1. Issue of licensed beds not being used within a given time frame
2. Pros and Cons of Bed Transfers

The issue of excess licensed beds in the system poses many challenges for the planning process while the formula establishes criteria for determining the number of licensed beds needed it does not adequately address the availability of alternative services that are not accounted for nor governed by the planning formula and as a result occupancy has steadily declined from the planning target of 90%. The Long Term Care Questionnaire provides self reported occupancy peaks as well as census as of December 31 of the reporting year however staff as well as subcommittee members question its reliability as a planning tool. In addition there is concern that modification to the manner in which licensed beds are counted could have unintended adverse effects on availability of beds particularly for Medicaid funded individuals throughout the state and particularly in specific planning areas.

New projects awarded by the Health Facilities and Services Review Board are required to achieve 90% occupancy of their licensed capacity within 24 months I propose that failing to do so should have the licensed bed capacity reduced to 90% of the peak census. Although the 90% occupancy target is an existing requirement there is no consequence of not achieving this outcome as a result projects retain licensed capacity despite not ever hitting occupancy targets. This adds an enforcement component to the planning process that is currently lacking as well as providing a strategy to adjust the number of new licensed beds being added to the inventory based on utilization. This would be a first step in slowing the number of new beds being added to the inventory.

Bed transfers or bed buying and selling adds a dimension to the existing system that currently doesn't exist in Illinois this introduces new variables which require careful consideration. The advantages of enabling facilities to add beds to meet consumers' needs over and above the 10% or 20 beds rule provides a means for facilities to develop new unique programs for consumers that are not currently being met. This is different than adding beds to serve an expanding number of existing residents/patients which the 10% or 20 beds rule satisfies. New programs require a minimum number to maintain integrity from quality of care, quality of life, and financial perspectives. This provides an alternative for facilities in planning areas that do not have a bed need but have demand for services that are not being met by competing facilities whether this be due to lack of Medicaid beds, poor quality, sponsor groups (ethnic, religious, service league), etc.

Facilities can downsize by converting excess capacity to capital and reinvest in modernizing the environment, furnishings, and equipment to be more competitive. Alternatively facilities are either closed or sold. The process should remain subject to an expedited planning process, track where beds are, validate that buyers and sellers satisfy minimum requirements, etc. to maintain the integrity of the system. Proceeds of the sale of beds must be used to improve the facility and retire debt.

Among some of the pitfalls are no facilities willing to sell beds, current values of facilities are based on the number of licensed beds and how that is recalculated, buyers hoarding beds to increase the value, new projects trying to sell beds before the end of the initial 24 month period, facilities at risk of losing their license selling beds, new projects that are denied buying beds, purchased beds not hitting occupancy targets, etc.