slippery slope that I think the hospitals -- the providers need some assurance. Today it might be 1 percent of revenues, tomorrow it might be 2 percent, and then the next year 4 percent. I think that's -- you know, if I'm a provider, I would be worried about that.

CO-CHAIR GARRETT: Maybe it could be built in --

MR. DRANOVE: Yes.

CO-CHAIR GARRETT: -- that there would be a cap.

MR. DRANOVE: Yes. Well, how do you keep legislators from changing their minds?

CO-CHAIR DUGAN: Oh, well, now. We have to.

CO-CHAIR GARRETT: Okay.

MR. DeWEESE: We have a couple questions here in Springfield.

CO-CHAIR GARRETT: All right.

CO-CHAIR DUGAN: Go ahead, Kurt.

MR. JONES: Hello. This is Mike Jones.

I'm wondering, you know, trying to think of some examples or models that might have elements similar to your floor and trade concept.

Are you familiar with the sale of carbon emission credits --

MR. DRANOVE: Yes.

MR. JONES: -- where some companies who are low polluters can sell credits to high polluting companies?

MR. DRANOVE: Of course.

MR. JONES: Would you care to react and tell me if your concept is somewhat similar to that, if we can create a market for this sale?

MR. DRANOVE: Yes, it is, although there won't be a market for, oh, here's a charity care patient, who is going to bid to take care of them? It won't go that far obviously.

But it's no accident that I'm calling this a floor and trade system because the cap and trade system is either you clean up, or you pay somebody else to clean up.

So here it is either you provide the care, or you pay somebody else to do it.

MR. DeWEESE: I have a couple of questions, I guess, somewhat more along the line of a comment.

I think it's kind of rhetorical to talk about the cost and time of the CON process, especially when you talk about the value that is going to be gained by the approval of that certificate of need.

I'm not sure that the cost, especially for those projects that are approved, is excessive, nor is the sort of hassle factor of going through that process really that extensive when, in effect, they're trying to just demonstrate the need.

So it does seem to me, though, that's kind of a rhetorical kind of thing that a lot of people talk about in terms of excess regulation, but it does seem to me as though it's a step-wise kind of realistic cost that you're going to recover through the value of a project that you ultimately get approved.

The other question --

MR. DRANOVE: Kurt, can I respond to that?

MR. DeWEESE: The other comment --

CO-CHAIR GARRETT: Kurt, can he respond to that?

MR. DRANOVE: I didn't realize there was a tape delay.

By the fact that providers are always seeking certificate of need is prima facie evidence that the value exceeds the cost, but the cost is still considerable.

When I have been involved in these things, I was amazed at how many lawyers and experts were involved who were putting in far more hours than I was, and they were, you know, getting paid far more than I was for my little contribution. I do

feel that some of what's done in review is relatively high cost and relatively little benefit versus other things.

I'd like hospitals -- I'm asking hospitals to do something that was a historical obligation, it's no longer perceived that way, and I think if we're going to ask hospitals to give something back, it's fair to look at what is more burdensome to them and maybe have this quid pro quo.

MR. DeWEESE: So you're saying that the cost in this case is what -- is over and above the fees that are charged, but what applicants do to assure their approval, essentially getting the consultants and others in line to help them sort of move the process to an approval.

MR. DRANOVE: I'm sure Ken probably -- it's got to be seven figures plus for a hospital application.

MEMBER ROBBINS: For a very large and complex application, it is very extensive, when one hires the architects, the engineers, the lawyers, the consultants, the lobbyists.

CO-CHAIR GARRETT: The irony of this is that the small hospitals, they can't afford to

pay this. It's a cottage industry of lawyers, who, you know --

MR. DRANOVE: On top of that, all of the hospitals that oppose the process, they hire their own teams of lawyers and consultants, and it is a cottage industry.

I'd love, and I know that this is what this task force is all about, to find ways to fulfill what not myself, but others, believe is the valid purpose of CON, without incurring these costs.

CO-CHAIR GARRETT: But having this up-front requirement.

I'm sorry. Kurt, go ahead.

MR. DeWEESE: Well, I think, again, that to me is probably not well-documented, and it depends on the project and, again, the size of the project and, again, the relative value of the project that will ultimately be approved.

But I think the other comment or question that I had is in relation to what happens when these facilities do have to pay some additional resources, that presumes that you have some mechanism or some way of applying those resources to meet those community needs.

It doesn't seem to me as though this really says you're pumping money into the system is really going to achieve what you need to preserve the safety net. It doesn't necessarily mean that Hospital A, which is losing services, is going to be the beneficiary of those payments. There may be other needs in that community that you need to address beyond just propping up that hospital.

I don't think there is anything that you have suggested as to how you identify those needs of that community that might benefit from those additional resources, whether it goes into a state fund or into a foundation.

It doesn't seem to me that you're providing a mechanism that actually assures that there will be access. If Hospital A moves completely across the county and leaves that community high and dry, there is nothing there that says that you're going to put something there in the place of that hospital that was lost to that community.

MR. DRANOVE: I think you make a terrific point. I think it is important to think about what we're going to consider to be a qualifying use of the funds.

I would hazard a guess that any designated safety net provider in the state, say a provider that qualifies for disproportionate share payments would be one example of how you could define them, would have no shortage of ideas about how to spend additional capital that was available to them.

Even if that wasn't ideal in the eyes of some omniscient planner, I would rather leave those decisions in the private sector than have that money go to a state agency and have the state agency be responsible for deciding which of those are worthy projects and which are not.

CO-CHAIR GARRETT: Kurt, you know --

MR. DeWEESE: I guess I do think it goes back to something that was said at an earlier meeting, and that is that you have some evaluation of what the state-wide needs are and where you need to provide those resources to prop up the service deficits.

MR. DRANOVE: I think we do need to have some involvement in identifying what a qualifying expenditure is, but I would try as much as possible to leave those decisions in the hands of the providers.

MR. COX: Senator, this is Greg Cox from Springfield. I have a couple questions, if this is the time.

CO-CHAIR GARRETT: Go ahead.

MR. COX: Doctor, I thank you for your testimony, and I thank the task force for their patience with me.

This is somewhat along the lines of Senator Brady's questions. Any kind of additional commitment of charity care by a facility is obviously going to have an impact somewhere else. He was going along the lines of increased insurance rates for other people.

Your response to him was that the ability to cost shift is greatly diminished given the current climate of how insurance industries have a little bit more power in the negotiation process. From everything I've heard from hospitals, that's probably an accurate description.

However, if we apply this charity care requirement to only the facilities that come in and apply for a certificate of need, won't that have an adverse impact on the people that come in and apply for a certificate of need and therefore

have an adverse impact on access to health care services?

MR. DRANOVE: Well, I think I -- perhaps I wasn't clear. This is a two-pronged approach, and as Patrick Devlin pointed out, they can be separated.

All nonprofit providers have some obligation to meet in exchange for their tax-exempt status, and I would suggest that we move more in the direction of making that obligation met by charity care. I'm not suggesting you move all in that direction or even the majority of the way in that direction. I'm suggesting moving towards that direction. That's one prong.

The other prong is, all providers get a benefit, and this is not just nonprofits. All providers get a benefit when they get a certificate of need. A certificate of need is sought usually by providers who are likely to be the most prosperous. It's also where you have the greatest worry about cream skimming.

So I think the second prong is to have a second obligation. Whether it's in addition to the nonprofit obligation or a substitute for the

nonprofit obligation can be discussed, but that's a second way in which the obligation can come out.

MR. COX: So you would propose that we apply the charity care standard across the board, not necessarily tied to the CON, similar to legislation proposed by the Attorney General's office earlier?

MR. DRANOVE: Yes.

MR. COX: All right. I appreciate that.

I have tried desperately in the past months between special sessions to try to get a better picture of the financial status of hospitals in the State of Illinois. I have looked at as many Medicare cost reports as I can.

It appears to me, and this is very preliminary, that the operating margin for the average hospital in the State of Illinois is about 3 percent. And, Ken, you can correct me if I'm wrong, if I'm way off base on that.

But if an average operating margin is 3 percent for a hospital and they average 1 percent for charity care, that would be a 4 percent margin. If we give a standard of 5 percent

charity care for a hospital, their operating margins on average go to negative 1 percent.

Wouldn't that be difficult to do, to mandate basically that all hospitals have to lose money?

MR. DRANOVE: I couldn't imagine a 5 percent standard. In my conversations with --

MR. COX: Well, the previous legislation was 8 percent.

MR. DRANOVE: In my conversation with the State Attorney General's office, I have not put forth a 5 percent standard.

CO-CHAIR GARRETT: Can I just jump in? We haven't come up -- we're just exploring this idea. It could be that it's based on, you know, meeting a threshold of a Medicaid population or something like that where -- the last thing anybody wants to do is to put the hospitals out of business.

But it's not just about writing a check. I mean, there are other benefits to the hospitals that will apply, including, you know, corralling the ambulatory service centers.

MEMBER O'DONNELL: I'd also like to make a comment. We found -- this is Heather

O'Donnell with the Center for Tax and Budget Accountability.

We found in our study on nonprofit hospital tax exemption and charity care that the total uncompensated care costs, which is charity care and bad debt, that oftentimes when hospitals provide an increased amount of charity care, their bad debt column goes down and their charity care column goes up. So the total uncompensated care cost remains the same.

I think that's been the experience of a couple of hospitals downstate that have actually increased their charity care costs and their overall costs have not gone up.

MR. DRANOVE: Could I say that a lot of valid --

MR. COX: The only thing --

MR. DRANOVE: A lot of valid issues have been raised from all parts of the political spectrum, those who are worried a lot about, you know, protecting the poor, those who are worried a lot about protecting the hospitals, and everything in between.

My goal here was to give a framework in

which parameters can be put in place so that we actually get everybody on board, and everybody realizes that this could be a net plus for everyone who is participating.

So yes, you could throw out a particular parameter that would clearly slam one side or another. I have no desire to see that happen.

MR. COX: Well, my only point is, and from the Medicare cost reports I've looked at, the operating margins that are sustained by the average hospital don't come from patient care. They come from investment income and other sources. So really patient care, as far as the operating margin, just covers their cost of providing care.

My only point is we have a very slim margin here. If we tinker with that margin too much, we could have a very bad adverse impact on our hospitals in this state; and I think you can ask Mr. Robbins, I'm not a particular apologist of the hospitals, but this is just what the numbers say to me.

CO-CHAIR DUGAN: We appreciate that. I think as Senator Garrett said, we'll get the

testimony, and then we can determine as a task force which way we want to go. We're going to be discussing this all further. We have not made any decisions that this is what we're going to do, that we're going to -- we're listening to opinions and ideas as to what can happen here.

We've got long-term care coming up. There's still a lot. We can have these discussions as a task force then when we start looking at all of this stuff.

MR. COX: Well, can I make one more last comment on Mr. Mark's comment?

Mr. Mark said that the task force doesn't have an objective criteria for charity care. He is correct in that. But every task force meeting I have been at, they use charity care as a guide when considering applicants.

But I wanted to remind everybody on the task force that the Board is not bound by any objective criteria. They can completely make their own decisions without following the rules or the statute.

CO-CHAIR DUGAN: That's what we're --

MR. COX: It's their discretion.

CO-CHAIR DUGAN: That's what we're doing here. That's why there's a task force looking into the Health Facilities Planning Board and the CON process. That's what we're doing here in the first place, I think.

MR. COX: But currently they can make that determination because they do have that discretion.

CO-CHAIR DUGAN: I agree. Thank you.

Are there any other questions? Otherwise, we need to keep moving.

MR. CARVALHO: I actually just have questions and comments on some of the conversation today, and, Mike Jones, you might want to help me out on one of them.

In the conversation about Medicaid and Medicaid funding and improving Medicaid funding, perhaps what the alternative is or something like that, I think one thing people -- I just want to make sure that factually people have something in mind, which is the base Medicaid rate is quite low, but there are a lot of add-on payments that you've authorized and the Department, HFS, has created which mean for the safety net hospitals at

least, Medicaid comes close, in some cases exceeds, but in most cases it comes close to covering costs.

So if the particular hospitals you're concerned about are the safety net hospitals, the Medicaid program with all of its add-ons actually is coming close to covering costs for them. It's for the other hospitals who in the chart for SEIU perhaps are in the upper quartile who are getting Medicaid reimbursed at much less than their cost.

CO-CHAIR GARRETT: Wait. Can I just say that something?

MR. CARVALHO: Yes.

CO-CHAIR GARRETT: Yeah, they can meet costs, but they don't have enough revenue generated to maybe invest something extra so they can then purchase the MRIs and the CT scans and be competitive in the diagnostic sector.

MR. CARVALHO: Right, right. What I don't want people to lose sight of is you don't necessarily have to inflate everybody's Medicaid reimbursement in order to benefit the safety net.

Now, a footnote to that, and Dr. Dranove made a reference to it, and I don't want to skip

over it because it's an interesting point, that's looking at it from the provider's perspective.

There's also the perspective of the client; which is to say, if you are a client which is enrolled in Medicaid, you are perceived in some places as a second-rate patient because your reimbursement in some institutions is going to be low.

You don't necessarily want to create a climate where people who are on Medicaid are only going to be welcomed in challenged hospitals and be unwelcome in hospitals that have wonderful amenities.

I just wanted to make sure that everybody was reminded that Medicaid at least for the safety net hospitals pays much better than for the other hospitals.

MEMBER LYNE: Could I interrupt?

MR. CARVALHO: Sure.

MEMBER LYNE: But you see our costs, the safety net hospitals costs are so much less --

MR. CARVALHO: Right.

MEMBER LYNE: -- than those upper-end hospitals. So we're still not necessarily getting

paid as much as the upper-end hospitals per day, just so everybody else understands here.

MR. CARVALHO: I didn't want people to come away with the wrong --

MEMBER LYNE: There are hospitals that have twice our costs.

MR. CARVALHO: Yes.

MR. DRANOVE: That's kind of a chicken and egg question. Are your costs low because your reimbursements are so low that you just can't afford --

MEMBER LYNE: Yeah, what are you going to use to spend?

MR. DRANOVE: Yes.

CO-CHAIR GARRETT: To the point about providing additional services.

MR. CARVALHO: Okay.

MR. DRANOVE: Yeah, exactly.

MR. CARVALHO: To clarify, my takeaway wasn't that the safety net hospitals are doing fine. My takeaway was that the cost of helping them out isn't necessarily the process of putting a slug of money everywhere, but maybe targeting it.

Second, there were allusions to two recent applications where moves were approved, and since they are no longer pending, I can clarify. The move of the services in East St. Louis was, I think, about four, maybe five miles, and it was from one not very economically viable place to another not very economically viable place. So it wasn't from a poor area to a well-to-do area.

The one that was approved last week was a move from the corporate limits of Joliet, which is an economically challenged village -- city, to the corporate limits of New Lenox?

MR. MARK: New Lenox.

MR. CARVALHO: New Lenox, which obviously is a more affluent town, but the move was three miles. So the resource as a nontaxpayer to Joliet, and I guess a nontaxpayer to New Lenox, because it's a not-for-profit hospital, but in terms of the medical resources, they're three miles away.

The final point is about bureaucracy. Any time -- and trust me, I've worked in the public sector and the private sector, and half of my time in the public sector is railing against the

bureaucracy from the inside, so I'm no fan of bureaucracy.

Before we lose sight of what bureaucracy means, anytime you want to interfere with what the marketplace will otherwise do, you create bureaucracies to do that. The marketplace will not do other than what it wants to do without some intervention that makes it do it.

So, for example, when you created the CON process 30 years ago, and you asked us to focus upon cost, it needs information to focus upon cost. So if you say you don't want the facility to cost $500 a square foot, yeah, you need the paperwork on how big is the facility and where are the square footage and what are the costs, and all that paperwork is generated.

The only way to -- there are two ways to reduce the bureaucracy. One is to try to get it to be a little smarter in how it operates, and in the last several years, that's what Jeff Mark and his staff have been doing on the rules.

Then the other is to change the mission. You really can't have an intervention without a bureaucracy. You can't effect an intervention.

Even if you leave the tradeoffs in the private sector as Dr. Dranove would prefer, presumably you're going to want some oversight of that to ensure that the tradeoffs are being done according to the public purpose that you have established in your statute. So there's still going to be bureaucracy there, albeit more efficient because it's done in the private sector rather than the public. But you cannot eliminate bureaucracy and have an intervention that serves a public purpose almost by definition.

Now, my truly last point, on the cost shifting, as Dr. Dranove pointed out, having a CON does interfere with the marketplace, and it interferes with intervening competitors, and that is a good from the perspective of the person who has the CON.

So perhaps part of the cost shifting or the -- you agree not to have the adverse impact that some have suggested it might, is that you trim costs in a way that you can get away with because you don't have a market to intervene. What do I mean by that?

If you've got that hospital building in an

affluent area, then you are, in effect, pulling money away from that hospital because of the floor and trade that Dr. Dranove proposed, then some of the amenities that that hospital might otherwise build because they say, well, we need to because that's what our customers expect, but you won't have that market pressure to provide what, quote, customers expect because no else can come into that market and compete with you providing that.

So if you wanted to build 42-inch plasma TVs and instead you put 35-inch nonplasmas there to pay the tradeoff that Dr. Dranove proposes, you won't have to worry that another hospital is going to build down the street the 42-inch to compete.

So that's where some of the trade may come, not from the other adverse things. I'm done.

CO-CHAIR GARRETT: Okay.

MR. DRANOVE: Are we wrapping up, or can I respond?

CO-CHAIR GARRETT: Yes. Go ahead and respond, and then we're going to go into a working lunch.

MR. DRANOVE: Okay. Am I gone for the working lunch?

CO-CHAIR GARRETT: You're welcome to stay.

CO-CHAIR DUGAN: You can stay. You just have to move out of the way.

MR. DRANOVE: I'd have to work.

MEMBER BRADY: There are no free lunches, you know.

MR. DRANOVE: You're absolutely right. If you intervene in the market, you create a bureaucracy, and you create winners and losers. I've heard a very similar debate about profits in a closely related sector which is the pharmaceutical industry, which has been the beneficiary of regulation and also punished by regulation.

Some pharmaceutical companies make more money than others. Some make a lot of money. One of the arguments has been we can't allow for the importation of prescription drugs from Canada because doing so would cut into pharmaceutical industry profits. If we cut into profits, we'll see less research and development, and that's bad for consumers.

The argument always seems to be, yes, we're

making money, but the amount of money we're making is the right amount. If you take a penny away, that's bad.

I don't know what the right amount of money is here. All I know is that you're going to be trading things off. If you take money away in the form of a higher charity care obligation, it does come from somewhere.

I would like all of you to collectively think about whether what it's coming from is more valuable than where it's going to, and the answer to that question will help lead to the right answer of how much charity care you should oblige the providers of the state to provide.

CO-CHAIR GARRETT: And what the value is for hospitals to have, you know, I hate to say, a noncompetitive situation. There is value to that, if you believe in the CON process.

MR. DRANOVE: Yes. Okay.

CO-CHAIR GARRETT: Thank you very much for your testimony.

We're going to eat and talk at the same time.

(Whereupon, a recess was had from

11:58-12:18 p.m., after which the hearing was resumed as follows:)

CO-CHAIR DUGAN: Okay. You guys all came as a group here, and we have you all at the table as a group to discuss long-term care and that particular issue.

So if you guys kind of want to tell us how you want to start.

MR. BOZZI: Well, let's do this. I'm Dennis Bozzi, and I'll start, and Judy will follow.

CO-CHAIR DUGAN: Okay.

MR. BOZZI. Judy is the chair of Life Services Network, and I'm the president of LSN, Life Services Network.

And then the home health care is, of course, Billie.

CO-CHAIR DUGAN: Billie needs time to eat, so yes, that would be good for you, too.

MS. COMSTOCK: They'll go first, and then Billie, and then Terry and I will bring up the rear. How is that?

CO-CHAIR DUGAN: That sounds very

good.

MR. BOZZI: We're together as a group, but we're a little different too. I thank you for the opportunity, by the way.

We're very close in many ways, but we are different organizations. Life Services Network has 500 members, and I guess to sum it all up, we're a senior living association, a lot of assisted living, community care retirement communities, supportive living, home and community based; and we overlap and work with our colleagues here all the time in harmony when it comes to things like Medicaid reimbursement and regulation and all the rest of it.

But I'm really glad to have a chance to just give you a broad view of where we see things going with this reform, and I passed a couple of things out. They're just illustrations.

MR. DeWEESE: We can't hear here in Springfield with all the wrapping on the microphones.

MR. BOZZI: Okay.

MR. DeWEESE: The potato chip sacks are getting in the way of the discussion.

CO-CHAIR DUGAN: Well, let me get it out, Kurt, so I can eat it.

MR. CARVALHO: I've saved some chips for you, Kurt.

CO-CHAIR DUGAN: Yeah, we've got some for you, Kurt.

MR. BOZZI: Okay. Well, I passed out a couple of illustrations, and I'm sorry that I don't have them for Springfield, so we'll get more of them. But I wanted to give you an illustration of what the senior living market is and where I think there is some major, major lack of linkage between the conversation you had this morning, for instance, and us. We're not the same business.

Hospitals, you go there to get better. It's usually a short period of time. You're patients. Not residents, you are patients.

In senior living, it's where you live, it's your home, it's a place where you live and age in place a lot more; but the point is, it's not the same model. There is some overlap definitely. There is a component of long-term care in nursing homes that are rehabilitation oriented. Obviously, that's a health care overlap with some

hospitals as well.

But a lot of it is a place where you live and grow and enjoy life. So it's a different kind of process. So I wanted to make that point, and by the illustrations, I just wanted -- I know you do a lot of reviews, the CON Board does a lot of reviews of CCRCs, community care retirement communities.

I wanted to give a visual. These are campuses. These are places where it's primarily independent living apartments or cottages. It's primarily assisted living, and there is a health care, long-term care component. The smallest part of it is the health care and the long-term care component of a community. So that has been the trend and continues to be the trend.

So my point, I guess, the big point is that we definitely don't fit into the same kind of medical model that we talked about today, and that's where I hope you can help us go to the future and really get some thoughts and ideas to make it more efficient, more reasonable, and just a better place for people who live in these places, not just stay for a week or two and go

home. Some do, but most live in, and that's the issue.

We take care of older people. You know, although I'm happy that, what, the 70-year-old today is the 40-year-old of the past or whatever. I'm glad to hear that. I think everybody is.

The fact is aging does have deficits. The fact is that our job is to make sure that life continues, learning -- life-long learning continues; and so our role is a lot more than just the medical part. There's a spiritual, there's a social component of quality of life that's part of this.

Again, although quality care is certainly a component, but quality of life doesn't fit in to the standard hospital medical model of the CON process and how you make evaluations. So that's kind of my broad pronouncement on that issue.

I'm going to talk briefly about continuing care retirement communities and some of the issues that you have heard about. I know Susan Garrett has talked with us about issues as well.

The fee process, the fee -- and Billie will talk about that, too, right, so I won't get into

too much; but the fee process is an issue in terms of having to pay fees for the nonmedical part of the community. That's an issue that's ongoing, although we've made some progress here and there with it.

The CCRC variance is an important part of the CON process. It allows for those nursing home or health care units to be used by residents of the community, that has to stay where it is now. I believe it's five apartments to every one nursing home bed. It used to be four, and now it's five. I think it's fine the way it is.

Another big issue is the square footage allowance for the bedroom or for the residential portion of the CCRC, and Judy will talk about that, too.

But basically, we're forced to look at -- I think originally it was 414 maximum square footage per bed is still kind of -- but the Board has been flexible, and it's been expanding it to a larger amount that makes sense.

Again, this is where people live, not where they stay for a week or two hopefully and go home, but they live in these apartments and these units.

So we want to talk -- we'll talk more about that as well.

I guess the other issue that I'll preempt, I guess, is the issue of bed need methodology, and what are our issues on that.

We know there has been an expansion of many options for older people, most of which are not under the jurisdiction of the Health Facilities Planning Board because it's not a health facility, and it's not a place you go for a week and go home. So assisted living, supportive living, it's an important residential component, as well as home care, which is expanding rapidly.

So that's kind of the broad process of -- the broad perspective I wanted to give today because sometimes -- like this morning, I mean, it's lovely to hear about all the issues of hospitals, but the truth is, we're a different kind of entity with our own particular uniqueness and problems and challenges and opportunities to help people live a good quality of life as they get older.

That's it for me. How do you like that?

CO-CHAIR DUGAN: Good. Judy, do you

want to try to go into a little bit more --

MS. AMIANO: I'll dive in and try not to have any redundancy.

I would agree with Dennis that -- and, you know, I'm also an operator of one of these CCRC campuses and a very large SNF and had the privilege of going through the CON process here in 2008. So I bring kind of some contemporary knowledge as a provider in terms of what that feels like, not only on the preparation end, but on the outcome when you're trying to achieve something different for the residents that you serve.

I would agree wholeheartedly with Dennis. You know, we provide an environment that is their home. It is not episodic care generally. We do do a very large component, and most SNFs do, of that episodic care which transitions people out of the hospital environment, but by and large, you're looking at people who have an average length of stay of about 18 months in skilled facilities in the State of Illinois today.

So given that consideration, where you live and spend sometimes your final days needs to be

approached in a different manner than an acute-care hospital.

Picking up on what Dennis mentioned about the square footage requirements, the current maximum still is 414 square foot per bed. While the Planning Board has been wonderful in terms of working beyond that, as you're preparing your CON, you've got these built-in restrictions already there that you really as a provider have to really navigate your way around and talk your way through with that Planning Board.

So having a model -- you know, it doesn't accommodate innovative models, basically. Someone who would come in today with an all private room model, which is what consumers want, is not going to be successful simply because of the square footage requirement unless you're fairly crafty in your approach with the CON Board.

This current model of the SNFs was borne out of the hospital-based model in the 1960s with the advent of Medicare and Medicaid; but as people live in our facilities, you know, we need a more contemporary approach to what that living environment looks like because it's different

today than it was in the 60s.

By the age of most of you on the task force, you probably have had some sort of experience with a loved one or an extended family member in a skilled nursing facility. That feeling of having two people in their final days share that very small space is not a pleasant thing. So as a provider, we really would advocate for some change in that square footage requirement on a move-forward basis.

The second thing I'd like to speak to is the price per square foot, and, again, we just went through this. We were limited to $183 a square foot. That is quite challenging even to build a residential house in today's current construction costs. You overlay on that all the things you need to have, all the bells and whistles of a modern health care facility, and it's really darn near impossible. So there needs to be some approach to that.

Now, there is some variability in those numbers around the state, but it's a pretty narrow margin. For my facility, for example, it was $183 a square foot.

Then not only is your square footage an issue, then you've got this price per square foot that becomes also a very hard burden on providers who are attempting to provide some innovative services for clients in the buildings that they're doing.

So I would definitely advocate for review of those cost-per-square-foot thresholds in the process as you move forward.

The other thing that I would make a recommendation for is to amend the process based on the scope or the impact of the project. I, for example, was doing a 40-bed expansion to a facility that's been in existence for a number of years, and I had to go through every same exact hurdle as a brand new entrant into the market, a brand new facility.

Somehow that seems like a waste of resources in terms of you've got a provider who has had no public opposition, there is a bed need in the market, and all of the criteria has been met. It seems a little wasteful to go through all of those same steps as someone who might be starting up a brand new service within the market.

MEMBER LYNE: What was the time frame between -- you said the addition you're talking about was pretty similar to the original application?

MS. AMIANO: The facility is 13 years old.

MEMBER LYNE: So then you did it, and then you came back for 40 additional beds 13 years later.

MS. AMIANO: Well, in the process you're allowed to add 10 beds or 10 percent, whichever is the lessor every two years.

But from a construction perspective, it is impossible to build anything, you know, for 10 beds. You can't afford to do it. So most providers will go through this.

For example, when we did that expansion, we actually built 20 beds, made them private for two years, and then they became semi-private after those two years. You know, you get creative in that, but the reality is, an expansion project to an existing has to go through the exact same process as a brand new facility.

So it would seem to me that that would be

something that could be reviewed, or could you maybe perhaps consider a fast-track process for something like that? You know, I think there's just really an opportunity there for that.

Are you going to talk more about CCRCs?

MR. BOZZI: No.

MS. AMIANO: Okay. I think the other thing I would like to see is the frequency with which the planning areas and the inventory updates are done -- there was an impact to the SNFs -- there we go.

CO-CHAIR DUGAN: That's all right. Go ahead.

MS. AMIANO: The SNF inventory was updated in 2008, and that corrected many historical issues that had been hanging out there, but the prior update to that, I believe, was done in 2002.

MR. MARK: 2006.

MS. AMIANO: 2006. Okay. It seemed like 2002.

I would propose a more contemporary methodology for computing need. There's flaws in the methodology. For example, and I'll just use

our market area, which is similar as many others. We've got a very large veterans home. We've got dedicated MI facilities. Those are all within the same inventory. So there's no recognition that if you have restricted admission practices, for example, you'll only take veterans, that is looked at in the same planning methodology as a straight-up SNF licensed bed.

So as you go through this reform, there needs to be some approach to take into consideration facilities that have restricted admission and what that means to that market in terms of bed availability.

The other issue which Dennis touched upon briefly, which I'll end with, is the CCRC campus. We currently have providers within our membership that are going for a brand new CCRC and the licensed beds, the skilled nursing beds are only one component.

What we're finding is that they're having, you know, upwards of $100,000 in fees for the application because of the dollar amount of the whole construction, but not just of the skilled nursing beds. So they're lumping everything into

that review process when it really, under statute, should only be the skilled beds.

So we need some methodology moving forward that can look at and extrapolate those skilled nursing beds since those are under the purview of the Board without taking into consideration the entire CCRC campus.

With that, I'll close and turn it over to Billie.

MS. PAIGE: Thank you. Good afternoon.

CO-CHAIR GARRETT: Wait, can I just -- we have recommendations from Pat Comstock. Do you have anything?

MR. BOZZI: We'll get it to you.

MS. AMIANO: I can send it to you.

MS. PAIGE: Now?

CO-CHAIR GARRETT: Go.

MS. PAIGE: I want to accomplish two things while I'm here today. One is to offer you some thoughts specific to long-term care regulation and then to give you some general thoughts and suggestions about the process which will apply to both long-term care, hospitals,

ASTCs, whatever the Board is doing.

Let me start a little cryptically. A long time ago in a galaxy far away Ken Robbins and I went to a Planning Board meeting. I represented my first client before the Illinois Health Facilities Planning Board. That was more than 20 years ago.

Our firm also represents a provider that was mentioned in the previous presentation this morning, the largest provider of long-term care services in the nation, HCR Manor Care. They operate facilities in 29 states. Therefore, we've watched and represented nursing homes and manor care for a long time.

Let me make my suggestions or give you my thoughts specific to long-term care.

The Planning Board should limit the criteria by which they review applications for long-term care projects. I would suggest there are three issues that are the most important. One is obviously need, the other is financial viability or feasibility, and then any quality issues that may exist for the applicant.

Issues such as size are important insofar as

the cost of the project, and as has been stated, the Illinois size cap is lower than most of the other states. Reducing the number of criteria would make preparing and reviewing applications, we believe -- I believe much more manageable and coherent.

Most states, for example, have abandoned evaluations of capital costs, realizing that for the most part they have no relationship to private pay charges or Medicaid payments, particularly in states like Illinois where Medicaid reimbursement does not have a capital cost component. Illinois has more specific review criteria than the norm.

The Planning Board should produce a simple bed need formula and not compromise that formula by entering into unending and circular discussions with applicants about what long-term care facility is how far from another.

In long-term care, it has been my experience that in a given area, it is usually well-known about why certain other providers are not and probably never will be fully utilized. Let me just expand on that for one second.

Judy mentioned the bed need. They come out

with a new bed need. So my client, other nursing homes who may be clients of mine or clients of some of my colleagues look at that and think, oh, now there's a 150-bed need in this planning area. I would like to build a 100-bed nursing home.

So you put the application together, you go before the Board, and you say -- first, you look at the staff report, and you go, how did I get a negative on need, they just said that there was a need for 150 beds.

The reason you get a negative is because within 45 minutes drive time, there are two nursing homes that aren't full, and then you say, well, then why do we have a bed need?

Well, you have a bed need because the demographics are such that right now in the latest bed need formula, it says you need 150 beds. But these nursing homes really need to be full, and you say, but they'll never be full. It won't happen. Sometimes it's because the nursing home is old. Many times that's it.

People want private rooms these days, both in hospitals and nursing homes. Many nursing homes have therefore tried to take a two-bed or a

three-bed room and pare it down and put one bed in it, but sometimes it doesn't work.

So I'm not sending my mother to that nursing home. I'm going to send her over here where she can have a private room, and it's a little bit newer. Some nursing homes are quite old.

So overlay the bed need with some of the things, some of the reasons why -- and quite frankly, if my colleagues will forgive me, there are nursing homes that nobody wants to send anybody to. It just happens. So if that's within your planning area, it can give you a negative on whether, in fact, there needs to be the facility that you wanted to build.

One idea that might relieve the maldistribution of beds could be what is allowed in varying degrees in the following states: Florida, Maryland, Michigan, New Jersey, North Carolina, Ohio, Virginia and Washington; that is, to permit the sale of licensed beds, operating beds from one provider to another.

This allows a provider with a fully occupied facility to buy licensed bed operating rights from a provider with low occupancy. It could be a

win-win for everybody. The buyer provider gets additional beds to serve a growing community, the seller provider gets cash to use in upgrading its SNF, and the state planners get vacant beds utilized without an increase in inventory and a vehicle to encourage older or substandard facilities to upgrade.

States put a number of restrictions on this practice, such as not allowing the bed supply in one area to decrease below the state average, but this practice seems to be an effective measured way to improve accessibility while the Board maintains approval over the process.

I raise this issue since neither the Planning Board nor the Department of Public Health can be more effective in encouraging providers with older facilities to upgrade their product until the state increasing Medicaid reimbursement for nursing homes in Illinois.

Of the 29 states that I have information on, those are the 29 states that HCR Manor Care is in, Illinois ranks 28th. The state that is ranked first has a rate 129 percent higher than the Illinois rate. I do have here a copy of the chart

that I was sent which will show you the states in the order in which -- and you will see that Illinois is next to the bottom.

The Planning Board -- there should be representation of the long-term care industry on the Board. There always was one prior to this Board. It was very useful to have someone on the Board who understood this industry both past and present. It was required that the person was active in the management of long-term care. So you could assume that that person was up-to-date in the knowledge of how the industry was moving.

Now, I'd like to make some general comments which are pertinent both to long-term care and to other health care facilities that are regulated.

When the Planning Act was passed in Washington, the thought was that both cost and quality would be positively impacted. Every state had a Board that oversaw health care facilities that the public needed and paid for.

Every state had one until the 80s when Ronald Reagan became president and not only removed the sanctions that states would have if they didn't have one, but specifically in the

first year permitted states to singly opt out of the federal planning law.

Now, I will tell you that those states that opted out and no longer had a Planning Act -- and the one that I know the most about is the State of Texas. Take a trip to Texas, and you will drive by vacant psychiatric hospitals that were built in droves when that state did away with it's Planning Act. That's just one example.

Illinois did disband the health service agencies which had created huge bureaucracies at the local level; and then once you got past there, you had to go to the state to see if the state agreed with the HSA; and then even after that, you could still have a kind of administrative review. The Board functions -- the state Board still functions in much the same way that it did those 20-plus years ago when I first represented clients, and that I think is the major problem.

While the Board should be majority consumers, the health care industries whose facilities are regulated by the Board should be represented on that Board by having at least one member on the Board. I mean, hospitals, long-term

care facilities, ambulatory surgical treatment centers, and end-stage renal disease, dialysis centers.

The Board, and I'm sure you've heard this over and over again -- except I remember this morning someone said, I think it was the first presenter, who said five was enough.

Therefore, I'm saying that you should have at least nine members on the Board, and that would enable you to have four representatives of the various industries that are regulated and five consumers, keeping a majority consumer board. The Board, by the way, was always majority consumers.

I would also state as forcefully as I can that there was never a hint of favoritism or misconduct on the part of any of the provider members during the entire course of the history of this Planning Board.

There is also a tremendous lag in filling vacancies on the Board. This was true even before the Board members were directly appointed by the governor. The present situation with respect to timely appointments has simply emphasized in my mind, and I don't know really how to do this, if

there should be a limit as to how long a seat can remain vacant before you replace the members.

The current Board, for example, has not had the required number of members, five, since 2005. That is now three years ago.

Perhaps one of the ideas is if the Board lacks a quorum and an application is a positive one, it would automatically be approved should whatever time you set, you know, not go past without a replacement member.

I know you all know that there have been at least two, maybe three occasions -- Mr. Mark can correct me -- where the Board has not -- two occasions where the Board has not been able to meet simply because it couldn't get a quorum, and I think both times they were down to like three members. When you get down to three members, you're done because you've got to have all three of them present in order to conduct a Board meeting.

It would benefit both applicants and the Board itself, I think, if the staff could spend time communicating with the applicants regarding pre-application and post-approval issues. Again,

I know you've discussed this in many cases.

As a consultant, it's not against my best interest when I say that the staff was very helpful when developing an application, particularly a complex one. There are all kinds of ways to make public those kinds of discussions -- in writing, by email, however you do it.

But the current statute because of its strict ex-parte section really prohibits you from talking to the staff -- prohibits you from talking to the Board at all once you've filed a letter of intent, but prohibits you from talking to the staff except about the most perfunctory of things where you might have a really legitimate question that could be solved before you send in an application, which, in fact, could produce a problem, a compliance issue, or whatever.

So I'm recommending that whatever statute we produce should take a look at that ex-parte section, and I'm not saying you do away with it, but I think you should at least write it in such a way that staff communication between the applicant and the staff member could occur in certain sets

of discrete circumstances.

And now the issue of fines. There are far too many of them. They are far too high. With respect to long-term care, let me suggest that you might look at the states of New Jersey, Maryland and Florida. With respect only to long-term care, you might look at the State of Ohio.

CO-CHAIR GARRETT: Why are people or these facilities being fined?

MS. PAIGE: Oh, for a variety of reasons. It could be as simple as you did not file your annual report.

CO-CHAIR GARRETT: What is the cost of the fine?

MS. PAIGE: Significant.

CO-CHAIR GARRETT: What is that?

MS. PAIGE: Well, I'll give you an example. Until this Board, the largest fine that any client of mine had received was $7,500, and I thought that was horrible.

The last -- the fine that I am now involved in will probably be in the area of $100,000.

CO-CHAIR GARRETT: So you're involved. So they're appealing their fine, and they had to

hire -- I'm glad they hired you, but they had to hire you to pay you to appeal their fine.

MS. PAIGE: Well, in this example, I'm a continuing consultant to them, so I'm on a monthly retainer anyway.

CO-CHAIR GARRETT: Okay. But let's say --

MS. PAIGE: But if I wasn't, yes. Typically, they would hire an attorney to do that because it's usually a legal issue.

MEMBER SCHAPS: What's it for at that level?

MR. MARK: Tell them, Ms. Paige.

MS. PAIGE: What's it for at that level? I assume that it's like anything else, it's supposed to make you not do it again.

MEMBER SCHAPS: But what was the violation?

MS. COMSTOCK: No, they want to know the number.

MS. PAIGE: Oh, the number.

CO-CHAIR DUGAN: Not filing the report?

MS. COMSTOCK: What was the $100,000

for?

CO-CHAIR GARRETT: Yes.

MS. PAIGE: Well, this goes back several years, quite frankly. It was a case where the applicant in this example went over the approved amount of the project, had requested a declaratory ruling because of what had happened, and somehow that got lost in the ether someplace.

Then what we sent in, we sent in a request, a closure application that we were going to close out the project. That never got -- and then the Board got disbanded. This was when the new statute was coming in, and then there was like a four-month hiatus before there was a new Board. So a whole series of things happened. Okay.

MS. COMSTOCK: Some the facility's fault, some not.

MS. PAIGE: Yeah, I'm not saying it's all the Board's fault. I'm not saying that at all. It's the process that we have today.

And so we negotiated -- we're negotiating how much that should cost.

MR. MARK: If I may, just for clarification, I don't want to get too involved in

something that's being litigated --

MS. PAIGE: Yeah, that's why I'm trying to be general about it.

MR. MARK: -- but in this particular case, it was fairly significant infractions to the Board's rules. I think Mr. Urso went through this with the task force some meetings ago where in terms of these infractions, we start with the statutory language that dictates the sanction authority of the Board to establish the initial fine, but then during the negotiations, oftentimes and most of the time, there's a settlement way below the initial statutory limit.

CO-CHAIR GARRETT: It just seems like so much red tape, and then a bureaucracy to deal with it, and a cost that is --

MS. PAIGE: Well, understand, understand, I am not at all arguing against some kind of sanctions if you do something wrong. What I'm saying is, if it's just the fines right now -- is somebody talking over me?

MR. CARVALHO: Yeah, me.

CO-CHAIR DUGAN: Yes.

MS. PAIGE: Oh, Dave, I'm sorry. I

couldn't see you, Dave.

CO-CHAIR DUGAN: He's in the back of the room.

MR. CARVALHO: Let me give you an example. Following up on what I said earlier about if you're going to intervene in the market, you have to set up certain bureaucracies.

Right now the Facilities Planning Board is supposed to determine need; right? How do you determine need? It needs to know what exists. How does it know what exists? People file their profiles. How do they wind up not knowing what exists? People don't file their profiles.

Absolutely essential to determining the need is having the information in the profiles. If people aren't going to file the profiles -- it may sound like a minor paperwork thing to the Board, but then you don't have the information to determine need, and that's when these fines are --

CO-CHAIR GARRETT: But need can be defined without so much red tape. I think that's what everybody is saying.

MR. CARVALHO: It's a form. You fill out the form, and you say how many beds you have.

MS. PAIGE: I guess in relation to that -- this goes back to the staff should be able to talk to the applicant, and I know that Mr. Mark and his staff, to the extent that they can, will call about things like that.

But if I've got an application pending, and there's some problem that I've had in the past or some problem right now, I believe they feel that they're precluded from talking to us or they have to talk to us in a rather perfunctory manner, and that's all I'm saying.

I think there would be fewer compliance issues -- this is just me talking -- if staff and the applicant were able to communicate. I really do. I mean, that's just my own personal thing, but anyway --

MEMBER O'DONNELL: So maybe your issue isn't necessarily fines. It's the ability to communicate with staff.

MS. PAIGE: It's fines, too, in terms of the amount of the fine. Mr. Mark is quite right. It's established by statute, and it's established in a way that makes the fines much, much larger than they were say, oh, I would say --

CO-CHAIR GARRETT: How did that change? I mean, I guess the legislators changed it, but what motivated them to do that?

MS. PAIGE: I believe, and I'm looking at Ken now, I think it was inserted when you did the large revision of the statute and took out, you know, a lot of stuff that needed to be reviewed. I think that section with respect to the specific fines --

MEMBER ROBBINS: It doesn't sound like I would have been in favor of high fines.

MS. PAIGE: No, no, I don't mean you put it in there, Ken.

MEMBER ROBBINS: I know what you mean.

MS. PAIGE: I mean, that somehow it got in there, but it goes back maybe 10 years, but it was never applied in quite the way it's being applied now in the sense that right now everything is applied to the maximum.

You know, if you're going to do fines, there ought to be at least -- there's a minimum, and there's a continuum, and then there's a maximum. Right now everything is applied to the maximum, but I'm not arguing legalities at all. But I

think that a change needs to be made there. That's all I'm saying.

The other thing I'd like to talk about and give you an example of is something that, again, Judy brought up, and that is the CCRC and the application fees.

I believe that my client, and my client at the time was Franciscan Sisters of Chicago, they are building, as we speak, the Clare, which is a 35, 37-story high-rise right by Loyola University.

The entire cost of that project was over $200 million, but the only part of that project that was reviewable by the Board was $7 million of it. We were required not only to pay the fine as if it was the $200 million, and then we reached a --

MR. MARK: A fee.

CO-CHAIR DUGAN: Fee, not a fine.

MS. PAIGE: Fee, excuse me. I'm sorry, they both begin with the letter F.

MR. MARK: Right.

CO-CHAIR DUGAN: So do a lot of things.

MS. PAIGE: I know. We were required

to pay the fee as if they were going to review the $200 million, and they couldn't because CCRCs are independent living, assisted living, long-term, skilled -- the only thing that was reviewable was skilled care, but that also means that you've got to prepare the whole thing as if the Planning Board was going to review, which again is a cost.

So I believe that --

CO-CHAIR DUGAN: Excuse me, Billie. Why would we do that? Why if we're only reviewing one part, why would we -- why would the applicant have to do the whole thing?

MR. MARK: And the applicant does not have to submit all the detail on the entirety of the project.

My understanding of the rationale, and this goes back through multiple boards, is that the total project cost is considered within the financial feasibility because you cannot separate one floor out of a $100 million project and look at the debt numbers and financial --

CO-CHAIR DUGAN: But usually in these complexes, and I'm just looking at a complex, you've got one building that's your assisted

living. You have one building that's your skilled care, and then you have -- you know what I mean, and those types of things.

MR. MARK: Right.

CO-CHAIR DUGAN: It's like a community of different --

CO-CHAIR GARRETT: Levels of care.

CO-CHAIR DUGAN: Correct.

MR. MARK: And I don't know the exact answer to this, but within the Board's rules, there are also provisions under which the Board created rules such that a project could not be broken out into components to avoid CON. So one of the aspects of that -- and that applies to not just long-term care.

MS. PAIGE: No, it applies to hospitals, too.

MR. MARK: It applies to hospitals, ASTCs, ESRDs, is that -- and I think Sister --

MEMBER LYNE: Here I am.

MR. MARK: -- there you are -- Sheila is very familiar with this because they include a total threshold of dollars, the entirety of the project is submitted to the Board.

Ms. Paige is absolutely right that we do not review the detail of anything in this case but the skilled nursing; however, the entirety of the project is submitted as part of the financials.

MS. PAIGE: So long as you mentioned hospitals, though, in the case of hospitals --

MR. MARK: Same thing.

MS. PAIGE: -- it's a split between clinical and nonclinical.

MR. MARK: Right.

MS. PAIGE: And nonclinical is defined in the statute. I mean, there are things in the statute that you cannot look at, but you look at the entire thing, and I understand the cost issue, but I can't just tell you the cost.

I've got to tell you how I got -- I'm saying you've got to work the whole thing up at least on the financial part. I've got to know -- I've got to tell you how I got to where I was going, and my view is that we should only have to tell you that for the part that you're reviewing --

CO-CHAIR GARRETT: Right.

MS. PAIGE: -- and not for the part that you're not reviewing because that's my

risk --

MR. MARK: Yeah.

MS. PAIGE: -- if I'm going to build something other than the skilled nursing that's going to cost me more than I can afford. If the state thought that it should be reviewed, you know, they would have passed a different statute.

I mean, for example, my best example, and Sister Sheila in particular will appreciate this, was the state used to have size requirements and review chapels. I kid you not. That was taken out by Mr. Robbins and his cohorts.

I mean, if you look at the statute, there is a list of things, from parking garages to chapels to gymnasiums that all used to be reviewable that are not now, and those are called the nonclinical components. They only review the clinical components, but you've still got to go through -- you've still got to tell how much the other piece is going to cost. That's all I'm saying.

CO-CHAIR GARRETT: Could you put these recommendations in writing for us?

MS. PAIGE: Yes.

CO-CHAIR GARRETT: Okay.

MS. PAIGE: I will send them all to you.

CO-CHAIR GARRETT: Okay.

MS. PAIGE: I think this Board is doing as good a job as it can given the fact that it really has been strapped for the entire time that Mr. Mark has been there at least for staff. Why? Because every year or two there is a sunset date, and who wants to work there, No. 1.

No. 2, you lose experienced staff because they get offered something else over here, and they say, well, you know, I might as well take this because who knows what's going to happen in the next 12 months.

CO-CHAIR GARRETT: Well, let me just intervene here. One of the things that I did notice is that staff may be down, but consultants really -- not you, you are a consultant, but consultants that the Health Facilities Planning Board hires outside of the state's -- in many ways, you can say they have replaced staff.

MS. PAIGE: Oh, I think that's because they can't find staff that wants to work there as employees. I mean --

CO-CHAIR GARRETT: Well, you and I don't --

MS. PAIGE: No, no, I'm making that assumption simply because over the years, you know, I've watched staff come and go and come and go, and staff usually stayed at the Planning Board for a long period of time.

CO-CHAIR GARRETT: But there's no need now because -- so what's happened? There has been a shift. For whatever reason, they're not hiring staff, for whatever reason. Instead you will see the consultants are remarkably high.

MS. PAIGE: I can't speak to that.

CO-CHAIR GARRETT: I know. I can.

MS. PAIGE: But anyway, it was my view that -- maybe I should say employed staff because I think you're better off with employed staff, quite frankly. You know, and I'm not criticizing the fact that they're using consultants for whatever the reason, but what I have noticed is that the experienced staff one by one is leaving, and they've just lost another chief reviewer.

CO-CHAIR GARRETT: Well, here's the problem with this, and I've got to just step in.

MS. PAIGE: Okay.

CO-CHAIR GARRETT: And I deferred it a few minutes ago.

They can say we don't have staff, so we can't do a lot of this stuff. When, in fact, what they do have are the resources to hire consultants, which they are doing, but if they want to pull back in an arbitrary way, they can conceivably do that.

So there's a control factor when you can say no staff, but the consultants over here, we're going to decide when and if we're going to give them a call, and those kind of decisions hold up projects.

MS. PAIGE: Anyway, I think that's all I have to say for right now. I think I've caused enough trouble.

CO-CHAIR DUGAN: Okay.

Pat, your turn.

MS. COMSTOCK: I never thought I'd hear you say that.

MS. PAIGE: Your turn, Pat. Aren't you sorry you came after me?

MS. COMSTOCK: No, no.

Pat Comstock, the director of the Health Care Council of Illinois, which is an independent organization that is the public policy arm of both the Illinois Council on Long-Term Care and the Illinois Health Care Association.

Together we represent more than 600 long-term care facilities in Illinois, more than 53,000 employees, and more than 66,000 beds, or 66,000 residents are part of our group.

In order to kind of refocus us back to the nursing home side of the business, in my opinion, we are sort of like a square peg trying to fit ourselves into the round hole of the health facility planning process in Illinois.

The primary focus of health care planning by the Planning Board has centered around hospitals. The Planning Board rules and regulations are focused more on hospital concerns. The certificate of need application process was primarily developed with a hospital focus, and so for that reason, we're sometimes out there, a different kind of business serving a different kind of resident, and we hope today together to communicate that to you and get you to realize

that.

Second, I think we all up here want to offer ourselves as resource people to you as you begin to sift through the mountains of paper that have been created by the good work that you're doing. There is a long-term care representative among you, but all of us here at the table and folks that we also have with us are willing to work closely with you as you get beyond this 40,000-foot level and start working through the minutia, if you will, of what you're really going to put in place.

CO-CHAIR GARRETT: Can I just interject? Sorry.

What would be really helpful, since we have kind of a combination of all of you together, you all have different ideas and recommendations, some of which overlap, if you could at some point in time get together and come up with your collective reforms or your collective proposals. So we don't just take yours and yours and yours and start thinking would they do this or would they -- so if you could sort of duke it out behind the scenes and come to us with sort of a unified approach,

and then we can take a look at it and see what we think.

MS. COMSTOCK: We'll be happy to do that. We have kind of started that process among ourselves, and that's why you'll see some consistency in what we're presenting today, but we could do better at that, and we certainly will.

With me is Terry Sullivan, who most of you know when he wears his hat as the executive director of the Illinois Council, but he's here with me today in his role as regulatory coordinator for Health Care Council of Illinois.

Also behind us is Chuck Sheets and in Springfield is Charles Foley, who are two folks that serve as consultants, attorneys, helpers to long-term care facilities in addition to Billie, and so they're available to you as a resource.

We did pass out -- Terry and I passed out a document that has six specific recommendations that we would like to make for your consideration today, and we'll factor those into bigger picture talks with other folks as we leave here today.

But first and foremost we would like to propose to you that long-term care, because we

have been that square peg trying to fit into the round hole, long-term care needs its own -- its own board, a subcommittee of the board, some different group of people to make decisions with respect to our projects because we are different.

I'm not saying that what Billie presented might not be an option, but, again, we're just asking for some different consideration of our concerns.

It's not that we don't think that there should be a level playing field, that everybody ought to have to comply with similar rules and regulations; but the way things are structured right now, it puts us actually one down in many respects in the process. So the current regulations really don't provide that level playing field because our projects are so different.

CO-CHAIR GARRETT: But, Pat, instead of having a separate subcommittee or whatever, a separate board, what if you all came together and made a recommendation to revise or amend the current statute, so you wouldn't be the round peg in a square hole, so that we wouldn't be going

into another bureaucracy?

MS. COMSTOCK: And I know that part of your mission here is to try to reduce that bureaucracy, and I don't think that -- however, we get there --

CO-CHAIR GARRETT: Yes.

MS. COMSTOCK: -- we need to get there, and we'll certainly start to think in those terms.

CO-CHAIR GARRETT: That would be great.

MS. COMSTOCK: Just a couple of things that relate so some things that have been said by previous speakers.

One of the things that makes us unique is right now, in addition to the residents that Dennis was talking about, and we have residents, and these places are these folks' homes, we also do have the rehab component. And right now for the folks that we represent, about 40 percent of our residents are discharged within 90 days.

Another way you could look at it, if you look at the cost reports we filed and that sort of thing, it's not uncommon for our facility to have

100-percent resident turnover in the course of a year, particularly if it's a facility that focuses in on those rehab residents or develops a specialty, if you will, on rehab residents.

CO-CHAIR DUGAN: I wanted to ask, is that different than how it was years ago?

MS. COMSTOCK: It's dramatically different.

CO-CHAIR DUGAN: Only because it has been, in my opinion, you don't stay in the hospital anymore. You go to usually a nursing home, do the rehab, and then get released and go home. It's just that you spend the time now in the nursing home.

MS. COMSTOCK: Correct.

CO-CHAIR DUGAN: Nursing homes I think are fulfilling a different type of role also in the community than they used to before.

MS. COMSTOCK: Precisely.

CO-CHAIR DUGAN: Like an additional responsibility.

MS. COMSTOCK: Right. So the residents that we serve are that rehab population that used to only be served in the hospital, and

also the resident, the longer-term residents we have are much sicker with much more high -- much higher medical needs than you used to see in our facilities 10 years ago.

So pretty much gone are what you think of as the rest home of the past because those folks have gone to other community options that have become available in the last few years, supportive living facilities or other community options that we've all been working on to insert into the care delivery process in Illinois.

MEMBER O'DONNELL: I have a quick question --

MS. COMSTOCK: Sure.

MEMBER O'DONNELL: -- sort of going back to your earlier point about the venue that addresses long-term care facilities, and this is more a question for Dave or you.

Are there rules and regulations addressing specific types of facilities, like long-term care facilities?

MR. MARK: Absolutely. Long-term care has a separate section in the rules the same way as ASTCs do, or dialysis centers, or cardiac cath

as a service. That's how the Board defines it.

So there is an entirely separate section of the rules to address nothing but long-term care. In fact, I believe we have two, I believe. One is general long-term care, and we have a specialized long-term care.

CO-CHAIR DUGAN: When were those rules written?

MR. MARK: They were written some time ago, but we currently have revised drafts that are in process in JCAR now.

CO-CHAIR DUGAN: Okay. So you have updated them?

MR. MARK: Yes. And we have always as a matter of standard practice, we have invited the people at this table, the people in the audience to participate in our rules development process. Some have to more or less degrees.

MEMBER LYNE: To what extent -- I'm sorry.

MEMBER O'DONNELL: I was just wondering if you don't feel that those regulations are sufficient to address long-term care needs, or have you participated with Jeff and the staff on

drafting, you know, updating these rules?

MS. COMSTOCK: I am personally not aware that we've been invited to sit with the department at the rule-drafting stage before something has been put in writing.

MR. MARK: Ms. Comstock, I could document a number of public hearings we had where your office was contacted, all of your offices were contacted and invited to participate. I think Mr. Sullivan attended one of our meetings way back, but the response has been scarce.

MS. COMSTOCK: To continue, when the rules are filed and they start to go through the JCAR process, we have been diligent in responding to those first notice rules and regulations and making our comments and suggestions for changes between first notice and second notice in the JCAR process. Some of those recommendations have been embraced, and others have not.

So it is our opinion that we need to do more in the rule-making process or the rule revision process in the long-term care area and appreciate your suggestion, Senator Garrett, to actually try to move in that direction, and we will proceed

accordingly.

CO-CHAIR GARRETT: Refine is the key word there, too.

MEMBER LYNE: This that you passed out, did this come from you?

MS. COMSTOCK: The two of us.

MEMBER LYNE: There are the six recommendations here. If we -- I was just looking at one of the -- Recommendation No. 6 on Page 6 referring to how it is in Ohio, and we should be able to -- facilities should be able to buy or sell existing excess CON and license capacity and relocate those beds from one facility to another within a local planning area or within 45 minutes.

Now, Jeff, I guess, what do they have to go through in order to do this?

MR. MARK: Again, for the record, several of the concepts that have been proposed by this panel we've heard before, and we've always said, and correct me if anyone has not heard this, submit a proposed rule to us because many of these issues stated in this document can be addressed by Board rule.

MS. PAIGE: Okay. I'm not sure that

this particular issue can be addressed by Board rule. That's the whole reason I brought it up, the whole issue of selling the operating rights to a bed.

MR. MARK: The concept of bed banking, I think some people call it, Chuck Foley has talked to me about it for three years, and I've suggested come in, let's talk about it and see if we can prepare a proposal for the Board.

MS. PAIGE: But that involved paying for the bed.

MR. MARK: I don't know.

MS. PAIGE: I think that's -- for me at least, that's where --

MR. MARK: I just want to go on record that --

MS. PAIGE: -- we may be talking about statutory revision and not --

MR. MARK: -- staff has not been averse to any of these concepts.

MS. PAIGE: Yes.

CO-CHAIR DUGAN: How does it happen, I guess, was the question. We need to be a little bit better maybe, you know, to try to involve

them.

MEMBER LYNE: Make the overture.

MR. SULLIVAN: Representative, I have to say that things have probably changed in the past six years in terms of the communication between the Planning Board and the professional associations. Part of that was that there used to be a long-term care representative on the Board, and there used to be a long-term care subcommittee that provided a forum to continue to address those issues.

We don't have a regular forum in order to review and continue to develop long-term care issues which I think probably leads to our primary recommendation that there needs to be a planning process, a board, a subcommittee that deals strictly with long-term care issues because they are very different from hospitals.

They're simpler. The structure of nursing homes are far less complex. The need for an application probably does not need to go into the depth that it does with hospitals because we are a much simpler organization.

CO-CHAIR GARRETT: Terry, let me ask

you. Let's say -- let's just pretend that you guys give us some recommendations and whatever we decide to do, we recommend those legislatively. Would it make sense that maybe -- who do you go to now? If you want to talk about long-term care, do you go to Jeff? Is there anybody in particular on staff that you can have that conversation with specifically who is knowledgeable?

MR. SULLIVAN: Short of Mr. Mark saying give us a call whenever you want to, there is not a regular forum that we have had the opportunity to input in in the past six years.

CO-CHAIR GARRETT: So if you wanted to go into his office and have this conversation that we're all having now, what prevents that from happening?

MS. COMSTOCK: Nothing.

MR. SULLIVAN: Nothing. Although I would say that a lot of our recommendations probably need some legislative input.

MS. COMSTOCK: But we can work together on that.

CO-CHAIR GARRETT: All right.

MS. COMSTOCK: There's nothing formal

preventing us from doing that as long as we're not talking about a specific project.

CO-CHAIR GARRETT: I think part of the problem, at least some of the stuff that I'm hearing is there's a communication breakdown for whatever reason.

MR. BOZZI: The subcommittee we had years ago was very effective.

CO-CHAIR GARRETT: Yes.

MR. BOZZI: Never escaped us, nothing escaped them. We were really together on it.

CO-CHAIR DUGAN: Constantly on top of anything that may be happening.

CO-CHAIR GARRETT: Can't you put your own subcommittee together and then make recommendations through legislation or even directly to the rule-making --

MR. BOZZI: Well, sometimes it's easier -- you want to be more efficient, and you want to resolve issues. So sometimes it's better to do a dialogue initially and not --

MS. COMSTOCK: It would be really nice if we had a collaborative opportunity with Jeff and his staff or some other structure. We are

lacking that at this point in time. We've made attempts at it, and we have failed.

CO-CHAIR GARRETT: I hate to get into this, but I've got to understand. What is it? I feel like there is like a wall here.

MR. SULLIVAN: There is a wall.

MS. PAIGE: I can only speak for myself. I have not found Jeff -- I have found it very easy to communicate with him. That's not the problem.

I think what we're talking about is, when there was a long-term care representative on the Board, that person then was, if you will, the chairman of this committee that Dennis is talking about of long-term care people who were not on the Board, but who this particular person, because they were on the Board, got together, and they made their recommendations which made a very direct and quick way to do it.

And that's why I'm recommending that we go back to the old way and the same things with hospitals or surgery centers or whatever you want to talk about. If you have a representative on the Board, you get immediate feedback, and that

person then is responsible for making sure their industry is involved. You know, one person is not going to be the answer.

MR. SULLIVAN: I think the main point, Senator, is that we are saying over and over again, nursing homes are not hospitals, and the one meeting that Mr. Mark referred to that I went to that was on long-term care, the whole meeting was about long-term care hospitals.

CO-CHAIR GARRETT: Okay.

MR. SULLIVAN: And I think -- LTACHs, and I think we have the feeling of everything -- the current Board, the focus is on let's worry about hospitals, and, oh, we have this little separate service of the hospitals called long-term care.

Well, we're not. We are not hospitals, and we're very different, and I think that's probably the point that we're all making.

MR. BOZZI: But all bureaucracies, you know, we want to keep everything the same. We want to look at everything in the same way, the same procedures, the same processes. It's just a way to function, and I think with us, it's been a

detriment because we're not the same, but yet the Board in its history is looking at it from the medical model perspective all the time.

Even though there's a lot of willingness to cooperate, bureaucracies tend to organize.

CO-CHAIR GARRETT: But I think there's sort of like power in -- I mean, maybe not too much power, but why not -- the hospital associations, when they want to make changes, they draft legislation, and they find one or two legislators who would be in agreement, and they try to pass that legislation.

I don't understand why you've got to get permission --

MR. BOZZI: It happened. We did it.

MS. COMSTOCK: We did that last year.

MS. PAIGE: As you know, Senator Garrett, I've introduced legislation on behalf of hospital clients or nursing home clients, whatever clients that I need to try to help, and I usually get the support of whatever industry that the client wants, but that takes, you know --

CO-CHAIR DUGAN: We should be able to have a system where all the groups are working

together.

MS. PAIGE: That takes six months at a minimum.

MS. COMSTOCK: It would be nice to have conversations that would lead up to the drafting.

CO-CHAIR GARRETT: Right.

MS. COMSTOCK: But if you're saying have we taken the lead in drafting a comprehensive reform package, we're in the process of doing that right now because this task force was formed giving us the opportunity, we thought, and some license, we thought, to develop a more comprehensive view.

So we've been putting Band-aids on little pieces of it over the years, but we've been able to get legislative support for it.

It would be nice to have a more collaborative relationship where we could go in and talk about areas that are of concern to us, and there would be some people that would understand that from our perspective, not just from the hospital perspective.

CO-CHAIR GARRETT: You know, let's let

Kurt DeWeese and some of the others in Springfield --

MS. PAIGE: Oh, Kurt's there. Okay.

MR. DeWEESE: If I could just suggest that there -- I don't think there's a limitation on the Board establishing standing technical advisory committees that could give you this review process.

I don't know that you have to have a guaranteed member on the Board to make that happen. In fact, you could have -- but it does seem to me that the commitment from the Department, from the Board should be there be sort of standing technical advisory committees where these kinds of standards, review, and rules, et cetera, would be kind of ongoing.

MS. PAIGE: No. All I was suggesting, Kurt, was that was the way it worked when there was a member on the Board, and there was some immediacy to it because if something came up, right then and there, that member heard it, and by the next day, the associations that are represented here -- I'm not an association, obviously -- would get to work on it.

And everything doesn't require a statute or a rule. That's the other thing.

MR. DeWEESE: Right.

MS. PAIGE: If you're talking about it, it may well be custom and practice than it is a rule or a statute, but you're absolutely right, there's nothing that precludes that kind of thing from happening now, other than time.

CO-CHAIR GARRETT: Does anybody else from Springfield have any questions or comments?

MEMBER RUDDICK: Actually, I do.

CO-CHAIR GARRETT: SEIU, yeah, go ahead. I was going to say SEIU was the one that said only five members and no specifics.

MEMBER RUDDICK: Yeah, we did. I don't think that was a major part of our presentation, but we did raise it.

CO-CHAIR GARRETT: Okay.

MEMBER RUDDICK: But I wanted to --

MS. PAIGE: And why was that? I'm sorry, I missed that part.

MS. COMSTOCK: I'll tell you about it.

MS. PAIGE: She'll tell me about it. Forget it.

CO-CHAIR GARRETT: Well, no, I'd like to know why it was. I'm serious, too. Why was that?

MEMBER RUDDICK: I think there was -- I think the larger point was not to get into categorical factions.

CO-CHAIR GARRETT: But why five?

MEMBER RUDDICK: Keith responded to that.

MS. COMSTOCK: Yeah, Keith did.

MS. PAIGE: I just didn't hear it.

MEMBER RUDDICK: Keith spoke to that earlier. I think the Board, as you know, was reduced in size because of problems that were going on before, and so I think if all -- you can have a problem with appointments getting filled whether it's five, whether it's 15, or whatever the size of the Board is.

MS. PAIGE: Let me disagree with you to this extent. There was no problem going on when the Board was reduced. The Board was reduced, and I was very closely involved in that at the time that that last legislation was pending.

It was because -- it had to do with sunshine shining on the Board more than anything else, and it was easier for the sun to shine on five people than 10 people. It was just that simple really because there was a discussion, as a matter of fact, with the former executive secretary of the Planning Board that said, you really don't want to do this, it's too small. So there was no real deep-set reason because there had never been a problem.

CO-CHAIR GARRETT: Okay. I'm sorry.

MEMBER RUDDICK: You know, I was actually trying to address something else.

And actually the comment of Ms. Paige with respect to the sunshine shining, I think is relevant to what I wanted to say and some of this interaction that we're talking about here between the Board and folks that are regulating.

I think that, quickly, and Terry didn't get a chance to even go through these recommendations, but on reading them, you know, some of them make a lot of sense; but I would think that the proper way for any kind of recommendations to come forward from an industry and the people that are

regulating them would be better in some sort of a formal committee process, and everybody who might be concerned knows more than a kind of informal, like let's just get together and come up with some ideas for legislation.

CO-CHAIR DUGAN: And I think that's what they're saying. They want a committee.

MEMBER RUDDICK: I just wanted to clarify. So I think a formal committee is better than just like, hey, come on in the office, and let's talk. Some of the conversations here seem to be drifting toward a direction that maybe we can just sit down and talk about it.

MS. PAIGE: No, no.

MEMBER RUDDICK: I wanted to ask a couple questions. I don't know. Are you going to go through these recommendations?

MS. COMSTOCK: Well, we were, but --

MR. SULLIVAN: I think interestingly, we all prepared testimony not in unison, but these six recommendations that we have in our paper pretty much reinforce and reflect the same concerns, and so as Susan said that we get together, I'd say it would probably take us about

15 minutes to come up with our --

CO-CHAIR GARRETT: I think that was the "get together."

MEMBER RUDDICK: Right.

MR. SULLIVAN: In 15 minutes, I think we could probably have, if not, maybe eight at the most recommendations, although the CCRC issues are probably Dennis' issue more than our issue.

CO-CHAIR GARRETT: Yes.

MR. SULLIVAN: But as a combined long-term care situation, yes, we could easily come up with recommendations that amplify what we're saying here.

MEMBER RUDDICK: I was going to ask, Terry, on Recommendation No. 2, you talk about the impact of the system.

MR. SULLIVAN: Right.

MEMBER RUDDICK: And clearly that has taken away some --

MR. SULLIVAN: That's a significant part of the occupancy issue that Billie talked about, that bed need says there is 150 beds needed, but all nursing homes in the area are at 80 percent occupancy with 250 beds not filled.

Why did that happen? Because assisted living, supported living, CCRCs, other residential alternatives that are very appropriate have happened in the past 10, 15 years; but the bed need formula pretends they don't exist.

MEMBER RUDDICK: So this would act -- so the effect of this would be to reduce the bed need.

MR. SULLIVAN: That probably would be the effect --

MS. PAIGE: In some cases.

MR. SULLIVAN: -- in some cases depending on the areas. Some areas are much more heavily in assisted living and supported living than other parts of the state, but I think that would reflect in the bed need more accurately and how nursing home occupancy would be affected.

MEMBER RUDDICK: Just out of curiosity because you mentioned supportive living specifically not being regulated by the CON process --

MR. SULLIVAN: Right.

MEMBER RUDDICK: -- you're not recommending that.

MR. SULLIVAN: We're not recommending it.

MS. COMSTOCK: No, we're not recommending that.

MR. SULLIVAN: They should be considered in the nursing home or bed need, but there's no need to start doing a CON process for supported living and assisted living.

As a matter of fact, Public Health and Health Care and Family Services do all of the review of licensed assisted living. So the numbers are easy to come by, and there is a good review process in place from both of those departments.

MEMBER RUDDICK: So I'm still trying to understand this concept of selling. You know, the state gives you an authority to have a certain number of beds that you, in a sense, are licensed before the CON, and then you can sell that.

So you're sort of -- that becomes sort of an asset that --

MR. SULLIVAN: That you can sell.

MEMBER RUDDICK: -- an asset which would become even more valuable if you reduced the

number of beds in an area by factoring in assisted living.

MR. SULLIVAN: I think we've had conversations along those lines with both Mr. Mark and Mr. Carvalho of how many unoccupied, unused beds are actually out there, and we would like to reduce those, but the problem is, like I say here, if you have a 100-bed facility and you close down 20 of your beds, suddenly your facility is worth 20 percent less.

MEMBER RUDDICK: Right.

MR. SULLIVAN: So people hold on to that unused capacity. Whereas, in fact, if they could sell it to somebody else who was going to do something with it, you, in fact, do not increase the number of beds that are in the system, but allow for modernization, for new facilities, as well as to allow a facility to reduce its beds and not suddenly have less assets.

MS. PAIGE: There is a way to bank those beds or escrow them, and there's another statute that even talks about that with respect to hospitals. But you don't have to give up the beds. What you're doing is you're selling -- I'm

trying to be very precise -- the operating rights to those beds.

CO-CHAIR GARRETT: Like air rights.

MS. PAIGE: Like air rights or whatever, my right to those beds. You can operate these beds because I can't fill them.

CO-CHAIR DUGAN: Do you mean like somewhere else?

MS. PAIGE: Yeah. I'm the nursing home over here, and I need beds. You're the nursing home over there, and you've got too many. But you're not going to just give them away.

So you can sell me the operating rights to X number of beds, and you can even write it in such a way that at the point where this facility over here needs them, you won't take it away from this facility, but now this facility can demonstrate that it also needs this many beds.

The way that it was explained to me, and you guys know much more about this than I do, is that it helps both parties, No. 1. The state still retains the authority to regulate that, but they don't -- you don't have to go through all the stuff of applying and this and that. It could be

temporary. It could be permanent. We don't know at this point. The other facility may just need some monetary assistance, where this other facility over here simply needs to be able to operate some beds.

CO-CHAIR GARRETT: Can you give us the specifics when you make your proposal?

MR. SULLIVAN: Sure.

MS. COMSTOCK: Sure.

CO-CHAIR GARRETT: And what states and all that?

MS. COMSTOCK: Sure.

CO-CHAIR GARRETT: You come to an agreement on what you think would be the best for Illinois.

MS. PAIGE: Okay.

MR. SULLIVAN: I think the corollary to that also, Senator Garrett, is both federal and state encouragement that facilities modernize and convert to private rooms. This process would allow more -- an older facility with 100 beds to go down to 70 beds and convert a number of those rooms to private rooms, which is what the consumers are looking for.

MS. PAIGE: Yes.
MR. SULLIVAN: That's the future of long-term care.
MS. PAIGE: Yes.
CO-CHAIR GARRETT: Kurt --
MEMBER RUDDICK: Oh, I'm sorry.
CO-CHAIR GARRETT: Go ahead.
MEMBER RUDDICK: I just want to -- right now if your facility was at 80 percent occupied, you wouldn't be able to do that because you wouldn't meet the 90 percent standard; is that what --
MR. SULLIVAN: If you wanted to modernize, right now you have a 90 percent standard to go before the Board to have to modernize. I mean, what's the purpose of an occupancy standard if you're not adding beds? If you're adding beds, it makes sense.
MEMBER RUDDICK: Okay.
MR. SULLIVAN: If you're adding beds, let's modernize our facilities. We need to be able to have a more streamlined process without having an occupancy standard, or for that matter, the same involved application process that you

would if you're adding beds or building a brand new facility.

CO-CHAIR GARRETT: You're going to write that.

Okay. Kurt, do you --

CO-CHAIR DUGAN: I think Kurt was next.

MR. DeWEESE: Just backtracking a little bit in terms of the composition of the Board, one of the things that Billie didn't mention was that when we had a 13-member Board, there was representation by the union, by the physicians, nurses.

MS. PAIGE: Right.

MR. DeWEESE: Essentially, you had seven additional members, and I think what I understood in terms of history is that there's a general opposition at least on the part of the speaker to those kind of categorical representations on this kind of a regulatory Board, sort of following the Commerce Commission model.

MS. PAIGE: Yes. But the speaker -- yes, absolutely right.

MR. DeWEESE: And on that basis, it does seem to me as though you could provide for some ex-officio nonvoting members to perhaps provide that level of expertise or the technical advisory committee, standing technical advisory committees to provide that kind of input without actually changing the nonbiased representation of those members who are actually voting.

MS. PAIGE: Kurt, as usual you're absolutely right. The speaker said that to me, that he did not want any providers on the Board. His issue was conflicts of interest.

The problem is this statute that we have now is so tightly written, it's so difficult to find anybody unless they're retired, and I've got nothing against retired people.

They got it.

CO-CHAIR GARRETT: We got it.

MS. PAIGE: But you're absolutely right, Kurt.

MEMBER SCHAPS: I had a question that sort of came up this morning. It's a totally different subject, but can anybody explain the history of the change so that nursing homes

were -- when there's a change of ownership, and whether or not nursing homes are not subject to review?

MS. COMSTOCK: Sure.

MR. SULLIVAN: We're familiar with the legislation.

MS. COMSTOCK: Yes, we are.

CO-CHAIR GARRETT: Lou Lang, who isn't here --

MS. COMSTOCK: We're only somewhat familiar with that legislation.

MEMBER SCHAPS: What's the history?

MS. COMSTOCK: Well, the legislation surfaced for, I think, three reasons. One, this whole long-term care is a different aspect that we've talked about.

Second, that changes of ownership happen on the nursing home side with much greater regularity than they do on the hospital side. The same nursing home could be bought and sold three or four different times in a year for financial reasons or other reasons. So changes of ownership happen much more frequently on the nursing home side because we're just such a different animal.

MS. PAIGE: That's true.

MS. COMSTOCK: And third, and probably the one that motivated us the most to take immediate action was there was a backlog of 120 change of ownership applications that fall during that year that we passed the bill at the Planning Board level, and so what we had was facilities that wanted to change ownership because they were in financial difficulty, and they were not able to make that change. In other words, they had buyers, but they were losing their buyers because of the time lag involved in getting through the change of ownership process at the Planning Board.

So our members came to us and said we can't do business this way. You've got to do something to change it, and so for that -- and also there is a parallel process in the Department of Public Health licensure section that requires us to go through very similar steps to do a change of ownership. So we were doing it twice. A change of ownership process in the licensure section and a change of ownership process at the Planning Board that were very similar.

So for routine changes of ownership, we got

that changed.

CO-CHAIR GARRETT: Is that public information through the Department of Public Health?

MS. COMSTOCK: It's all FOIA-able, yes.

MR. SULLIVAN: It's part of the licensure application process.

MEMBER LYNE: What was the year of that change?

MS. COMSTOCK: A year ago.

MS. PAIGE. Yeah, last year.

MS. COMSTOCK: Lou was the sponsor in the House and Ira Silverstein in the Senate.

CO-CHAIR GARRETT: Did you want to comment on that, Jeff?

MR. MARK: Our view of the world is a little different on it, if you want to hear it, I would be happy to --

CO-CHAIR DUGAN: No, that's okay.

MR. MARK: Okay.

MEMBER ROBBINS: I don't know whether the panel is best to answer this or Jeff or Dave or both. Up, you know, to this point, I think

it's been acknowledged that most of these conversations prior to today have been hospital-centric.

So could we go back to Square One and ask, why is long-term care regulated by the Health Facilities Planning Board in the first instance?

Is it because -- or is the goal the same as it is for hospitals, recognizing the differences that exist between hospitals and long-term care, is it cost, quality, and access?

What's the root reason that this industry is regulated?

MR. MARK: If I may, I mean, in practical terms given the change in the statute recently, the only time a long-term care facility would come before the Board is if it were to establish -- wish to establish a new facility, do a very, very major renovation. We're talking about over $9 million, and you can do a lot of renovation in those nursing homes for under $9 million, and the only other thing would be a significant increase in beds.

Otherwise the facility --

CO-CHAIR GARRETT: What does

significant mean?

MR. MARK: Over 10 percent or 10 beds.

MS. AMIANO: 10 beds.

MS. COMSTOCK: Or if a facility wanted to totally replace itself.

MR. MARK: Well, that's major renovation, that's what -- it would not come before us for change of ownership where the Board looks at character and background of the applicant. It would not come before us for discontinuations. That was changed in the legislation.

The short answer to Ken's question is it's under our jurisdiction because it says so in the statute.

CO-CHAIR DUGAN: That's the way they've always done it.

MR. MARK: The statute does not differentiate the purpose for different facilities.

MEMBER ROBBINS: So presumably it is regulated because it ought to have an effect on cost and quality or access.

MS. PAIGE: Correct.

MR. MARK: Yes, presumably.

MEMBER ROBBINS: Others have asserted that those purposes are not necessarily well met when it comes to the regulation of hospitals, and we've got experts come in and say, well, it hasn't had much to do with cost, it hasn't had much to do with quality, and it hasn't had much to do with access.

Would experts say the same thing about the regulation of long-term care?

MR. MARK: I don't know for certain. My guess is yes, but I don't know.

MEMBER ROBBINS: Let me get on that. Do long-term care facilities benefit from protection against competition in the same way that hospitals do?

MS. PAIGE: Yes.

MR. SULLIVAN: I'd say, Ken, the answer is why we included -- having them around since '77. I remember the discussions, and I think the answer probably comes down to Sheridan Road in Chicago where that small, little section of Chicago had 9,000 excess beds, and people said, how did that happen?

MS. PAIGE: Yeah.

MR. SULLIVAN: And it was sort of like we need to have a fairer or more equitable access around the state, which is how we came up with a bed need formula. I presume Sheridan Road still has 8,000 excess beds. So you can't build a nursing home on Sheridan Road anymore, not that you can find space to.

But I think we came up with a bed need formula that says these are areas based on the senior population where more nursing homes are needed, and these are areas where you really can't fit another nursing home or everybody gets hurt.

MEMBER ROBBINS: Would it be fair to say that those nursing homes that are licensed and have received certificates of need are protected by the Health Facilities Planning Act from competition?

MR. SULLIVAN: I think the competition is -- yes, there is some protection against areas becoming so over-bedded that everyone goes out of business.

MEMBER ROBBINS: To what extent -- and I realize we have different classes of nursing

homes, so I would invite everybody to answer for themselves.

To what extent do long-term care facilities or retirement facilities provide charity care or free services, however the right way is to term that?

MS. COMSTOCK: I'll say it depends upon how you define it. Some of us believe that any of us that serve a Medicaid resident are performing charity care because our rates, as has been reported earlier, are so far below everyone else that there is no way that our Medicaid rates even come close to the 75 percent level that you sometimes get at, Ken, but Dennis --

MR. BOZZI: Well, obviously, that issue, and the other issues are discounts and pricing of monthly fees, other discounts that are part of the standard resident contract that all of our members have.

CO-CHAIR GARRETT: Right.

MR. BOZZI: So it's in-kind or cash, in-kind as well as charity.

CO-CHAIR GARRETT: I think where Ken is going is, if we take up this proposal that was

brought forward today, could that same proposal apply to your business? You know, that if a certain cap and trade -- what did they call it, a floor and trade.

MR. SULLIVAN: I think you might get different answers from this panel.

CO-CHAIR GARRETT: Does that make sense to you if we're asking hospitals to provide additional funds or some sort of a service, you know, some sort of a benefit?

MR. COX: Senator, this is Greg Cox in Springfield. One of the things that should be brought up is that there is a 90/10 mix between non-for-profit hospitals and for-profit hospitals. The mix on nursing homes is -- and everybody will correct me if I'm wrong -- I think it's about 70 percent for-profit and 30 percent non-for-profit.

MS. PAIGE: Right. That sounds about right. That sounds about right, Greg.

MR. COX: That's a big difference in the charity thing because when you're talking charity care, you're talking about not-for-profits receiving tax benefits, and only about 30 percent of the nursing homes receive that benefit.

MEMBER ROBBINS: But, Greg, the proposal being made this morning would not have made a distinction between investor-owned and not-for-profit institutions. It would have applied that obligation across the board because the benefit that was being talked about in the CON context was the protection from competition, not the value of the tax exemption.

So my question is, if there is protection from competition in the long-term care environment as it is asserted that there is in the hospital environment, wouldn't you apply the same thing?

CO-CHAIR GARRETT: It's to protect the value for that.

MR. CARVALHO: The value comes because you are protected.

CO-CHAIR GARRETT: Right.

MEMBER O'DONNELL: An economic protection from the competition.

MEMBER ROBBINS: So if that is the value, should everybody protected from that competition be treated the same when it comes to uncompensated long-term care?

CO-CHAIR GARRETT: That is a really

great question. I mean, I think that what's good for the goose is good for the gander.

MS. PAIGE: Right.

MS. COMSTOCK: Sure.

CO-CHAIR DUGAN: Yeah, as long as nursing homes have to come to the CON for the same reason that hospitals do, where they are the same, then they should be treated the same. Where they're different, then they may have to be different, but it's certainly something that I think we need to make sure we look at, if that concept is something that --

CO-CHAIR GARRETT: And I think that David also had suggested that everybody was in the mix.

MEMBER ROBBINS: I think he did.

MS. COMSTOCK: Yes.

MEMBER ROBBINS: But I was just wondering how they felt about it.

MS. PAIGE: I'll tell you, the whole concept scares me to death, but I will tell you it's not a question of protecting franchises as much as it is -- and I had a brief conversation with Ken, it's probably a function of being around

too long, and -- there's nothing new under the sun anymore. This is not new. It's just painted differently.

We went through the whole issue of when hospitals and -- nursing homes, unfortunately, Pat, were not included at that point and were going to be treated as utilities.

So, I mean, the reason it scares me to death is because I don't believe that -- this is just a personal observation -- on the one hand you've got health planning, that that ought to be somehow linked, coupled or otherwise with the whole issue of charity care.

I think that that should be separately regulated, whether it's the attorney general that does it or anybody else. I just don't think it's compatible with the concept of health planning because it will come across as punishment on the one hand, you know, or reward on the other. You know, it's like having a kid, you know, a carrot and stick kind of thing.

I just don't think that that's what health planning ought to be. I'm done. You wanted to know how I felt, and I've never been reluctant to

tell you before.

CO-CHAIR DUGAN: I think many of us up here, we also -- the health planning part of it, We're still trying to find that part of our health planning.

MS. PAIGE: I'm just saying decouple it if you're going to do both.

CO-CHAIR DUGAN: Right.

MS. PAIGE: Don't mushroom it together.

MR. SULLIVAN: I mean, like I said, I think we all probably have different opinions about how this might go.

MS. PAIGE: That's a scary subject.

MS. COMSTOCK: And we haven't had a chance to talk amongst ourselves since that presentation; and frankly, you know, it was a bit mind-numbing to try to grasp all that. So I'm still sorting it out in my head frankly.

MEMBER ROBBINS: Would it be possible for you all to get together and then let us know where you stand on that?

MS. COMSTOCK: Sure.

CO-CHAIR GARRETT: Well, not so much

where you stand. It's the easiest thing to say no, and everybody wants to say no, and then we've just wasted eight months or a year of our time.

We're trying to really openly and honestly look at the opportunities. If you're talking about banking the beds -- I mean, all that can be factored into a formula.

And to what Billie is saying, it's the CON process, certificate of need that is based on other things, not just health planning. So the problem is we've got two bipolar situations to begin with.

MS. PAIGE: Take some lithium and stop talking about it.

CO-CHAIR DUGAN: Judy.

MS. AMIANO: I think that, you know -- I didn't hear the whole context of the conversation this morning, so I can't comment, but I would agree with Billie in that it scares the bejesus out of me.

But I think part of the challenge is we've been sitting here saying that, you know, this industry is different; and the fact is, there really is competition in the SNF environment from

the supportive living, from assisted living, from home- and community-based services.

It is not -- this Board does not protect us from competition. I mean, the notion that it does is not accurate. I am also not a proponent that those should be in this process either. I think one of us suffering the pain is quite enough in the industry, but the fact of, you know, well, if we protect you, then what is the quid pro quo here is not really the appropriate way to think about this, I would say.

MEMBER LYNE: May I also speak?

MR. DeWEESE: Here in Springfield, going back to something that Ken Robbins asked about in terms of the origin of the evolvement of long-term care in this area, and I believe that there was a significant cost-containment element, and that has really become more significant as the extent of the state's payment for Medicaid services became more significant.

As Terry mentioned, you have not only the problem of excess beds and having to pay for those through the Medicaid system, I think there's also the concern, something contrary to what Billie

said earlier, is there is a capital component of the Medicaid nursing home rate, and so the state, I guess, does have some sort of a vested interest in containing those capital costs in relation to its Medicaid rates.

So I think that still prevails to some extent, and certainly some states, especially in the area of cost containment, have focused on -- put moratoriums on long-term care beds or actually reducing the number of long-term care beds in the interest of their Medicaid cost containment, so even just health- payor cost containment, not paying for an excess number of under-utilized beds in the system.

I think that's still there. It's not so much the competitive element, so much as it is trying to get the proper balance between the types of long-term care services that are needed and recognizing the diminishing number of actual nursing home beds and what the state might have to pay for them.

MR. SULLIVAN: Kurt, you're absolutely right that the Medicaid formula puts maximums on the size of bedrooms and stuff like that, which is

an appropriate function of the Medicaid agency.

I'm not sure in a consumer-driven market right now that it's an appropriate function for the CON Board when consumers want private rooms and larger rooms. Just like in assisted living and supportive living right now, consumers are the ones who are driving what is being developed, whereas we are -- the nursing home industry is kind of being captured in an old model from the 1960s, and the Medicaid agency has a vested interest in maintaining maximums, but that shouldn't be true for the entire profession and every nursing home under the sun. Let consumers have some say-so. I don't think that maximums are a CON function.

MS. PAIGE: I agree.

MR. DeWEESE: But I think what I hear you saying is, it's not so much the total bed need as it is the types of beds that we're developing.

MR. SULLIVAN: I think the future of the entire long-term care profession is changing dramatically in what consumers want, and consumers are driving that, Kurt.

I think our recommendations are going

towards the CON process shouldn't be reflective of something that was developed back in the 60s and 70s.

MS. PAIGE: And that's pretty true across the board, as you know, Kurt.

CO-CHAIR GARRETT: Well, we're going to keep going. I'm sorry.

MEMBER LYNE: Keep them separate, too, the acute care from long-term care. There is enough in each one, I think, and it's not all similar. So let's not complicate our lives further.

CO-CHAIR GARRETT: Dave Carvalho.

MR. CARVALHO: I'm just hiding back here.

CO-CHAIR DUGAN: Stand up, Dave.

MR. CARVALHO: I actually want to take Ken's point one further, and I actually was waiting to raise this. I'm surprised he raised it.

In listening to the testimony thus far, I don't think you've established why this should be within the CON at all. Because if you don't regulate changes of ownership, if you don't want

to regulate size, if you don't want to regulate cost, all we are serving is a function of protecting you from competition. If 70 percent of you are for-profit, why are we protecting a for-profit industry from competition?

So I think you really ought to step back and make the case, what public purpose is being served by regulating you?

CO-CHAIR DUGAN: Yeah, exactly.

MR. CARVALHO: I can see the private purpose, keeping competitors out, but what public purpose is being served by continuing -- what public purpose would be served by continuing the regulation, especially with what you called reforms which is basically limitations on the public process getting into your business?

CO-CHAIR DUGAN: Correct.

MR. CARVALHO: So what is the reason you --

CO-CHAIR GARRETT: Don't answer. Think about it.

MR. SULLIVAN: Yes. Thank you.

CO-CHAIR DUGAN: That's a very good point. The more you listen to it, the more you're

thinking why are we even doing it that way with you guys anyway.

MR. SULLIVAN: Just to briefly answer, historically Dave's answer without getting into the future is that I think the planning process of the past 30 years for long-term care has encouraged beds where they didn't previously exist. I think in 1977 when we started on this, it was a very unbalanced state.

MS. PAIGE: Oh, absolutely.

MR. SULLIVAN: And since then with bed need saying you can't have any more beds, if you do need them down in LaSalle County -- you know, as a matter of fact, we have beds in LaSalle that weren't there --

CO-CHAIR DUGAN: Correct.

MR. SULLIVAN: -- and we have kept the cap, say, in Chicago where there was no more need for beds.

MEMBER SCHAPS: Are there people in the beds in LaSalle County?

MR. SULLIVAN: There are people in the beds based on the senior population.

CO-CHAIR DUGAN: I think right now the

way we've done it was with the assisted living and the supportive living, and then the nursing home, the whole continuum of care. Now, I think it's completely changed.

MS. PAIGE: Oh, yes.

CO-CHAIR DUGAN: I think it's a whole different thing than what it used to be.

MR. SULLIVAN: And certainly right now, retirement centers and assisted living are not regulated through the CON process --

CO-CHAIR DUGAN: Correct.

MR. SULLIVAN: -- although that's an entire private pay market.

When two-thirds of the nursing home residents are on Medicaid, it does become a public policy issue.

MEMBER RUDDICK: And it has the cost-containment factor. Hypothetically, if someone came to build -- if you didn't regulate through CON, someone could build 100 new nursing homes, and they took a whole lot of patients now, and the remaining nursing homes went from 80 percent occupancy down to 50 percent occupancy, 30 percent occupancy, it would have an impact on their cost

per patient because then the system would go up or the quality would fall down, one or the other.

So to the extent the government is financing a big chunk of the program, that's I think the argument for the CON regulation.

CO-CHAIR DUGAN: And I think regulation of the industry I think is certainly something that I agree with, but the CON part to me is a whole completely different thing. That's the part that possibly could --

CO-CHAIR GARRETT: What should we give them as a directive? Should we say come up with your legislation? Should we ask them to make a case for being part of the CON process? And then to Ken's point, how could you see yourself factoring this whole proposal of floor and trade? Not foreign trade, floor and trade.

MR. SULLIVAN: Correct. I think you will get a very solid, consistent recommendation from all of us with a little bit --

CO-CHAIR GARRETT: Do it.

MR. SULLIVAN: -- of a minority report on a few issues.

MEMBER LYNE: That's fine. Okay.

Thank you.

CO-CHAIR GARRETT: I think we're giving you, I think, a different directive. We'll get you back, but I think that would be very helpful to us and to the hospitals as well.

MR. SULLIVAN: Okay.

MS. COMSTOCK: Do you have a time frame in mind?

CO-CHAIR DUGAN: What, to have it to us?

MS. COMSTOCK: Yeah. Do we have a couple months to get this done? Do we have two weeks to get this done?

CO-CHAIR GARRETT: A month.

CO-CHAIR DUGAN: I'd say a month.

CO-CHAIR GARRETT: Then if you could work either with us or with Jeff to get this -- we'll bring you back on the agenda.

MR. BOZZI: You've asked us I think like a really high elevated -- elevation question. I think we can do it.

CO-CHAIR DUGAN: You guys can handle.

MR. BOZZI: We can handle it, but it's not the same question about having a task force go

through some of the minutia we talked about. This is a big question about whether we should --

MS. COMSTOCK: Well, we'll start, and we'll give you feedback if we're not -- if we're finding land mines that we didn't think about.

CO-CHAIR GARRETT: Can I just ask one question before you guys go?

MS. COMSTOCK: Of course.

CO-CHAIR GARRETT: This whole notion of selling nursing homes, I know this is bigger than what we want to talk about. Is this a profitable enterprise and that's why it happens?

MS. PAIGE: Some.

MS. COMSTOCK: Well, do you want to know why --

MR. SULLIVAN: No.

MS. COMSTOCK: Our profit margin is even less than what was -- on the state-wide average is even less than what was reported on the hospital side.

CO-CHAIR GARRETT: I don't know that much about tax law, but I know if you hold on to something for X number of years and then you sell it, you can take a tax loss, you can do all sorts

of, you know, maneuvers within the accounting.

MS. COMSTOCK: That's beyond me.

CO-CHAIR GARRETT: But is there anything to that? It's just so prevalent.

MS. COMSTOCK: I don't know enough --

MR. SULLIVAN: I would say that there's an awful lot of nursing homes that are being sold because the current owner can't make ends meet.

MS. PAIGE: Right, that's what I would say.

MR. SULLIVAN: And there needs to be an infusion of financing, and often it's the new owner that can bring in that infusion.

CO-CHAIR GARRETT: But is it just all new owners showing up?

MR. SULLIVAN: No.

MS. COMSTOCK: No.

CO-CHAIR GARRETT: The same group of people that are --

MS. AMIANO: There's a lot of consolidation.

MS. COMSTOCK: Lots of consolidation, for example, there's one particular operator in

the state that has helped a lot of small nursing homes that would have normally gone out of business, and because he's a large provider, economies of scale have allowed him to operate some facilities that other people couldn't.

CO-CHAIR GARRETT: I think in order to move forward, I don't know if you agree with me, do we need to understand this better?

MR. DEVLIN: As far as I understand, I mean, in terms of the change-of-ownership concept in the State of Illinois, you can do a change of ownership of a league of nursing homes; but then Manor Care, I believe just came in and purchased 40 nursing homes --

MS. PAIGE: No, no. Here's what --

MR. DEVLIN: It's a wide range in terms of the concept.

MS. PAIGE: Manor Care started out as Manor Care over here.

MR. DEVLIN: Yes.

MS. PAIGE: Manor Care was then bought by HCR which was a smaller company. It was a minnow, you know, gulping down the whale, and it became HCR Manor Care.

Then -- and this was the big issue last year was, and it was coincidental because I represented Manor Care for a long time, it had nothing do with the bill and statute that these folks passed.

The Carlisle Group came in to buy Manor Care, and it really was happenstance that this bill was signed maybe a month or two before they were closing on the deal. The deal had been pending for a long time.

You know, I guess it seemed as if there was collusion, but there wasn't. This is really an example in a big sense, Pat, of what you're talking about. They get sold all the time.

MS. COMSTOCK: Can I just quickly, the change of ownership that you hear referred to as the Manor Care/Carlisle sale, although we might have some discussion with our SEIU colleagues, in general, we believe that that was an anomaly --

MS. PAIGE: Yes.

MS. COMSTOCK: -- not typical of what happens. Manor Care looked really good to the investor group Carlisle because they had very low Medicaid. As a population --

MS. PAIGE: Except in Illinois.

MS. COMSTOCK: -- they have -- right, but you have to look at the whole thing.

MS. PAIGE: I know, but except in Illinois.

MS. COMSTOCK: They have very low Medicaid, maybe 20 percent.

CO-CHAIR GARRETT: Okay. We don't need to discuss this now.

MS. COMSTOCK: So they looked good to invest in. The rest of us don't look that good.

MEMBER RUDDICK: I think just one -- I don't think we want to get into all the pros and cons of the Manor Care thing, but I just would -- I would agree with Pat to the extent that the Manor Care deal was an anomaly and was not the typical type of sale. A lot of concerns about that type of sale that we had and other people had had.

I think the problem that came out of that was in our view was that the state did not have the proper authority, because of the bill that had been passed for other legitimate reasons, to really look into the Manor Care and Carlisle transaction as much as it should have, given how

unique that was and what the potential effects of that was. So that was where our concern came in, and we can argue all day about the Manor Care, but I don't think we want to do that.

CO-CHAIR GARRETT: Okay.

MEMBER RUDDICK: But that was just -- it wasn't a typical --

CO-CHAIR GARRETT: Okay. I just want to say it's not about Manor Care.

MS. PAIGE: It's just that it was raised this morning.

CO-CHAIR GARRETT: Is there a way for us if we are looking at this approach, the floor and trade, to factor in -- I just think it's important to understand the selling of nursing homes -- hospitals aren't sold -- and how that works if we're really going to look at this issue legitimately.

Is there anybody here or in the audience that can just sort of do sort of a position paper on what the nursing home --

MS. COMSTOCK: Yeah, we can get that done for you. We'll get it done.

CO-CHAIR GARRETT: Any other questions

before they leave?

CO-CHAIR DUGAN: Go ahead.

MEMBER ALTHOFF: Hi, it's Senator Althoff from McHenry County. I've been really good and quiet.

CO-CHAIR DUGAN: We noticed that, Senator.

MEMBER ALTHOFF: I have. I want to go back to the comment that Ms. Paige made with regard to her concerns about the increasing fines.

MS. PAIGE: Okay.

MEMBER ALTHOFF: Is that with regard to all applications, Billie, or nursing homes only?

MS. PAIGE: Oh, no, that was part of my general comments. It affects nursing homes. It also affects hospitals or any other, surgery centers, any facilities that are covered by the Planning Act. If you have a compliance issue, it can turn into a fine, and the fines right now are always at the maximum.

MEMBER ALTHOFF: Is there a reasoning for that? Can I look at our guys? Jeff and David, is there a reasoning for that? Can you

respond to that allegation?

MR. MARK: Which part of it, Senator, that we issue the fines or they're at maximum?

MEMBER ALTHOFF: Yes, Jeffrey, both of those. Are there more of them because the applications are not being done appropriately, and are the fines always at the maximum?

MS. PAIGE: No, no.

MR. MARK: No. Fines are not issued for applications. Fines are issued for such things as -- we just issued some recently for failure to return annual questionnaires. That was after two written requests over a period of three months to submit your annually required data.

In the State of Illinois, out of approximately 16-, 1,800 facilities, we did issue 34 fines, I believe, for $1,000 each. This is intended to be a deterrent. This was the maximum fine as dictated by the statute.

What Billie Paige was referring to earlier are fines that are issued for far more serious offenses. We've issued some for, I think, the example she gave was a project going above the permit level without coming back to the Board for

an alteration.

We've had instances where people go beyond the expiration date of the permit, and as such invalidate their permit, and Ms. Paige is correct that our legal staff has been taking the statutory language as its guideline for the initial determination of the fine.

During negotiations, oftentimes, if not all times, that dollar amount is drastically reduced. I believe, it's also fair to point out that in many, many instances, the Board settles for clinical services going to the community of a dollar value in lieu of any cash coming to the Board or the State of Illinois.

MS. PAIGE: That's true.

MR. MARK: And that has -- we've literally gotten millions of dollars worth of medical care and other services to the communities.

MEMBER ALTHOFF: That's what I wanted to hear. Thank you.

CO-CHAIR DUGAN: Okay. Thank you.

CO-CHAIR GARRETT: Thank you, guys.

CO-CHAIR DUGAN: Thank you very much.

CO-CHAIR GARRETT: Okay. Now, we've got the Village of Plainfield, if they would like to come up; and if they do that, then Jeffrey Mark and David Carvalho will have to excuse -- recuse themselves.

They went through an application process, and they wanted to sort of weigh in and tell us what that was like. We will give you 15 minutes. Is that okay? Are you all right with that?

MEMBER BRADY: They're still in the application process?

CO-CHAIR GARRETT: They're still in the application process, so based on the ex-parte communication, they called, and I talked to the staff and said that if we have time, we'll ask them to come up and talk about this.

Quickly come up, and if you have a spokesperson --

(Whereupon, a recess was had, after which the hearing was resumed as follows:)

MR. CARVALHO: Mike? Mike Jones in Springfield?

CO-CHAIR GARRETT: Is Mike Jones there

in Springfield?

MR. CARVALHO: Mike?

CO-CHAIR GARRETT: Mike Jones?

MR. CARVALHO: What did you say, Mike?

MR. JONES: We can hear you, but there's a lot of noise, and we can't make out what you're saying.

MR. CARVALHO: Okay.

MR. JONES: If you could kind of review who the panel is, and what --

CO-CHAIR GARRETT: We will.

MR. CARVALHO: Yes, but what I needed to tell you is that when I leave, you have to leave, too, because you're now an ex-officio member of the Board. The subject -- yeah, listen in and then leave.

The subject matter is a pending matter before the Facilities Planning Board; namely, the application by Edward Hospital to build a hospital in Plainfield. You are an ex-officio member of the Board, as am I, so we both need to leave because we're not allowed to receive ex-parte communication. So whatever is said today is ex-parte, and we're not allowed to hear it, and

they're not allowed to -- I mean, they're not allowed to say it while I'm in the room.

CO-CHAIR GARRETT: It just shows how crazy the whole process is. They should be hearing it.

CO-CHAIR DUGAN: So whoever, whether it be on the phone or anybody has to leave?

MR. CARVALHO: Anybody who is staff for the Department of Public Health that has -- that's in their area.

MS. SULLIVAN: This is Myrtis Sullivan. Should I get off the phone?

MR. CARVALHO: Myrtis, no, the person from your agency is Jerome Butler, so just don't tell him about this.

CO-CHAIR DUGAN: We'd like to -- yeah, we've only got about 15 minutes that we're going to give them. So we want to get going on it.

MR. JONES: Okay. I'm going to leave the room. I'll be back in about 20 minutes.

CO-CHAIR DUGAN: Okay.

MR. DeWEESE: So this is not entirely an official record of the task force?

MR. CARVALHO: This is part of the

task force. It's not part of the CON record. I mean, I guess I can take a copy of the transcript and give it -- actually, I probably can't.

So just for the rest of the task force's benefit, there is currently pending an application that's up for consideration by the Health Facilities Planning Board.

It was deferred several times awaiting new rules to go into effect. They went into effect this year. It was considered at the Planning Board meeting last week, and it was deferred for discussion between the staff and the applicant regarding a possible modification to the application.

It succeeds an application that was done in 2003 or 2004, which was ultimately turned down. This was a follow-up application.

We will not be able to -- after you hear from them, if you have questions, we won't be able to answer them.

CO-CHAIR DUGAN: Okay.

CO-CHAIR GARRETT: All right.

MR. CARVALHO: Okay.

MEMBER BRADY: Wait a second. Are you

going to be able to read the minutes?

CO-CHAIR GARRETT: It's crazy. That's just how crazy this whole thing is.

MEMBER BRADY: There's no reason --

CO-CHAIR GARRETT: It is what it is. So let's move forward.

MR. HARRIS: Chairman, I just do want to clarify one thing. Alex Harris, I'm the village administrator for the Village of Plainfield. I have three elected officials.

We do not have an application in front of you.

CO-CHAIR GARRETT: Right. It's the Village.

MR. HARRIS: We are elected -- excuse me, I am staff to our elected officials. We are not a hospital entity. We are 40,000 residents in the western suburbs of Chicagoland.

We do not have an application in front of you. You are not the body that's reviewing that. We are here to talk about the certificate of need process from a municipality perspective, and we think it's very important that you hear that, especially after five hours of testimony about how

important other components of this are.

So that being said, I don't see how this has any relationship with the Health Facilities Planning Board, but if I may, Chairwoman, I would like the opportunity to very quickly get through our 15 minutes.

CO-CHAIR GARRETT: Okay.

MR. HARRIS: I think each of the trustees -- we have a board meeting this evening. So we actually have to get back to Plainfield, so we can actually have a quorum. We have half of our elected officials here. Indeed as an open meeting, I just want to represent very quickly what this means to the Village of Plainfield.

With that, we want to identify that we're very impressed that two big things happened. One that the task force was created, and we truly appreciate the efforts that you're going through all today as well as the opportunity to read the transcripts from before.

But also Section 12.5 where you looked at high-growth areas, and indeed that legislation is very important and I think something to consider as you go to implement what this task force comes

up with, how those rules are implemented and how they're actually received by the certificate of need process.

With that, we just want to highlight, as I started to say, that as a municipality not as a hospital, we're really here to talk about the fact that today for five hours, we heard, as you have in the past, about indeed the providers, often the employees, the bonding opportunities, the economists that review this, and indeed the legal support of this process.

As someone who supports our elected officials and supports our residents, we want to make sure that the task force considers the patients, which are indeed our residents. Our residents are almost 38,000 people in the Village of Plainfield, but more importantly an area called A-13 by the Illinois Health Facilities Planning Board that encompasses to our south, Joliet, the fourth largest community in the State of Illinois; to our north, Naperville, the fifth largest community in the State of Illinois; to our west, Aurora, the second largest city in the State of Illinois; and to our east and west, Bolingbrook,

Oswego, Yorkville, Montgomery, Crest Hill. All that have, like Plainfield, been identified by Forbes.com in the last seven years -- we're the faster growing suburbs in the country.

The Village of Plainfield topped all of those as the fifth fastest growing in the country. That high-growth area is something that is very different than some of the communities that you've talked about in the State of Illinois, and we want to make sure that when you're looking at what's been done in the past, specifically Section 12.5, how indeed that is being implemented in this area.

With those patients in mind, we want to highlight that there's things that the certificate of need can't address, nor probably shouldn't address.

For example, right now, roads, transportation are very important in that area. The capital building you hear so much talk about in the papers is something that doesn't necessarily come into the health care equation, but is at the heart of what is important to the Village of Plainfield. How we get to the existing access to health care or hospitals in the greater

Chicagoland area is a very big problem.

We spend the majority of our budget, actually about 80 percent of our budget on roads to get access to these services, like health care. Indeed as a municipality, that's a huge burden of cost, and we know as a state, that's a huge burden of cost that is outside of what we typically think of as access to health care, but truly is our access to health care.

Another one of those is the fact that we as a community actually have a railroad that comes through our community, and in that, we actually have Canada National acquiring a railroad, which means half of our residents are actually cut off by a railroad; and therefore, even if we had the roads to those hospitals, a railroad is now cutting them -- cutting that access off.

Finally is the population growth that we talked about. Indeed, we cannot control the growth that's happening in our surrounding communities. Something that is very important when we talk about access to health care, as one municipality, we have very little control of what's going on, and in this case, we're turning

it over to an organization like yours to actually review what's happening as far as access to health care.

Therefore, we wanted you to look at three important things: one, high-growth areas, again; two, public hearings. It's very difficult for a municipality to sit back and listen to the fact that there's testimony given that indeed no one actually hears. They may read it, but they don't hear it.

We cannot have at a local government level an open hearing without a quorum. Indeed, it's illegal to do so; and therefore, as elected officials in the Village of Plainfield, whether it's the Plan Commission or whether it's a Village meeting, we have to have a quorum of elected officials to hear that testimony, we can't take it third party, and indeed is something I think very important for this state to consider when indeed they're talking about something as important as access to health care.

Then finally, the clear process -- the reason we're here is that in six years we have gone through three applications through one

provider for access to health care in the Village of Plainfield, and we thought best represented at the Health Facilities Planning Board, one of the Board members identified it as a six-year odyssey.

Indeed, we feel this is a six-year process for a very growing community that has not been well-served by this process. We're basically looking to say that a six-year odyssey is not a clear, clean straightforward process that allows a municipality to represent to its residents how you get access to health care, which is why half of our Board is here to really have a voice in that.

So as you keep the patients, as you keep our community and communities like ours in mind, we eagerly await what the task force has as far as its outcomes and hope that that task force is actually involved in the implementation of those outcomes, too, so that we know what we actually are putting in the legislation is actually what's going to be implemented by whatever process comes down the line.

With the patients in mind and certainly with our residents in mind, if you will bear a minute from our elected officials, or we'd be happy to

come back in another forum.

CO-CHAIR GARRETT: If you could give us -- I mean, we will -- I mean, it's sort of a struggle unless you can make it really short.

MR. DEMENT: Three minutes, two-and-a-half.

CO-CHAIR GARRETT: Okay.

MR. DEMENT: Good afternoon.

CO-CHAIR DUGAN: And I only ask that what you do is you give us suggestions on how we can make the CON better. That's, of course, what we're looking for.

MR. HARRIS: We will submit that.

CO-CHAIR DUGAN: That's what we're really looking for, and I certainly respect from a municipality standpoint as we look at that, and that should be kind of in a forum where we ask other municipalities to come, both from a rural area and, you know, a high-growth area and other areas which is very important.

I think to get the best benefit from it as a task force, we need to really have those types of issues addressed by local and rural officials, not just one community. Do you know what I'm saying?

I appreciate you coming, but --

MR. HARRIS: Representative, I think one of the things that we want to highlight is we were one of the first communities that when the task force was just getting started to get some of that testimony, and again as kind of a third-party, we truly want to make sure that someone that's been directly affected by this, going through three different applications, that you hear that perspective.

CO-CHAIR DUGAN: Correct, and that's the perspective that I think we want to hear is what actually happened, not that we don't understand what Plainfield is. Okay.

MR. DEMENT: Good afternoon, everyone. My name is Jeffrey Dement. I'm presently serving on the Plainfield Village Board.

I would like to thank the task force for allowing me to address this forum. The reason I am here today is to discuss the six-year trip to nowhere that the Village of Plainfield and Edward Hospital has been on.

Plainfield has a population, of course, of around 38,000 with no hospital within a 35- to

45-minute daytime drive.

Because of a few people on the Health Facilities Planning Board, our lives are being put in danger. Our residents are not getting the rapid comprehensive health care that many other hospital districts provide.

Additionally, we have one of the lowest hospital-bed-to-patient ratios in the state. So why is it that the Planning Board will not support our efforts to build a new hospital?

One reason is because the surrounding districts have too many beds. Is it fair or ethical to deny life-saving emergency care to Plainfield because of excess beds in other districts? That type of thinking is archaic.

Is it consistent policy when the Planning Board requires one hospital to comply completely with their guidelines and allows another hospital to receive special consideration?

The task force I am sure understands the frustration our community is feeling over this process. To that end, maybe the process is not broken.

Could it be that Edward Hospital's proposal

has become a personal issue for some of the Board members?

From watching the proceedings, it certainly appears that David Carvalho and Jeffrey Mark have been relentless in their opposition to Plainfield's certificate of need, and they have dominated most of the dialogue taking place at the meetings. Yet other hospitals with similar CON applications have moved quickly without complete compliance and a lot less negativity.

We ask for your help in overcoming the obstacles that Edward Hospital and the Village of Plainfield have been dealing with for six long years. Our Village president and Board of Trustees know that reform is very difficult in this political climate.

We thank all of you for your efforts, and we will assist in any way we can to improve the health care for all Illinois residents.

Thank you.

CO-CHAIR GARRETT: Thank you very much. So we can't comment on, but a question quickly.

MEMBER ROBBINS: Just a quick -- I

know you don't like the outcome so far, but what is it about the process that you specifically object to that you think could be improved?

MR. DEMENT: The thing that I see is that we have a definite need in our area. We have the lowest -- one of the lowest hospital-beds-to-patients ratios in the state. That is a substantial need. We need that particular legislation changed.

And when we have to drive 35, 40 minutes to get emergency care in this state, when most other districts don't have that problem, that's not only unfair, it's unthinkable. It's unthinkable to our residents because every one of you know how important the first five minutes is in an accident or an emergency.

We're being put in this traffic mess that we can't get through. It's involving the lives of our children in my estimation, everyone, but our children and grandchildren. That's some of the concerns we're dealing with, and I feel very strongly that we're not getting supported by the ex-officio members on the Health Facilities Planning Board.

MEMBER ROBBINS: So you think they have wrong bed need methodology or the wrong travel time methodology?

MR. DEMENT: Yeah, some of that.

CO-CHAIR DUGAN: Travel times we have talked about. Especially in Plainfield, I know I've been stuck there. You could sit there for 25 minutes to travel to --

MR. HARRIS: Yes, we have.

CO-CHAIR DUGAN: So, I mean, that is something that has been brought up here.

MR. HARRIS: We'll submit more than a handful of things that specifically go to this issue, but I think again we want to highlight that when you're looking at the bed ratio, that is relevant.

The economic side of it, we see the real world where we'll have, for example, a significant retail center coming into the Village of Plainfield, and we have a similar significant retail center coming into Bolingbrook, our neighbor. Both of them do exceedingly well. Both of them have high traffic. Both of them have very similar stores and indeed have gotten along quite

well.

We see that that is not happening on health care, where we can't get to the other access. So even if you look at a 45-minute time line to get there, often it means you're going through roads that have changed their names three times. We actually don't have any thoroughfare. Indeed we can't even afford to put the traffic lights in yet. We've grown so large -- or so quickly in a large area that has become quickly densely populated, very relevant to us.

So I'll go back and highlight the three things: One, high-growth areas that don't meet any of the expectations. Even when the rules were changed, they haven't been implemented the way indeed I think they were intended.

Secondly, that it is not an open process where these discussions about specifics that affect the residents and/or the patients of District A-13 have been heard. Certainly, the testimony has been taken, but they have not been heard and/or addressed by anybody.

Then thirdly, I think that we see that six years of going through this process is not

something that as a municipality or as a business or even as access to health care is something that you can quantify, and the way it effects the Village of Plainfield in its own planning, as well as the business side of it seems completely irrational and a poor way to do business whether it's for a village or for a state or for our health care.

CO-CHAIR GARRETT: Senator Brady.

MEMBER BRADY: Do you think that the criteria or the way you're suggesting is that the legislature or some other body are better defined?

MR. HARRIS: I think the elected officials would say categorically, yes, because we saw Bolingbrook actually have a hospital approved with actually more negatives than a hospital that was denied in the Village of Plainfield.

MEMBER BRADY: Secondly, do you feel it's unfair that someone in your situation has to appeal back to the same body that denied you; and therefore, something we ought to consider is a different appeal board for these decisions, as opposed to having to appeal back to the same body that's denied you repeatedly?

MR. HARRIS: Yes, and not only do we think yes, but we're very concerned that we're not a part of the process whatsoever.

The opportunity for your Chairwoman to actually have us speak in front of you is about the first voice we've had formally in six years, and indeed, remember, this is somebody that is reviewing the Illinois Health Facilities Planning Board, not actually the Health Facilities Planning Board directly.

MEMBER LYNE: Have there been public hearings?

MR. HARRIS: There has actually been testimony that's been taken, correct.

MR. DEMENT: But no Health Facilities Planning Board member was ever there.

MEMBER LYNE: Yeah, but people who knew about it came.

MR. LOMB: Oh, yeah, a lot of activity came, a lot of testimony, and we submitted --

MEMBER SCHAPS: Who organized that?

MEMBER LYNE: Was it positive?

MR. DEMENT: We had over 30,000 signatures from our community.

MR. HARRIS: As a matter of fact, Trustee Dement was just saying that we had over 30,000 -- with 38,000 people within the Village of Plainfield, we had 30,000 people submit letters of support for this hospital and indeed testimony. We filled our Village Hall, a brand new facility --

MEMBER LYNE: Was it positive?

MR. HARRIS: -- actually six different times for actual testimony that took longer than this meeting, if you can believe that.

But then may I also say that, yes, there have been objectors, and those are the other hospitals in the area that have indeed objected --

MEMBER LYNE: Like Joliet or --

MR. HARRIS: -- but we don't see that from the municipality side. Again, indeed, when we talk about patients and/or community, we want to get back to, when you're reviewing from a task force perspective, what the patients and what the community -- what the real impact of access to health care is because we're not a part of the process.

MEMBER LYNE: And the 35 to 40 minutes

was done by, you know, traffic experts?

MR. HARRIS: Yeah, as a matter of fact, in our --

CO-CHAIR GARRETT: I don't think anybody knows that.

MR. LOMB: That's one of the rules. It's one of the rules. It's been done at peak periods versus nonpeak and so on, so yes, it's been done, but the rules are the problem.

MR. DEMENT: -- over-built.

MEMBER BRADY: Crain's just came out with a release that showed that Chicago had 1,000 beds -- that Will, excuse me, had a population of 1,000 people per bed, and Chicago had 281, meaning, the whole thing is skewed. We haven't any information yet from our guys, which I've asked for, but the Crain's report shows this is ludicrous.

MEMBER LYNE: In '06 was that published?

CO-CHAIR GARRETT: Well, I think their point is that the municipalities don't have a voice in the process, and they ought to because if the hospitals control the process, of course,

they're going to deny the right for any other hospitals to come in. That's good for them, but not good for the people, good for the municipality, who both jointly agree.

Kurt, go ahead.

MR. DeWEESE: I have just two things. One is that if they would clarify the status of their application. It is still pending, I believe.

Also in relation to the bill that passed, the 12.5, I didn't hear where in that section, you know, we need to, I guess further -- we went through several iterations of that section and thought we had it right to address the Edward Hospital situation specifically at the request of some of the members of the House. It seemed like we were where you wanted to be, but what is there in the implementation that has affected the current determination?

MR. HARRIS: Sir, I think I would like to repeat that from the Village of Plainfield's perspective, we do not have an application in front of you. We're not a part of the process.

Indeed, there is someone that's actually

looking to build a hospital within the Village of Plainfield, and the Village of Plainfield just wanted to highlight the importance of access to health care and A-13, that indeed we're ultimately the crossroads for not only commuters getting to work or indeed kids getting to school or we think the residents of our area getting to a hospital.

When we talked about -- when we talked about 12.5 --

MR. DeWEESE: I understand that you are not the applicant, but obviously the current applicant --

CO-CHAIR GARRETT: What is the status of the application?

MR. HARRIS: My understanding is, just represented by staff here, that it was deferred last week.

CO-CHAIR GARRETT: Again, the third time.

MR. DeWEESE: So it is still pending.

MR. LOMB: The third application is still pending. That's correct.

MEMBER BRADY: I think, Kurt, they misinterpreted what our intent was.

CO-CHAIR DUGAN: Right, and that's what we're saying from 12.5, Senator Brady. I think that's what Kurt is asking. We thought when that was granted, that we addressed what the concerns were from other representatives. Are you saying it's not working?

MR. HARRIS: Representative, I would agree that we all thought indeed the legislation was appropriate; but through that process when we were actually -- the Village of Plainfield thought that access to health care within A-13 would be addressed, it was deferred because it had not gone through the rules committee. JCAR had not reviewed that process.

So we had gone and actually had one more delay in the six-year odyssey, but more importantly, I think all of us felt like a lot of work and effort went into looking at a high-growth area and identifying what a high-growth area was. The review of that has come down to, as one of the task force members had identified, that somebody like even Crain's has identified where there's more than two beds per 1,000, almost three beds per 1,000 in Illinois, and A-13 has less than one.

CO-CHAIR GARRETT: But in the Section 12.5, which takes into consideration A-13 -- so your application could have been deferred because, in fact, the rules haven't been finished on this?

MR. HARRIS: No, that was the last time. This most recent time, it actually has been --

MEMBER BRADY: They've done that, but I think what they'll tell you is we -- they said when you look at how they rated it, they're interpreting it differently than we intended it to be interpreted.

MR. LOMB: That's probably correct.

CO-CHAIR GARRETT: We appreciate so much you spending all this time out there, and it's very helpful to us.

MR. HARRIS: Well, in your future efforts --

MR. DEMENT: There's two things that I would just like to point out before I leave. The Health Facilities Planning Board, I think it has a degree of flexibility or discretion. Exactly what that is, I can't say as a Village Board member, but I think their discretion is fairly wide.

That's one issue.

The other issue I want to just leave on is that safety net. You've all talked about safety net today. Well, safety net not only applies to communities that are very poor, it also applies to average communities like the Village of Plainfield that are growing. Because when we don't have good, solid medical care, the safety net is not there for us. How are we going to adjust it, when it's not even there?

It seems like because we're an average community on the fringe of development, we get overlooked. If we were probably a very poor community, I'm sure we would get more, you know, input from the Health Facilities Planning Board.

But we have, you know, need in our community. We have a population. We have bed problems. Why can't we get it done? I don't really know. I think we need to talk to the Health Facilities Planning Board and their ex-officio members.

CO-CHAIR GARRETT: We appreciate it so much. Thank you very much.

MR. HARRIS: We appreciate all your

ideas, and we'll submit the letters that are addressing the things to reform very specifically based on the odyssey that we've gone through.

CO-CHAIR GARRETT: Kurt, you might want to look into, whoever staff is, Lisa -- Melissa, I'm sorry, Section 12.5 and the A-13 to see what's happening there.

CO-CHAIR DUGAN: Or what's not happening that should be.

MR. DeWEESE: And where the rule process is --

MEMBER BRADY: I sent a letter to all of you Friday addressing the question that I think is specifically to why our legislation didn't affect them. Can we get David and Jeffrey to respond to that letter, as well as to questions we've got --

CO-CHAIR GARRETT: Did you send it to them, too?

MEMBER BRADY: I sent it to them.

CO-CHAIR GARRETT: To all of us?

MEMBER BRADY: To all of them.

CO-CHAIR DUGAN: I wasn't going to say, I didn't get one.

CO-CHAIR GARRETT: I never got it.

MEMBER BRADY: It should have gone out Friday.

CO-CHAIR GARRETT: Well, today is Monday.

CO-CHAIR DUGAN: We might want to make sure we have copies of these, too.

CO-CHAIR GARRETT: Is there any other business before the task force?

MEMBER BRADY: I've got a couple of questions I'd like to ask, follow-ups. It won't take long.

CO-CHAIR GARRETT: Okay. We all have to go.

MEMBER BRADY: What's our agenda for the next meeting?

CO-CHAIR GARRETT: I don't know yet. We're just trying to get through this one.

CO-CHAIR DUGAN: Former members of the Board.

MEMBER BRADY: The letter I would like them to address.

CO-CHAIR GARRETT: Can we get that letter, and then we'll respond to it? I promise

you. We're very good about that.

MEMBER BRADY: You are.

CO-CHAIR DUGAN: We do respond.

MEMBER BRADY: You are.

CO-CHAIR GARRETT: If there's no other business before us, we will adjourn until September -- August, what are we?

CO-CHAIR DUGAN: August 15th.

CO-CHAIR GARRETT: August 15th. Thank you very much.

(Which were all of the proceedings had in the above-entitled matter ending at 2:31 p.m.)

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

I, Joanne E. Ely, Certified Shorthand Reporter No. 84-4169, Registered Professional Reporter, a Notary Public in and for the County of Kane, State of Illinois, do hereby certify that I reported in shorthand the proceedings had in the above-entitled matter and that the foregoing is a true, correct and complete transcript of my shorthand notes so taken as aforesaid.

IN TESTIMONY WHEREOF I have hereunto set my hand and affixed my notarial seal this _____ day of _____, A.D. 2008.

_____
Notary Public

My commission expires
May 16, 2012.