City of Bloomington
Common Council

Legislative Packet

Regular Session
6 December 2006

Office of the Common Council
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City of Bloomington Indiana

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To: Council Members
From: Council Office
Re: Weekly Packet Memo
Date: December 1, 2006

Packet Related Material

Memo
Agenda
Calendar

Notices and Agendas:

Notice of Sidewalk Committee on Monday, December 11th at noon in the Council Library

Committee Reports

Disclosure of Conflict of Interest for Duncan Campbell, an Appointee to the Historic Preservation Commission

- Memo from Jacqueline Moore, Assistant City Attorney

Contact: Jacqueline Moore at 349-3551 or moorej@bloomington.in.gov

Legislation Scheduled for Announcements and Final Actions:

Ord 06-24 To Repeal and Replace Title 20 of the Bloomington Municipal Code Entitled, "Zoning", Including the Incorporated Zoning Maps, and Title 19 of the Bloomington Municipal Code, Entitled "Subdivisions"

- Announcement of Decision to Further Consider UDO; Revised Schedule for Consideration of the UDO

Contact: Daniel Sherman at 349-3562 or shermand@bloomington.in.gov

Res 06-14 To Confirm Resolution 06-13 Which Designated an Economic Revitalization Area, Approved a Statement Of Benefits, Authorized a Period of Tax Abatement, and Declared Intent To Waive Certain Statutory Requirements - Re: 2300 Rockport Road and 2101, 2105, 2109, 2112, 2113, 2116, 2117, 2120, 2121, 2124, and 2125 Susie Street (City of Bloomington Department of Housing and Neighborhood Development, Petitioner)

- Statement of Benefits

(Please see the materials regarding Res 06-13 and Ord 06-23 as found in the 1 November 2006 Council Legislative Packet.)

Contact: Ron Walker at 349-3534 or walker@bloomington.in.gov
Danise Alano at 349-3477 at alanod@bloomington.in.gov

Res 06-17 A Resolution Supporting the Renewal of the Bloomington Urban Enterprise Zone

- Zone Map; Memo from Doris Sims, Assistant Director of HAND

Contact: Doris Sims at 349-3510 or simsd@bloomington.in.gov

Res 06-16 A Resolution Supporting State and Federal Legislation Enacting Universal Publicly-Paid Health Insurance

- Memo from Dr. Robert Stone, Director, *Hoosiers for a Commonsense Health Plan* and State Coordinator, Indiana Chapter, *Physicians for a National Health Program;* Articles from following sources: New England Journal of Medicine, NY Times and the New Yorker; Congressional testimony by the Commonwealth Fund.

Contact: Dr. Robert Stone at 333-8085

Legislation and Background Material for First Reading:

Ord 06-25 Establishing the Commission on the Status of Black Males as a Permanent Commission

- Memo from Craig Brenner, Special Projects Coordinator for the Community and Family Resources Commission and Liaison to CSBM; 2005 Annual Report

Contact: Craig Brenner at 349-3471 or brennerc@bloomington.in.gov

Ord 06-26 To Authorize the Issuance of Bonds by the Monroe County Redevelopment Commission Pursuant to IC 36-7-14-3.5

- Memo from Financial Solutions Group; Indiana Life Sciences Education & Training Institute – Draft Business Plan

Contact: Susan Failey at 349-3553 or faileys@bloomington.in.gov

Ord 06-27 To Vacate a Public Parcel - Re: Right-of-Way Running North /South Along the East Side of 111 South Grant Street (Trinity Episcopal Church - Rectors and Wardens, Petitioners)

- Map of Area; Map of Right-of-Way; Memo to Council from Lynne Darland, Zoning and Enforcement Manager; Petition; Letter from Petitioner; Rendering of Proposed Improvements; Photographs of Site; Photo Rendering of Proposed Improvements; Note of Support from Mayor; Transmittal Letter to Utilities; Insert Indicating Utility Responses

Contact: Lynne Darland at 349-3529 or darlandl@bloomington.in.gov

Minutes from Regular Session:

None

Memo

Two Packets for Meetings During the Week of December 4th through 8th – One for the Regular Session on Wednesday and Another for the Special Session on Monday and Thursday Regarding Amendments to the Unified Development Ordinance

We have two legislative packets for you to review during this first week of December. The first is for the Special Session on amendments to the **Ord 06-24** (Unified Development Ordinance) and includes the amendments you are scheduled to consider at meetings on Monday and Thursday night that begin at 6:00 p.m. You should also bring your November 27 – 29, 2006 Council Legislative Packet for those meetings as well. The second is the December 6, 2006 Council Legislative Packet (this one) which contains items for the Regular Session on Wednesday night. Those items are discussed below.

Disclosure of a Conflict of Interest

There is a Disclosure of Conflict of Interest for you to accept on Wednesday night regarding one of the appointments to the Historic Preservation Commission (HPC). Duncan Campbell serves on the HPC as, in essence, a joint appointment of the Mayor and Council. He may be awarded $400 grants throughout the year for consultation services with the City. The attached state disclosure form announces this financial interest before the transaction occurs and would insulate Duncan from certain liabilities once it has been accepted and filed with appropriate officials.

Second Readings

Item One – Decision and Announcement in Regard to Further Consideration of Ord 06-24 - Unified Development Ordinance (UDO)

We are in the midst of considering the UDO during the course of Special Session meetings that began last week and should wrap up on December 20th, rather than as originally scheduled on December 14th. The change in date will assure that we have complied with statutory procedures. Statute requires that the Council decide whether to further consider the UDO at the first regular meeting after the UDO has been certified to us and announce as well as publish notice of that decision at least 10 days before a hearing where you will consider written objections to the proposal. We can comply with statute by deciding and announcing further consideration of the UDO on Wednesday, publishing notice of that decision and of a public hearing for written

objection soon after, and holding that public hearing on December 20th in the course of taking final action on the ordinance.

Item Two - Res 06-14 Confirming Res 06-13 - Re: Granting Tax Abatements for the Construction of Single-Family, Energy-Efficient, "Green" Affordable Housing on 12 Lots in Evergreen Village Subdivision at 2300 Rockport Road and Along Susie Street

Res 06-14 confirms Res 06-13 which granted preliminary approval for tax abatements for the construction of single-family affordable, energy efficient, "green" housing on 12 lots in Evergreen Village Subdivision located at 2300 Rockport Road and along Susie Street. As noted in the materials sent out with the initial tax abatement, which can be found in the 1 November 2006 Council Legislative Packet, the HAND department is pursuing this affordable housing project on property owned by the Redevelopment Commission. Please note that the buyers would ultimately be the ones to benefit from the tax abatement.

The previous resolution (Res 06-13) was passed on November 8th. As noted in the memo for those pieces of legislation, the resolution took four actions which included:

- designating an Economic Revitalization Area (ERA),
- approving a Statement of Benefits,
- authorizing a 5-year tax abatement on improvements to real estate, and
- declaring intent to waive certain statutory requirements.

The proposed resolution confirms the first three actions and then waives the aforementioned statutory requirements. Those requirements deal with the timing of the project in relation to the certain steps in the tax abatement procedures. Under statute, the petitioner must file a completed statement of benefits and the Council must make the necessary finding of facts as well as designate the ERA prior to commencement of the project, unless those order of events are waived by the Council after it has held a legally advertised public hearing. (See I.C. 6-1.1-12.1-11.3)

That public hearing will take place during the public comment on this resolution at the December 6th Regular Session. It will also serve as an occasion for the Council to consider not only the objections to the waiver, but also the designation of the ERA. Please note that, in accordance with statute, the City Clerk has filed information regarding the proposed abatements and their benefits in the requisite governmental offices and also published notice of those filings and the upcoming public hearings.

Please also note that the City has already adopted Ord 06-23 which is required by statute and designated these lots as an Economic Development Target Area (EDTA). This designation broadens the list of uses ordinarily eligible for a tax abatement to include affordable housing in single-family residences.

Item Three – Res 06-17 – Supporting the Renewal of the Bloomington Urban Enterprise Association (BUEA) and Enterprise Zone

Res 06-17 supports the efforts of the Bloomington Urban Enterprise Association (BUEA) to renew our enterprise zone (Zone) for a final five years. The following paragraphs borrow from the memo from Doris Sims, Assistant Director of HAND, the renewal application (which is available in the Council Office), and material prepared for previous actions by the Council.

History

Enterprise zones were created by the General Assembly in 1983 to offer a package of tax incentives that help revitalize and generate employment in a distressed area within a locality. Our Zone began in 1992 with the encouragement of the former State Department of Commerce as a way to help Thomson Consumer Electronic and the community (see Res 91-37).

Thomson and the other zone industries saw immediate savings because, under a reinvestment agreement, they could keep 80% of their inventory tax and turn the other 20% over to the Zone. This money, along with other nominal revenues, was then available to foster reinvestment, encourage loans, and benefit individual residents of the zone. Over the next few years, the BUEA increased business participation in the program, helped with the expansion of zone businesses, and worked with neighbors regarding zone programs and projects. Then the departure of Thomson in 1997 significantly reduced zone revenues and led the BUEA to expand the boundaries of the Zone when it obtained a five-year renewal in 2002 (See Res 01-26).

As a cost-saving measure, the BUEA also agreed to let the City serve as administrator in 2000 and those duties were transferred from the Economic Development to the HAND department in 2002.

BUEA Composition and Duties

The BUEA consists of 12 members from the business and labor sectors, state and local government, and residents of the zone, who are appointed by the Governor (2), Mayor (6), and Council (4).

Under I.C. 5-28-15-14 it is required to:

- coordinate zone development activities and serve as a catalyst for zone development;
- promote the zone to those outside of it;
- establish formal lines of communication with zone residents and businesses; and
- serve as liaison between residents, businesses, the City, and the state board for any development activity that may affect the zone and its residents.

And, along with those required duties, it may:

- commence and coordinate community development activities that help employ residents of the zone, improve its physical environment, foster capital investment, and advise the City on use of Tax Incremental Finance District funds within its boundaries;
- recommend changes to the zone boundary and disqualification of zone businesses for zone benefits and incentives;
- incorporate as a nonprofit corporation (in which case it may receive land from the City's Redevelopment Commission); and
- request modification of a state or local law or regulation affecting the zone, which may be granted as long as it does not affect the health, safety, civil rights, or employment rights.

Request for Renewal

The Council is considering this action because statute limits the duration of an enterprise zone to 10 years, but allows the local associations to seek renewal with the Indiana Economic Development Corporation (state board) for another two five-year periods. We are now at the end of the first of those extensions. During the last two years of each term (otherwise known as the "phase-out period"), the state board may review the success of the enterprise zone and renew it based upon the following criteria:

- Increases in capital investment in the zone;
- Retention and creation of jobs within the zone; and

- Increases in employment opportunities for residents of the zone.

Accomplishments and Plans for the Future

According to the memo from Doris Sims and the application for renewal, the BUEA started a number of programs and initiatives since 2002. They include:

- a business consulting partnership with the South Central Small Business Development Center (SCSBDC) – which provided technical assistance to 63 businesses since 2003;
- a micro enterprise loan program through the SEED Corp. which manages a $50,000 revolving loan fund and provides loans for emergencies and physical improvements;
- scholarship programs for zone residents in concert with IVY Tech and the SCSBDC - which provided 22 scholarships to IVY Tech and six scholarships for other educational opportunities in the last five years;
- a low interest loan program for the remodeling and renovation of zone businesses – which has provided $90,000 in the last five years;
- grants of up to $10,000 for the historic restoration of the facades of zone business buildings – which amounted to about $75,000 in last five years;
- a school grant program - which provided $105,000 since 2003 to schools within the zone; and
- special projects – which provided $117,000 for the City's B-Line Trail, $100,000 to Middle Way House to help acquire the Coca-Cola Building; $75,000 to Rhino's to buy and renovate real estate in order to expand their facilities; over $45,000 to improve sidewalks and plant trees in two zone neighborhoods, among other actions, in the last five years.

In the next five years, the BUEA intends to continue these core programs and start new ones and in its renewal application set forth program objectives and benchmarks for these programs. It also intends to expand its marketing to residents and businesses in the Zone. Please see the *BUEA webpage* for a brief description of the existing programs.

BUEA Revenues – Participation Fees

Doris Sims indicates that the Zone fund had a balance of approximately $4363,425 as of November 20th. Zone businesses contribute most of the Zone revenues by paying 20% of certain incentives and tax benefits they receive to the fund in the form of participation fees. The bulk of those fees previously came from the inventory taxes

zone businesses were allowed to forego, but that revenue stream expired this year. Other contributions come from their receipt of a gross income tax exemption, wage tax credit, investment cost credit, loan interest credit, and an enterprise zone investment deduction. The latter incentive began this year and led the City and the BUEA to enter into an agreement (approved in Ord 06-03) where the amount tied to certain tax abatements in our TIF districts would be returned to those TIF districts.

Total revenues should amount to about $163,500 this year, but should significantly shrink to about $60,000 when the inventory tax ends with the payment of taxes in 2007. Those revenues may then increase in the future when fees from the investment deduction begin to flow.

Item Four – Res 06-16 Supporting State and Federal Legislation Enacting Universal Publicly-Paid Health Insurance

This resolution is sponsored by Councilmembers Mayer, Ruff, Gaal and Diekhoff who worked closely with Dr. Robert Stone, Director, *Hoosiers for a Commonsense Health Plan* and State Coordinator, Indiana Chapter, *Physicians for a National Health Program*

Documenting the health care crisis in the United States, the resolution points out that:

- over 46 million Americans, 860,000 Indiana residents, and 15,000 Monroe County residents have no health insurance; and

- over 18,000 people die every year because they lack adequate health care; and

- tens of millions of Americans are under-insured, lacking sufficient coverage for vital care and medications; and

- even those with adequate insurance are facing growing premiums, co-payments and deductibles, as well the fear that their insurance may be cancelled (Indeed, a recent report issued by the Employee Benefit Research highlights that 60% of insured Americans reported paying increased amounts out of pocket for health expenses, causing 36% to reduce contributions to retirement plans, and 28% to have problems paying for

basic necessities like food and utilities. Employee Benefit Research Institute, *2006 Health Confidence Study*, 27:11 (November 2006).); and

- illness and medical bills are the leading cause of personal bankruptcy in the nation

To address these social problems, the resolution calls for universal publicly-paid health insurance that would provide for physician and hospital visits, pharmaceuticals, preventative care, dental care, long-term care, substance abuse treatment and mental health care without deductibles and co-payments, and would provide all patients and providers freedom of choice.

The resolution supports HR 676 the *United States National Health Insurance Act*, introduced by U.S. Representative John Conyers, Jr. HR 676 would create a publicly- financed, privately-delivered health care system that uses the already existing Medicare program by expanding and improving it to all U.S. residents, and all residents living in U.S. territories. The goal of the legislation is to ensure that all Americans will have access, guaranteed by law, to the highest quality and most cost effective health care services regardless of their employment, income, or health status.

The resolution also supports a proposal for universal, publicly-paid health care in Indiana to be introduced in the Indiana legislature in January 2007 and directs the City Clerk to send a copy of the resolution to the President of the United States, members of the Indiana Congressional Delegation, other members of the United States Congress in positions of leadership in the House and Senate and their committees with jurisdiction over public health, the Governor of Indiana and members of Bloomington's delegation to the Indiana legislature, and other leaders of the State legislature as deemed appropriate. The resolution also requires a copy of the resolution shall be posted on the City's web site.

In 1994, the Common Council passed Res 94-54 calling for a universal health care system. As Dr. Stone points out in a *Memorandum* accompanying this resolution, in the twelve years since Council passed Res 94-54, the crisis has only worsened: in 1994, 38 million Americans were uninsured, today more than 46 million are without coverage. "Co-payments and deductibles continue to skyrocket and the U.S. Congress has not enacted any substantial reform." Dr. Stone points out that the local Volunteers in Medicine corps are aggressively working to expand the current Community Health Access Program in an effort to reach even more community members in need. However, Dr. Stone emphasizes that this important

local effort, while key, does not address the larger social problem of the growing number of uninsured.

As explained in the attached journal article from the New England Journal of Medicine, *Cost of Health Care Administration in the United States and Canada*, and recounted by Dr. Stone, the U.S. spends 31% of its health care dollars on administration by private insurance companies. This compares with 16.7% in Canada's national health insurance program. The average overhead of U.S. private insurers (11.7 percent) exceeded that Canada's national health insurance program (1.3 percent) and Medicare (3.6 percent). *N. Engl J Med* 2003; 349: 768-75. As Dr. Stone highlights, "private insurance companies are posting record profits and their executives are raking in millions." Economist Paul Krugman explains the disparity: "According to the (World Health Organization), the higher costs of private insurers are 'mainly due to the extensive bureaucracy required to assess risk, rate premiums, design benefit packages and review, pay or refuse claims.' Public insurance plans have far less bureaucracy because they don't try to screen out high-risk clients or charge them higher fees." *Passing the Buck*, The New York Times, 4/22/2005.

Res 06-16 holds health care to be a basic human right and calls for a public-paid health insurance program to realize this universal right.

First Readings

Item One – Ord 06-25 – Establishing the Commission on the Status of Black Males as a Permanent Commission

Ord 06-25 makes the Commission on the Status of Black Males (CSBM) a permanent commission, like all other City boards and commissions. Recall that the CSBM was created in February 2001 to address the issues faced by African-American males in the areas of health, employment, criminal justice and education. Unlike any other board or commission, the enabling legislation for the CSBM contains a sunset provision which calls for the Commission to be reviewed every three years for the desirability of reauthorization. This ordinance eliminates the sunset provision and makes the CSBM a *permanent* commission in the interest of uniformity. The ordinance also makes two changes in the terms of service. First, it "cleans up" an outdated provision that speaks to initial terms of office as expiring on January 31, 2002. Secondly, it eliminates the requirement that all subsequent terms shall be for two years and expire on January 31. Controlling for both

changes, the proposed ordinance simplifies the term requirement as: "[t]he terms of all members of the commission shall be for two (2) years."

History

The CSBM was established at the recommendation of City administration, the MLK, Jr. Day Celebration Commission, and a group formed to study the merits of creating a commission devoted to the well-being of black males. The group filed a report recommending that the City create this new commission in order to:

- Document local condition of black males through forums; and
- Identify and address hazards that place local black males at grave risk particularly in the areas of employment, family, education, criminal justice and health; and
- Complement the work of the State Commission in recommending legislation, community education and action.

Appointments to the CSBM

In response to the above report, the City created the seven-member Commission; three members are appointed by the Mayor and two are appointed by the Council. The Bloomington Human Rights Commission appoints one member as does the MLK, Jr. Day Celebrations Commission. When making appointments, these entities are allowed to give preference to people with expertise in, or representing, one or more of the following areas: education, health, employment, criminal justice, Black history, the faith community and the social service community. As mentioned previously, Commission members serve a two-year term. The current members of the Commission are: Larry Brown, Cedric Harris, William Knox, David Hummons, George W. Tardy, Jr. Paulette Patterson Dilworth and Bev Smith.

Powers and Duties

According to BMC 2.23.070 the CSBM is empowered to:

- Develop action committees addressing problems of Black males in education, health, criminal justice and employment; and

- Serve as a catalyst to promote positive public and private remedies to the multi-faceted problems confronting Black males in our community and the resulting effects on the entire community; and

- Organize and convene community forums and neighborhood-based focus groups to discuss the status of Black males; and

- Network with like-minded groups such as the Indiana Commission on the Social Status of Black Males, the African American Male National Council and local commissions throughout the state, sharing ideas, information, data and plans.

Annual Reports

The Commission's enabling legislation requires the Commission to provide the Council and the Mayor with an *Annual Report* by the end of February of each year describing past and future activities. According to the *Report* issued in February 2006 (and included in this *Legislative Packet*), the Commission made great progress on several on-going initiatives. Recall that the Commission's 2004 Town Hall meeting on "Race, School Discipline, and Criminal Justice" resulted in creation of the Monroe County Community School Corporation (MCCSC) *Human Understanding and Diversity Forum*. After gathering feedback from the public, faculty, staff, and members of the Commission, the forum issued recommendations in December 2005 to MCCSC School Superintendent that address the school corporation's policies and procedures. The recommendations are appended to the Commission's *Annual Report.*

During 2005, the Commission also: addressed increasing the pool of African-American applicants for City positions; worked with the community's Racial Justice Task force to address the goals enumerated at the Town Hall Meeting, including the recommendation to place video cameras in all police vehicles in Monroe County; participated in the re-naming ceremony of *Ninth Street Park* to the *Rev. Ernest D. Butler Park*. The Commission continued its work with the Indiana Commission on the Social Status of Black Males and participated in the *7th Annual African American Male National Conference: Education vs. Incarceration,* in Indianapolis, where the Commission presented two workshops to attendees from around the country on the topic *Developing a Local Commission: Best Practices*. The 2005 *Annual Report* notes that during 2005, many guests and members of community and governmental organizations attended CSBM meetings in 2005. The Commission concluded 2005 by creating a new award to be presented annually during Black History Month that will recognize and affirm young African American males.

As indicated in the attached *Memorandum* from Craig Brenner, Special Projects Coordinator for the Community and Family Resources Commission and Liaison to CSBM, the Commission has continued its outreach and problem-solving work in 2006. The Commission began 2006 by presenting the first annual award recognizing and affirming young African American males to Bloomington High School North Junior Matt Herndon.

In 2006, the Commission continued to address the goals of the community's Racial Justice Task Force and convened representatives of local law enforcement agencies, including City of Bloomington Police to work toward the placement of digital video cameras in all police vehicles. As is noted in the *Memo*, the Commission continues to work closely the Indiana Commission on the Social Status of Black Males and its Executive Director attended a CSBM meeting in 2006. In October, the Commission was a co-sponsor of a Town Hall Meeting on Healthcare moderated by Dr. Edwin Marshall.

In November, the Commission held a planning retreat at which it discussed specific initiatives planned for 2007. As stated in the *Memo*, those initiatives include: instituting a mentoring program during the lunch hour in the public schools; supporting the 2007 *Men of Color Conference* at IU by providing programming specifically aimed at high school students; continuing to work with Dr. Edwin Marshall on health issues of concern to Black males; and reaching out to the new Monroe County Prosecutor.

Item Two - <u>Ord 06-26</u> Approving the Issuance of $5 Million in County Westside TIF District Bonds for the Construction of a Life Sciences Institute at IVY Tech

<u>Ord 06-26</u> approves the issuance of $5 million in County Westside TIF District bonds for the construction of an Indiana Life Sciences Education and Training Institute at IVY Tech. According to the business plan (attached), "this facility will be a partnership between Monroe County, Ivy Tech Community College-Bloomington, Bloomington Economic Development Corporation, Bloomington Life Sciences Partnership and local industry" and nurture a workforce that will serve this growing sector of the local economy. State law gives us a role in the County's decision because we have annexed three parcels within this TIF district and need to protect our interest in the tax revenues that flow from those parcels. This ordinance, in essence, concludes that our interest in these tax revenues is not impaired by the refunding of these bonds and approves the transaction.

Item three - <u>Ord 06-27</u> – Vacating a Strip of Right-of-Way Next to the Trinity Episcopal Church at 111 South Grant Street

<u>Ord 06-27</u> would vacate a strip of right-of-way next to the Trinity Episcopal Church at 111 South Grant Street in order to add to the west side of the church to make it more secure and more accessible to persons with disabilities.

<u>General Vacation Procedures</u>

Vacations of right-of-ways are governed by specific statutory procedures. Those procedures are found at I.C. 36-7-3-12 et seq. and start with the petitioner filing an application with the Council. The Clerk must assure that owners of property abutting the right-of-way are notified by certified mail of the proposed action and must also advertise the hearing where the public can offer its comments and objections against the ordinance to the Council (October 4, 2006). According to statute, the grounds for remonstration are limited to questions of access and the orderly development of the area. In the event the ordinance is adopted by the Council, then the Clerk must file a copy with the County Recorder and the County Auditor.

In Bloomington, we begin with a pre-petition application submitted to the Planning Department. Staff reviews the request and notifies all the utility services, safety services, and the Board of Public Works of the proposed action. After receiving the responses and evaluating the proposal in terms of local criteria, they prepare a report and an ordinance for the Council Office. The City Clerk then assures that an ad is placed in the paper and that abutting property owners have been notified by certified mail of the public hearing

Please note that the Council's action to vacate a right-of-way or an easement must be done in the public interest. It extinguishes the City's interest in the property and generally has the effect of splitting the right-of-way between the adjacent owners.

The following paragraphs summarize the application of the local criteria to this request as presented in reports and background material provided by Lynne Darland, Zoning and Enforcement Manager.

Petition

The rectors and wardens of the Trinity Episcopal Church are requesting that the City vacate a portion of the Grant Street right-of-way which lies next to their church in

order to move forward with some renovations. The portion they want vacated lies behind the sidewalk and runs for the entire length of the building.

Concerns of Surrounding Property Owners. The petitioners own the abutting property and Lynne does not mention concerns of owners of other surrounding property.

Description of Vacated Property. This ordinance would vacate a 20.24 foot wide by 127.60 foot long swath of street right-of-way along the east side of 111 South Grant Street, which is the side yard of the Trinity Episcopal Church and part of In-Lot No. 112 in the City of Bloomington. Please note that the legal description of this right-of-way was provided by the petitioner and is set forth in the ordinance and a map is enclosed with the materials.

Current Status - Access to Property. The staff report indicates that the Grant Street right-of-way is 82' on this block and the part to be vacated has served as green space and garden area for the church for many years.

Necessity for Growth

Future Status (Utilities and Safety Services) – I.C. 36-7-3-16 protects utilities who occupy or use all or part of the public way from losing their rights upon the vacation of the alley way unless they choose to waive those rights. Lynne has contacted all the utilities and only one raised issues that affected the vacation. In response to comments from CBU, the Petitioner reduced the length of the parcel by 4' on the south end in order to allow for the next phase of storm water improvements downtown. The Police and Fire departments were also contacted and found no problem with the vacation.

Private Utilization – The Petitioner has retained Christine Matheu to plan renovations that will mark the 100-year anniversary of the church. The renovations include additions to the Grant Street side of the church that are intended make the church more accessible to persons with disabilities and make the offices and nursery more secure. Although the Petitioner has not yet filed plans with the City, they have provided preliminary renderings and floor plans for this expansion which are included in the legislative packet.

Compliance with regulations – The Report says that the vacation "will not create any issues regarding compliance with local regulations."

Relation to City Plans – The Staff Report indicates that churches are a permitted use in the Downtown zone under the current zoning ordinance as well as the proposed Unified Development Ordinance (where they are listed as "places of worship") and that the proposal is consistent with City plans.

Growth Policies Plan (GPP) Guidelines and Zoning Requirements – The GPP wants the downtown to be a "compact, walkable, and architecturally distinctive area in a traditional block pattern that serves as the heart of Bloomington…" The site design standards should promote development on a "human scale," with new construction that conforms to "historic patterns of building mass, scale, and placement within a given site." The proposed Unified Development Ordinance (UDO) sets forth detailed standards for architecture in this area of the downtown, which is known as the University Village Overlay district. According to the Report, the "expansion …follows the architectural desires of the City with continuity of the existing architecture, massing, vertical relief of the exterior walls, and use of windows."

Historic Preservation - This church is listed as a "notable" structure on the City's Historic Sites and Structures Inventory. Depending upon the extent of external alterations and the timing of submittals to the City, this could mean that the improvements may trigger a period of delay in order for the Historic Preservation Commission to determine whether the church should be designated as historic and, therefore, making the external improvements subject to their review. Please note that in order to account for this possibility, the ordinance makes the vacation effective upon issuance of a building permit.

Approvals and Recommendation

The memo notes that the Board of Public Works voted in favor of the vacation on October 31st and recommends this vacation.

NOTICE AND AGENDA
BLOOMINGTON COMMON COUNCIL REGULAR SESSION
7:30 P.M., WEDNESDAY, DECEMBER 6, 2006
COUNCIL CHAMBERS
SHOWERS BUILDING, 401 N. MORTON ST.

I. ROLL CALL

II. AGENDA SUMMATION

III. APPROVAL OF MINUTES FOR: None

IV. REPORTS FROM:
1. **Councilmembers**
2. **The Mayor and City Offices**
3. **Council Committees**
   Disclosure of Conflict of Interest (Duncan Campbell - appointee to the Historic Preservation Commission)
4. **Public**

V. APPOINTMENTS TO BOARDS AND COMMISSIONS

VI. LEGISLATION FOR SECOND READING AND RESOLUTIONS

1. Ordinance 06-24 To Repeal and Replace Title 20 of the Bloomington Municipal Code Entitled, "Zoning", Including the Incorporated Zoning Maps, and Title 19 of the Bloomington Municipal Code, Entitled "Subdivisions"

Vote on Decision to Further Consider this Ordinance and Announcement of that Decision

2. Resolution 06-14 To Confirm Resolution 06-13 Which Designated an Economic Revitalization Area, Approved a Statement of Benefits, Authorized A Period of Tax Abatement, and Declared Intent to Waive Certain Statutory Requirements - Re: 2300 Rockport Road and 2101, 2105, 2109, 2112, 2113, 2116, 2117, 2120, 2121, 2124, and 2125 Susie Street (City of Bloomington Department of Housing and Neighborhood Development, Petitioner)

Asked to Attend: Ron Walker, Director of Economic Development

3. Resolution 06-17 A Resolution Supporting the Renewal of the Bloomington Urban Enterprise Zone

Asked to Attend: Doris Sims, Assistant Director of HAND (Housing and Neighborhood Development)

4. Resolution 06-16 Supporting State and Federal Legislation Enacting Universal Publicly-Paid Health Insurance

Asked to Attend: Robert Stone, MD, Director, Hoosiers for Commonsense Health Plan, State Coordinator, Indiana Chapter, Physicians for a National Health Plan

VII. LEGISLATION FOR FIRST READING

1. Ordinance 06-25 To Amend Chapter 2.23 of the Bloomington Municipal Code Entitled "Community and Family Resources Department" in Order to Establish the Commission on the Status of the Black Males as a Permanent Commission.

2. Ordinance 06-26 To Authorize the Issuance of Bonds by the Monroe County Redevelopment Commission Pursuant to IC 36-7-14-3.5

3. Ordinance 06-27 To Vacate A Public Parcel - Re: Right-of-Way Running North /South Along the East Side of 111 South Grant Street (Trinity Episcopal Church - Rectors and Wardens, Petitioners

VIII. PRIVILEGE OF THE FLOOR (This section of the agenda will be limited to 25 minutes maximum, with each speaker limited to 5 minutes)

IX. ADJOURNMENT

Posted and Distributed: Friday, December 1, 2006

City of
Bloomington
Indiana

City Hall
401 N. Morton St.
Post Office Box 100
Bloomington, Indiana 47402

Office of the Common Council
(812) 349-3409
Fax: (812) 349-3570
council@bloomington.in.gov
www.bloomington.in.gov/council

To: Council Members
From: Council Office
Re: Calendar for the Week of December 4-8, 2006
Date: December 1, 2006

Monday, December 4, 2006

4:30 pm Plat Committee, Hooker Room
5:00 pm Redevelopment Commission, Kelly
5:00 pm Plan Commission, McCloskey
5:30 pm Bicycle and Pedestrian Safety Commission, Work Session, Hooker Room
6:00 pm Common Council Special Session on the UDO (Unified Development Ordinance), Council Chambers

Tuesday, December 5, 2006

1:30 pm Development Review Committee, McCloskey
4:00 pm Monroe County Solid Waste Management District, Citizen Advisory Council, McCloskey
6:00 pm Neighborhood Improvement Grant Meeting, McCloskey
7:30 pm Telecommunications Council, Council Chambers

Wednesday, December 6, 2006

12:00 pm Bloomington Urban Enterprise Association, McCloskey
2:00 pm Hearing Officer, Kelly
7:30 pm Common Council Regular Session, Council Chambers

Thursday, December 7, 2006

10:30 am Addressing Coordination, McCloskey
5:30 pm Black History Month Steering Committee, Hooker Room
5:30 pm Commission on the Status of Women, McCloskey
6:00 pm Common Council Special Session on the UDO (Unified Development Ordinance), Council Chambers

Happy Birthday to Alicia Ayers, Parking Ticket Appeal Officer- Clerk's Office!

Friday, December 8, 2006

No meetings are scheduled for this date.

Posted and Distributed: Friday, December 1, 2006

City of Bloomington
Office of the Common Council

MEETING NOTICE

Common Council
Sidewalk Committee

The Common Council Sidewalk Committee will meet at 12:00 p.m. on Monday, December 11, 2006. The meeting will be held in the Council Library at City Hall (401 N. Morton Street). The purpose of the meeting is to discuss sidewalk projects and procedures for 2007. Because a quorum of the Council may be present, this meeting would constitute a meeting of the Council as well as of this committee under the Indiana Open Door Law. For that reason, this statement is providing notice that this meeting will occur and is open for the public to attend, observe, and record what transpires.

Posted: Friday, December 1, 2006

401 N. Morton Street Bloomington, IN 47404 City Hall Phone: (812) 349-3409 Fax (812) 349-3570
www.city.bloomington.in.us
email: council@city.bloomington.in.us

Public Notice of Hearing by the Bloomington Common Council of Ordinance 06-24 (Unified Development Ordinance)

The Common Council of the City of Bloomington is in the process of considering Ordinance 06-24, otherwise known as the Unified Development Ordinance (UDO), which amends the municipal code by replacing the entire zoning ordinance (Title 20) and incorporated maps as well as the subdivision ordinance (Title 19), over a series of meetings during the last week in November and the first three weeks in December of 2006. All these meetings will offer an opportunity for public comment and are being held in the Council Chambers at 401 North Morton and will begin at 6:00 p.m. unless otherwise stated below.

The Common Council published notice of these hearings in the Herald-Times on Friday, November 24, 2006, and is publishing notice of those hearings and announcements again on this date due to a revision in the schedule. The following is a summary of meetings that have or will occur in the further course of Council consideration of the UDO.

The Common Council held an informal introduction to the UDO on Monday, November 27th, Tuesday, November 28th, and Wednesday, November 29th.

The Common Council undertook a preliminary consideration of amendments on Monday, December 4th and Thursday, December 7th.

The Common Council decided to further consider the UDO and announced the schedule of hearings at its first regular meeting after certification of the UDO, which was a Regular Session held on Wednesday, December 6th at 7:30 p.m.

Having made that decision and announcement, the Common Council hereby publishes notice that it will further consider the UDO and will hear oral comments on the UDO and written objections to the UDO which have been filed with the City Clerk or county auditor at or before either of the two public hearings noted below. The first public hearing, the particulars of which were previously published in the Herald-Times (see above), will be held on Monday, December 11th at 6:00 p.m. The second public hearing will be at the Regular Session on Wednesday, December 20th, which begins at 7:30 p.m.

The Common Council will further consider proposed amendments to the UDO on Monday, December 11th after the public hearing and, if necessary, on Wednesday, December 13th and Thursday, December 14th.

Final adoption of the UDO, originally scheduled for Thursday, December 14th is now scheduled to occur after the second public hearing mentioned in the previous paragraphs. That hearing will occur during the Regular Session on Wednesday, December 20th, which begins at 7:30 p.m.

Please note, however, that consideration of the UDO may be continued from time to time as may be found necessary by the Common Council.

Revised Notice and Schedule for Common Council Consideration of Ordinance 06-24 Otherwise Known as the Unified Development Ordinance (UDO) which Amends the Bloomington Municipal Code by Combining and Replacing Title 20 (Zoning and Zoning Maps) and Title 19 (Subdivisions)

December 1, 2006

Meetings will offer opportunity for public comment and will be held in the Council Chambers and Begin at 6:00 p.m. unless otherwise noted below *(also see * at bottom of the page)*

Informal Introduction to the Unified Development Ordinance
Monday, November 27, 2006
Tuesday, November 28, 2006
Wednesday, November 29, 2006

Deadlines for Submittal of Amendments by Council Members
Tuesday, November 29, 2006 (noon)
Friday, December 1, 2006 (noon)
(Further deadlines may be adopted by the Council)

Preliminary Consideration of Amendments to the Unified Development Ordinance
Monday, December 4, 2006
Formal Motion to Consider Ordinance 06-24 followed by consideration of amendments
Thursday, December 7, 2006

Announcement of Further Consideration of the Unified Development Ordinance
Wednesday, December 6, 2007
7:30 p.m. – Common Council will announce it's intention to further consider the UDO and approve a revised schedule for consideration of the UDO during its Regular Session on this date (but take no other action on it at that time).

Hearing on Written Objections to UDO Pursuant to I.C. 36-7-4-606(c)(3)
Monday, December 11, 2006 *Note: The deadline for amendments may be extended to provide opportunity to convert written objections into amendments.)*

Preliminary Consideration of Amendments to the Unified Development Ordinance - Continued
Monday, December 11, 2006 *(After the aforementioned hearing)*
Wednesday, December 13, 2006 (*If necessary)*
Thursday, December 14, 2006 *(If necessary)*

Second Hearing on Written Objections to and Final Adoption of the Unified Development Ordinance
Wednesday, December 20, 2006
7:30 p.m. - The Common Council will hear further written objections and is scheduled to take final action on the UDO during that evening's Regular Session.

***** *Two meetings will occur at times other than 6:00 p.m. Those meetings are noted above and include Regular Sessions of the Council that will be held on Wednesday, December 6, 2006 and Wednesday, December 20, 2006 and will begin at 7:30 p.m.*

***** *This consideration of the UDO may be continued from time to time as may be found necessary by the Council.*

Posted and Distributed on: Friday, December 1, 2006

UNIFORM CONFLICT OF INTEREST DISCLOSURE STATEMENT
(Pursuant to and in Compliance With Indiana Code § 35-44-1-3)

A public servant who knowingly or intentionally has a pecuniary interest in or derives a profit from a contract or purchase connected with an action by the governmental entity served by the public servant has a conflict of interest subject to disclosure. A public servant has a pecuniary interest in a contract or purchase if the contract or purchase will result or is intended to result in an ascertainable increase in the income or net worth of the public servant or a dependent of the public servant. "Dependent" means any of the following: the spouse of a public servant; a child, stepchild, or adoptee (as defined in I.C. 31-3-4-1) of a public servant who is unemancipated and less than eighteen (18) years of age; and any individual more than one-half (½) of whose support is provided during a year by the public servant.

1. Name and Address of Public Servant Submitting Statement: Duncan C. Campbell Preservation Development, Inc. 2300 Tapp Road Bloomington, IN 47403

2. Title or Position With Governmental Entity: Member of Historic Preservation Commission

3. a. Governmental Entity: City of Bloomington

   b. County: Monroe

4. This statement is submitted (check one):

   a. _____ as a "single transaction" disclosure statement, as to my financial interest in a specific contract or purchase connected with the governmental entity which I serve, proposed to be made by the governmental entity with or from a particular contractor or vendor; or

   b. XX as an "annual" disclosure statement, as to my financial interest connected with any contracts or purchases of the governmental entity which I serve, which are made on an ongoing basis with or from particular contractors or vendors.

5. Name(s) of Contractor(s) or Vendor(s): Property owners who apply for and are awarded grants by the Historic Preservation Commission

6. Description of Contract(s) or Purchase(s) (Describe the kind of contract involved, and the effective date and term of the contract or purchase if reasonably determinable. Dates required if 4 (a) is selected above. If "dependent" is involved, provide dependent's name and relationship): The contract is for consultation services with a professional in the preservation field.

7. Description of My Financial Interest (Describe in what manner the public servant or "dependent" expects to derive a profit or financial benefit from, or otherwise has a pecuniary interest in, the above contract(s) or purchases(s); if reasonably determinable, state the approximate dollar value of such profit or benefit.): The amount awarded in grants by the Historic Preservation Commission for consultation services is $400.00 per grant award.

(Attach extra pages if additional space is needed.)

8. Approval of Appointing Officer of Body (To be completed if the public servant was appointed by an elected public servant or the board of trustees of a state-supported college or university): I (We) being the Mayor (Title of Officer or Name of Governing Body) of the City of Bloomington (Name of Governmental Entity) and having the power to appoint the above named public servant to the public position to which he or she holds, hereby approve the participation of the appointed disclosing public servant in the above described contract(s) or purchase(s) in which said public servant has a conflict of interest as defined in Indiana Code § 35-44-1-3; however, this approval does not waive any objection to any conflict prohibited by statute, rule, or regulation and is not to be construed as consent to any illegal act.

Kevin R. Robling for Mayor

Elected Official

Bloomington City Council

Office

9. Effective Dates (Conflict of interest statements must be submitted to the governmental entity prior to final action on the contract or purchase.):

November 9, 2006

Date Submitted

Ongoing

Date of Action on Contract or Purchase

10. Affirmation of Public Servant: This disclosure was submitted to the governmental entity prior to final action on the contract or purchase. I affirm, under penalties of perjury, the truth and completeness of the statements made above, and that I am the above named public servant.

Signed: Duncan E. Campbell

(Signature of Public Servant)

Date: 11/9/06

Within 15 days following execution, copies of this statement must be filed with the State Board of Accounts, Indiana Government Center South, Room E418, Indianapolis, Indiana, 46204, and the Clerk of the Circuit Court of the county in which the governmental entity executed the contract or purchase. A copy of this disclosure will be forwarded to the Indiana State Ethics Commission.

CITY OF BLOOMINGTON
Legal Department
Reviewed By:
Jackie Moore
DATE: 11-9-6

CITY OF BLOOMINGTON
LEGAL DEPARTMENT
MEMORANDUM

TO: **Common Council**

FROM: **Jacquelyn Moore, Assistant City Attorney**

RE: **Conflict of Interest Disclosure Statement**

DATE: **December 1, 2006**

The attached conflict of interest disclosure statement is for Duncan Campbell, a member of the Historic Preservation Commission ("HPC"). The disclosure statement has been approved by the appointing authority as required by statute. Because all mayoral appointments to the HPC are also subject to approval of the Common Council, this statement is now submitted for your approval as well.

This statement is an "annual" disclosure statement to allow Duncan Campbell to be paid as a consultant to property owners who are awarded $400.00 grants by the HPC. These grants are periodically awarded as grant applications are received and reviewed. The end result of the consultation is a written report by the consultant regarding the historic significance of the property, analysis of possible financial incentives, zoning variances and abatements, and a brief analysis of the appropriate rehabilitation of the building.

RESOLUTION 06-14

TO CONFIRM RESOLUTION 06-13 WHICH DESIGNATED AN ECONOMIC REVITALIZATION AREA, APPROVED A STATEMENT OF BENEFITS, AUTHORIZED A PERIOD OF TAX ABATEMENT, AND DECLARED INTENT TO WAIVE CERTAIN STATUTORY REQUIREMENTS
Re: 2300 Rockport Road and
2101, 2105, 2109, 2112, 2113, 2116, 2117, 2120, 2121, 2124, and 2125 Susie Street
(City of Bloomington Department of Housing and Neighborhood Development, Petitioner)

WHEREAS, Petitioner, City of Bloomington Department of Housing and Neighborhood Development, has filed an application for designation of property it owns at 2300 Rockport Road and 2101, 2105, 2109, 2112, 2113, 2116, 2117, 2120, 2121, 2124, and 2125 Susie Street, Bloomington, Indiana as an "Economic Revitalization Area" ERA pursuant to I.C. IC 6-1.1-12.1 et. seq.; and

WHEREAS, petitioner intends to construct twelve single-family affordable housing units at the addresses listed herein, which shall be referred to as the Project, and wishes to obtain tax abatement for the improvements; and

WHEREAS, pursuant to state law, petitioners seeking designation for their property as an Economic Revitalization Area must complete a Statement of Benefits and must provide information in a timely fashion each year to the County Auditor and the Common Council showing the extent to which there has been compliance with the Statement of Benefits; and

WHEREAS, the application has been reviewed by the Planning Department, and the Economic Development Commission has recommended that the Common Council designate an "Economic Revitalization Area," approve a Statement of Benefits, authorize a five (5) year period of tax abatement and waive certain statutory requirements; and

WHEREAS, the Common Council has investigated the area and reviewed the Application and Statement of Benefits, which are attached and made a part of Resolution 06-13, and has found the following:

A. the estimate of the value of the redevelopment or rehabilitation is reasonable;
B. the estimate of the number of individuals who will be employed or whose employment will be retained can be reasonably expected to result from the proposed described redevelopment or rehabilitation;
C. the estimate of the annual salaries of these individuals who will be employed or whose employment will be retained can be reasonably expected to result from the proposed described redevelopment or rehabilitation;
D. the redevelopment or rehabilitation has received approval from the Planning Department, is consistent with the Growth Policies Plan, is expected to be developed and used in a manner that complies with local code, and provides housing in the downtown area; and
E. the totality of benefits is sufficient to justify the deduction; and

WHEREAS, the property described above has experienced a cessation of growth; and

WHEREAS, IC 6-1.1-12.1-11.3 authorizes the Council, after it has held a public hearing, to waive the statutory requirement that the initiation of redevelopment occur after the submittal of a completed statement of benefits by the Petitioner and after the designation of the ERA and the making of certain findings of facts by the Common Council; and

WHEREAS, the Common Council adopted Resolution 06-13 on November 8, 2006, which designated the above property as an "Economic Revitalization Area," approved a Statement of Benefits, authorized a five (5) year period of tax abatement, and declared an intent to waive the above mentioned statutory requirements; and

WHEREAS, the City Clerk published notice of the passage of that resolution, which requested that persons having objections or remonstrance to the designation or to the waiver of the statutory requirement that the initiation of redevelopment occur after the ERA designation, statement of benefits submission, and findings of fact appear before the Common Council at its meeting on December 6, 2006; and

WHEREAS, the Common Council has reviewed and heard all such objections and remonstrance to such designation;

NOW THEREFORE, BE IT HEREBY RESOLVED BY THE COMMON COUNCIL OF THE CITY OF BLOOMINGTON, MONROE COUNTY, INDIANA, THAT:

1. Pursuant to Indiana Code 6-1.1-12.1-1 et seq., the Common Council hereby affirms its determination made in Resolution 06-13 that the area described above is an "Economic Revitalization Area" and that the totality of benefits of the Project entitle the owner of the property or its successor(s) to a deduction from the assessed value of the related improvements for a period of five (5) years.

2. In granting this designation and deduction the Common Council incorporates I.C. 6-1.1-12.1-12. It also expressly exercises the power set forth in I.C. 6-1.1-12.1-2(I)(5) to impose additional, reasonable conditions on the rehabilitation or redevelopment beyond those listed in the Statement of Benefits. In particular, failure of the property owner to make reasonable efforts to comply with the following conditions is an additional reason for the Council to rescind this designation and deduction:

a. the improvements described in the application shall be commenced (defined as obtaining a building permit and actual start of construction) within twelve months of the date of this designation; and
b. the land and improvements shall be developed and used in a manner that complies with local code.

3. In granting this designation and deduction the Common Council, pursuant to I.C. 6-1.1-12.1-11.3, hereby waives the following statutory requirements:

a. I.C. 6-1.1-12.1-11.3(a)(2) Failure to submit the completed statement of benefits form to the designating body before the initiation of the redevelopment for which the person desires to claim a deduction under [I.C. 6-1.1-12.1].

b. I.C. 6-1.1-12.1-11.3(a)(3) Failure to designate an area as an economic revitalization area before the initiation of the redevelopment for which the person desires to claim a deduction under [I.C. 6-1.1-12.1].

c. I.C. 6-1.1-12.1-11.3(a)(4) Failure to make the required findings of fact before designating an area as an economic revitalization area under section 2, 3, or 4.5 of [I.C. 6-1.1-12.1].

PASSED and ADOPTED by the Common Council of the City of Bloomington, Monroe County, Indiana, upon this ___ day of _____, 2006.

_____
CHRIS STURBAUM, President
Bloomington Common Council

SIGNED and APPROVED by me upon this ___ day of _____, 2006.

_____
MARK KRUZAN, Mayor
City of Bloomington

ATTEST:

_____
REGINA MOORE, Clerk
City of Bloomington

SYNOPSIS

This resolution affirms the determination of the Common Council expressed in Resolution 06-13 to designate the property located at 2300 Rockport Road and 2101, 2105, 2109, 2112, 2113, 2116, 2117, 2120, 2121, 2124, and 2125 Susie Street as an "Economic Revitalization Area," approve a Statement of Benefits, and authorize a tax abatement for a period of five (5) years for the project proposed by the petitioner, City of Bloomington Department of Housing and Neighborhood Development. The petitioner is seeking a tax abatement for construction of affordable single-family housing. The petitioner is also seeking waiver of certain statutory requirements that an ERA be designated, a statement of benefits submitted, and findings of fact be made before redevelopment of the property can occur. The public comment on this resolution will serve as the legally advertised public hearing required by statute in order to receive public comment on the above actions.

STATEMENT OF BENEFITS
REAL ESTATE IMPROVEMENTS

State Form 51767 (R / 1-06)
Prescribed by the Department of Local Government Finance

FORM SB-1 / RE

INSTRUCTIONS:

1. *This statement must be submitted to the body designating the Economic Revitalization Area prior to the public hearing if the designating body requires information from the applicant in making its decision about whether to designate an Economic Revitalization Area. Otherwise this statement must be submitted to the designating body* ***BEFORE*** *the redevelopment or rehabilitation of real property for which the person wishes to claim a deduction. "Projects" planned or committed to after July 1, 1987, and areas designated after July 1, 1987, require a STATEMENT OF BENEFITS. (IC 6-1.1-12.1)*
2. *Approval of the designating body (City Council, Town Board, County Council, etc.) must be obtained prior to initiation of the redevelopment or rehabilitation.* ***BEFORE*** *a deduction may be approved.*
3. *To obtain a deduction, Form 322 ERA, Application for Deduction from Assessed Valuation of Structures in Economic Revitalization Areas, must be filed with the County Auditor by the later of: (1) May 10; or (2) thirty (30) days after the notice of addition to assessed valuation or new assessment is mailed to the property owner at the address shown on the records of the township assessor.*
4. *Property owners whose Statement of Benefits was approved after June 30, 1991, must submit Form CF-1/RE annually to show compliance with the Statement of Benefits. (IC 6-1.1-12.1-5.1(b))*
5. *The schedules established under IC 6-1.1-12.1-4(d) effective July 1, 2000, apply to any statement of benefits filed on or after July 1, 2000. The schedules effective prior to July 1, 2000, shall continue to apply to those statement of benefits filed before July 1, 2000.*

SECTION 1 — TAXPAYER INFORMATION

Name of taxpayer
City of Bloomington Housing and Neighborhood Development Department

Address of taxpayer *(number and street, city, state, and ZIP code)*
P.O. Box 100, 401 N. Morton, Suite 130, Bloomington, IN 47402

Name of contact person	Telephone number
Lisa Abbott	812-349-3401

SECTION 2 — LOCATION AND DESCRIPTION OF PROPOSED PROJECT

Name of designating body		Resolution number
Location of property	**County**	**DLGF taxing district number**
See attached list		Perry Township

Description of real property improvements, redevelopment, or rehabilitation. *(use additional sheets if necessary)*
See attached list

ESTIMATED	
Start Date	Completion Date
10/30/06	12/31/08

SECTION 3 — ESTIMATE OF EMPLOYEES AND SALARIES AS RESULT OF PROPOSED PROJECT

Current number	Salaries	Number retained	Salaries	Number additional	Salaries

SECTION 4 — ESTIMATED TOTAL COST AND VALUE OF PROPOSED PROJECT

NOTE: Pursuant to IC 6-1.1-12.1-5.1 (d) (2) the COST of the property is confidential.	REAL ESTATE IMPROVEMENTS	
	COST	ASSESSED VALUE
Current values	450,000	0
Plus estimated values of proposed project	1,919,791	
Less values of any property being replaced		
Net estimated values upon completion of project	2,369,791	

SECTION 5 — WASTE CONVERTED AND OTHER BENEFITS PROMISED BY THE TAXPAYER

Estimated solid waste converted *(pounds)* _____ Estimated hazardous waste converted *(pounds)* _____

Other benefits:
This PUD will have 12 green built, LEED certified affordable housing units with a 30 year affordability covenant.

SECTION 6 — TAXPAYER CERTIFICATION

I hereby certify that the representations in this statement are true.

Signature of authorized representative	Title	Date signed *(month, day, year)*
Lisa Abbott	Director	10/4/06

FOR USE OF THE DESIGNATING BODY

We have reviewed our prior actions relating to the designation of this Economic Revitalization Area and find that the applicant meets the general standards adopted in the resolution previously approved by this body. Said resolution, passed under IC 6-1.1-12.1-2.5, provides for the following limitations as authorized under IC 6-1.1-12.1-2.

A. The designated area has been limited to a period of time not to exceed _____ calendar years * *(see below)*. The date this designation expires is _____ .

B. The type of deduction that is allowed in the designated area is limited to:
1. Redevelopment or rehabilitation of real estate improvements; ☐ Yes ☐ No
2. Residentially distressed areas ☐ Yes ☐ No

C. The amount of deduction applicable for redevelopment or rehabilitation is limited to $ _____ cost with an assessed value of $ _____.

D. Other limitations or conditions *(specify)* _____

E. The deduction for redevelopment or rehabilitation is allowed for _____ years* *(see below)*.

Also we have reviewed the information contained in the statement of benefits and find that the estimates and expectations are reasonable and have determined that the totality of benefits is sufficient to justify the deduction described above. (IC 6-1.1-12-3(b))

Approved: *(signature and title of authorized member)*	Telephone number	Date signed *(month, day, year)*
Attested by:	Designated body	

* If the designating body limits the time period during which an area is an economic revitalization area, it does not limit the length of time a taxpayer is entitled to receive a deduction to a number of years designated under IC 6-1.1-12.1-4.

For residentially distressed areas, the deduction period may not exceed five (5) years. If the Economic Revitalization Area was designated prior to July 1, 2000, the deduction period is limited to three (3), six (6), or ten (10) years. For ERAs after June 30, 2000, the deduction period may not exceed ten (10) years. An area designated as an urban development area pursuant to an application filed after December 31, 1978, and prior to January 1, 1986, are entitled to a ten (10) year deduction.

RESOLUTION 06-17

A RESOLUTION SUPPORTING THE RENEWAL OF THE BLOOMINGTON URBAN ENTERPRISE ZONE

WHEREAS, the Common Council has a continuing interest in the economic betterment of the City; and

WHEREAS, the City of Bloomington has been active in and has been enhanced by the Enterprise Zone program since 1992 pursuant to Common Council Resolution 91-37; and

WHEREAS, in Resolution 01-26 the Common Council approved the renewal of the zone and modifications of the zone boundaries for an additional five years for the period of February 1, 2002 through January 31, 2007, to provide financial incentives to foster new and existing business development, and assistance to zone residents; and

WHEREAS, in Resolution 05-20 the Common Council endorsed the work of the Bloomington Urban Enterprise Association in the Enterprise Zone and supported its continuation;

WHEREAS, the City is eligible for one additional five year renewal of the Urban Enterprise Zone once its current designation expires on February 1, 2007; and

WHEREAS, the Bloomington Urban Enterprise Association, Inc., has developed an application for renewal to the Indiana Economic Development Corporation in cooperation with the City with a five year strategic plan;

NOW THEREFORE, BE IT HEREBY RESOLVED BY THE COMMON COUNCIL OF THE CITY OF BLOOMINGTON, MONROE COUNTY, INDIANA THAT:

SECTION 1. The Bloomington Common Council supports the renewal efforts of the Bloomington Urban Enterprise Zone for a five (5) year period to begin February 1, 2007, and concluding January 31, 2012.

SECTION 2. The Bloomington Common Council reaffirms its support of the renewal of the Bloomington Urban Enterprise Zone as outlined on the attached zone map of the City of Bloomington.

PASSED AND ADOPTED by the Common Council of the City of Bloomington, Monroe County, Indiana, upon this _____day of _____, 2006.

_____
CHRIS STURBAUM, President
Bloomington Common Council

ATTEST:

_____
REGINA MOORE, Clerk
City of Bloomington

PRESENTED by me to the Mayor of the City of Bloomington, Monroe County, Indiana upon this _____day of _____, 2006.

_____
REGINA MOORE, Clerk
City of Bloomington

SIGNED AND APPROVED by me upon this _____day of _____, 2006.

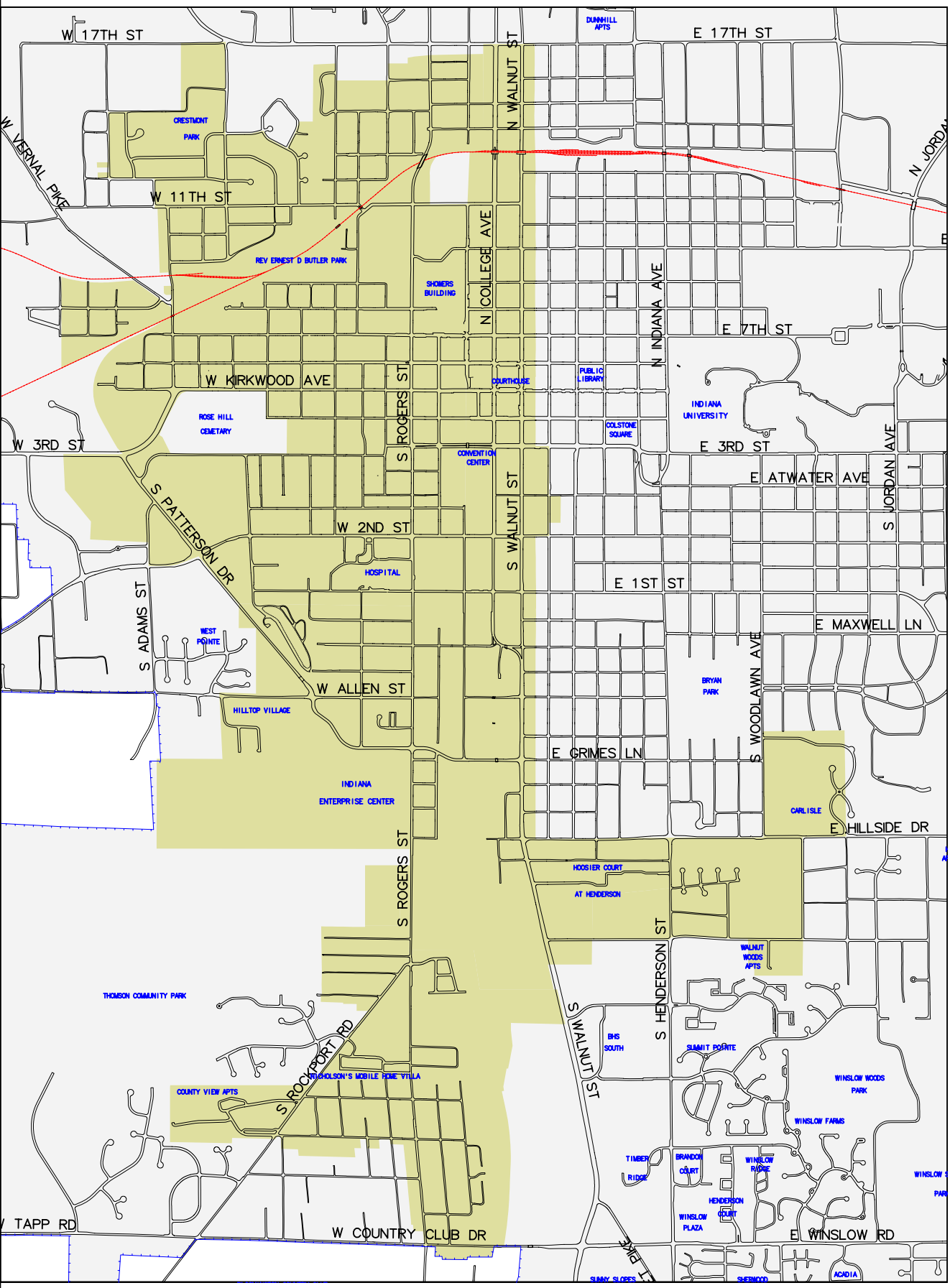
_____
MARK KRUZAN, Mayor
City of Bloomington

SYNOPSIS

This resolution offers the Council's support for the Bloomington Urban Enterprise Association's application to the Indiana Economic Development Corporation for renewal of the Bloomington Urban Enterprise Zone for an additional and final (5) years.

Bloomington Urban Enterprise Zone

Oct 12, 2005



City of Bloomington
Geographic Information System

For use as map information only, information is NOT warranted.

Scale: 1" = 1800'

TuezLP

Housing and Neighborhood Development (HAND)

Memo

To: City Council members

From: Doris J. Sims, Assistant Director, HAND

CC: Lisa Abbott, Director, HAND

Date: December 1, 2006

Re: BUEA renewal

The Bloomington Urban Enterprise Association (BUEA) is seeking a five year renewal of its enterprise zone which expires on January 31, 2007. The Urban Enterprise Zone was created in 1991 to promote economic development and enhance business vitality for businesses operating within the zone boundaries. As such, there are a variety of state tax incentives available to zone businesses. Until recently, the most prominent of these incentives was an exemption to the state inventory tax. However, this tax was eliminated effective this year. Nonetheless, several zone-related tax incentives remain, including the Loan Interest Credit and the Property Tax Investment Deduction.

The BUEA collects 20% of the savings claimed by each business due to zone-related tax incentives. Using these "participation fees," the BUEA has regularly operated six programs over the last five years in addition to funding several special projects. The six programs include the Business Technical Assistance Program operated through a partnership with the South Central Small Business Development Center, the Micro Enterprise Loan Partnership operated in collaboration with SEED Corp., the Ivy Tech and Resident Economic Development Scholarships, the Business Rehabilitation Loan Program, the Historic Façade Grant Program, and the School Grant Program. Special projects undertaken by the BUEA include granting close to $400,000 for a variety of activities, including a project to further progress on the B-line trail and facility acquisition and/or rehabilitation projects at Middle Way House, the Center for Behavioral Health, and Harmony Education Center.

Altogether, BUEA programs have created at least 800 jobs and zone-related tax incentives have led to nearly $24.5 million in capital investment and increases in wages to zone residents. Upon renewal for another five years, the BUEA plans to continue the programs offered over the last five years as well as implement new programs that work with the City of Bloomington to grow both inVenture and the city's new Certified Technology Park.

If renewed, the next five years will be the last for the enterprise zone and the BUEA. State code allows for enterprise zones to be designated for an initial 10 year period with no more than two additional 5 year periods allowed for at the discretion of the Indiana Economic Development Corporation.

RESOLUTION 06-16

SUPPORTING STATE AND FEDERAL LEGISLATION ENACTING UNIVERSAL PUBLICLY-PAID HEALTH INSURANCE

WHEREAS, over 46 million Americans, 860,000 Hoosiers and 15,000 Monroe County residents have no health insurance, and over 80% of these uninsured people live in families in which at least one family member works; and

WHEREAS, large and small businesses are having increasing difficulty providing health insurance to their employees, and this difficulty is adding to the number of uninsured; and

WHEREAS, The Institute of Medicine estimates that 18,000 people die every year because they lack insurance and cannot access adequate health care; and

WHEREAS, The Institute of Medicine estimates that tens of millions of Americans are under-insured, lacking sufficient coverage for vital care and medications; and

WHEREAS, even those with adequate insurance are facing growing premiums, co-payments and deductibles, as well as the fear that their insurance might be cancelled; and

WHEREAS, illness and medical bills are the leading cause of personal bankruptcy in the nation and Indiana has one of the highest rates of medical bankruptcy in the country; and

WHEREAS, this growing problem cannot be ignored any longer by our legislative bodies; and

WHEREAS, United States Representative John Conyers has introduced House Resolution 676, (HR 676), the *United States National Health Insurance Act*, which would provide healthcare to all; and

WHEREAS, a proposal for *Universal Publicly Paid Health Care in Indiana* will be introduced in the Indiana legislature in January 2007; and

WHEREAS, the Common Council passed *Resolution 94-54* in 1994 calling for a universal health care system and since that time, the health care crisis has only worsened; and

WHEREAS, health care is a basic human right;

NOW, THEREFORE, BE IT HEREBY RESOLVED BY THE COMMON COUNCIL OF THE CITY OF BLOOMINGTON, MONROE COUNTY, INDIANA, THAT:

SECTION I. The Council supports the principle of universal publicly-paid health insurance that would provide health care to everyone at reasonable costs.

SECTION II. The Council supports universal publicly-paid health insurance that would provide for physician and hospital visits, pharmaceuticals, preventative care, dental care, long-term care, substance abuse treatment and mental health care without deductibles and co-payments, and would provide all patients and providers freedom of choice.

SECTION III. The Council supports and endorses HR 676 the *United States National Health Insurance Act* and respectfully requests our elected federal officials to endorse and adopt HR 676.

SECTION IV. The Council supports and endorses State legislation providing for universal publicly-paid health insurance for all Indiana residents.

SECTION V. The Council directs the City Clerk to send a copy of this resolution to the President of the United States, members of the Indiana Congressional Delegation, other members of the United States Congress in positions of leadership in the House and Senate and their committees with jurisdiction over public health, the Governor of Indiana and members of Bloomington's delegation to the Indiana legislature, and other leaders of the State legislature as deemed appropriate.

SECTION VI. The Council directs that this resolution be posted on the City of Bloomington web site.

PASSED AND ADOPTED by the Common Council of the City of Bloomington, Monroe County, Indiana, upon this _____ day of _____, 2006.

_____
CHRIS STURBAUM, President
Bloomington Common Council

SIGNED and APPROVED by me upon this _____ day of _____, 2006.

_____
MARK KRUZAN, Mayor
City of Bloomington

ATTEST:

_____
REGINA MOORE, Clerk
City of Bloomington

SYNOPSIS

This resolution is sponsored by Councilmembers Tim Mayer, Andy Ruff, Chris Gaal and Mike Diekhoff and documents the problem of access to affordable health care. The resolution points out that the growing cost of health insurance makes adequate care inaccessible to many, causes over 18,000 deaths in the country each year, brings about great suffering, triggers personal bankruptcy and stifles small businesses. Concluding that health care is a basic human right, the resolution supports the principle of universal publicly-paid health insurance that would provide care to everyone. The resolution supports a plan that would provide for physician and hospital visits, pharmaceuticals, preventative care, dental care, long-term care, and non-discriminatory mental health care without deductibles and co-payments, and would provide all patients and providers freedom of choice. Finally, the resolution supports federal and State legislative initiatives to implement universal publicly-paid health care.

Memorandum

To:	Members of the Common Council, City of Bloomington
From:	Robert Stone MD, Director, *Hoosiers for a Commonsense Health Plan*
	State Coordinator, Indiana Chapter, *Physicians for a National Health Program*
Re:	Resolution 06-16 – *Supporting State and Federal Legislation Enacting Universal Publicly-Paid Health Insurance*
Date:	December 1, 2006

The Bloomington Common Council last considered a resolution in support of state and federal legislation enacting universal health insurance in 1994, Resolution 94-54. At that time there were around 38 million uninsured – now the numbers have grown to over 46 million. At that time it was noted that the insured population "sees co-payments and deductibles skyrocket and, even when covered for catastrophes, still faces the possibility of bankruptcy because their coverage is insufficient." This is also more true than ever. That resolution stated that it appeared the United States Congress was not ready to "enact any substantial reform," and they did not. In short, twelve years have gone by and the problem has only gotten worse.

There is reason to believe that the climate for real reform of our health care system may be changing. Governor Daniels has announced a new plan to cover some of the uninsured that he will be submitting to the General Assembly in January. A new group called Hoosiers for a Commonsense Health Plan has drafted legislation for universal, publicly paid health insurance in Indiana. Politicians from across the spectrum are hearing the cries of individuals and businesses asking for change, that our current system is failing and collapsing around us.

Here in Monroe County we have seen the community come together around a new entity to serve the uninsured, the Volunteers in Medicine Clinic, which will expand upon the current Community Health Access Program. We are making a significant effort to address the problems of the uninsured at the local level. We are seeing a partnership between the hospital, physicians, and the community, with the support of government, business, and individuals that has proven potent and exhilarating. This is something that we can and will accomplish. But we understand at the same time that there are larger problems we need to consider.

How do we address the larger political and societal issues? Bloomington has a well-earned reputation as an innovator and leader in our state. Our smoking ban ordinance has served as a model for local legislation at the state and national level. It has inspired a number of communities around the state to institute similar ordinances, with the result that our communities and our state are healthier. I hope that this resolution will inspire other communities around the state to pass similar measures in support of universal health insurance.

This resolution notes the growing number of uninsured, including 15,000 residents of Monroe County. This is a problem primarily of working people who cannot afford or have no access to health insurance. Some of these workers have two or three jobs, but still can't obtain insurance for themselves or their families. Large businesses are finding it impossible to compete globally

due to rising health care costs, while small businesses are struggling to offer coverage to their employees, and are all too often unsuccessful. Raises are being eaten up by growing health care costs.

Meanwhile, those without insurance live sicker and die younger, a tragedy reaping 18,000 preventable deaths per year, a September 11th every two months. And those with insurance face increasing insecurity as out of pocket expenses rise even as their coverage shrinks. So called high-deductible health plans are flooding the market, supposedly to make insurance more "affordable" while at the same time making serious illness more likely a financial tragedy. We have all heard by now that medical bills and illness are the number one cause of personal bankruptcy, a phenomenon unique to the US. But many still don't realize that 75% of those declaring bankruptcy for medical reasons had insurance at the time they got sick or injured. Too often insurance it actually "under-insurance," or coverage gets cancelled, and financial ruin compounds the personal calamity of serious illness.

We believe that we have the best health care system in the world in our great country, but that is sadly just a myth. We do have the most expensive health care in the world, on that point there is no argument. We spend 31% of our health care dollars on inefficiency and overhead. Private insurance companies are posting record profits and their executives are raking in millions. Meanwhile Medicare runs efficiently at 3.1% overhead. Our safety net is full of holes and millions have no access to preventative and life saving care. The World Health Organization ranks the US health care system as the 36th best in the world, below Canada, Western Europe, Australia, and even Costa Rica. The sad truth is that for those without good insurance here in the US, they might as well be living in a Third World country.

We could have the best health care system in the world. We have the resources and we are already spending enough money. We need to build the political will. This is not a Republican issue or a Democratic issue. This is an issue to unite us, not divide us. Health care is an essential part of the fabric of our communities. This is a national security issue. Health care for all is an idea whose time has come.

SPECIAL ARTICLE

Costs of Health Care Administration in the United States and Canada

Steffie Woolhandler, M.D., M.P.H., Terry Campbell, M.H.A., and David U. Himmelstein, M.D.

ABSTRACT

BACKGROUND

A decade ago, the administrative costs of health care in the United States greatly exceeded those in Canada. We investigated whether the ascendancy of computerization, managed care, and the adoption of more businesslike approaches to health care have decreased administrative costs.

METHODS

For the United States and Canada, we calculated the administrative costs of health insurers, employers' health benefit programs, hospitals, practitioners' offices, nursing homes, and home care agencies in 1999. We analyzed published data, surveys of physicians, employment data, and detailed cost reports filed by hospitals, nursing homes, and home care agencies. In calculating the administrative share of health care spending, we excluded retail pharmacy sales and a few other categories for which data on administrative costs were unavailable. We used census surveys to explore trends over time in administrative employment in health care settings. Costs are reported in U.S. dollars.

RESULTS

In 1999, health administration costs totaled at least $294.3 billion in the United States, or $1,059 per capita, as compared with $307 per capita in Canada. After exclusions, administration accounted for 31.0 percent of health care expenditures in the United States and 16.7 percent of health care expenditures in Canada. Canada's national health insurance program had overhead of 1.3 percent; the overhead among Canada's private insurers was higher than that in the United States (13.2 percent vs. 11.7 percent). Providers' administrative costs were far lower in Canada.

Between 1969 and 1999, the share of the U.S. health care labor force accounted for by administrative workers grew from 18.2 percent to 27.3 percent. In Canada, it grew from 16.0 percent in 1971 to 19.1 percent in 1996. (Both nations' figures exclude insurance-industry personnel.)

CONCLUSIONS

The gap between U.S. and Canadian spending on health care administration has grown to $752 per capita. A large sum might be saved in the United States if administrative costs could be trimmed by implementing a Canadian-style health care system.

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In 1991, we reported that people in the United States spent about $450 per capita on health care administration in 1987, whereas Canadians spent one third as much.[1] Subsequent studies reached similar conclusions, but all relied on data from 1991 or before.[2,3] In the interim, organizational and technological changes have revolutionized health care administration. The ascendancy of managed care and competition has forced providers to adopt more businesslike approaches. Mergers between hospitals and between health maintenance organizations (HMOs) have centralized "back office" tasks. E-mail has displaced regular mail, and the Internet allows insurers to offer on-line verification of applicants' eligibility, utilization review, and payment approval.[4] By 1999, nearly two thirds of U.S. health insurance claims were filed electronically, including 84 percent of Medicare claims.[5]

Canada's national health insurance system has also been subject to technological change and turmoil — strident debate over cost controls, the availability of medical technology, hospital closures, and the appropriate role of investor-owned providers. But its organizational structure has changed little. We evaluated whether the adoption of a more businesslike attitude, the proliferation of HMOs, and the automation of billing and clerical tasks have trimmed administrative costs in the United States and whether Canada's administrative parsimony has persisted in the years since our earlier study.

METHODS

To estimate administrative costs, we sought data on insurance overhead, employers' costs to manage benefits, and the administrative costs of hospitals, practitioners' offices, nursing homes, and home care. Our estimates use 1999 figures, the most recent comprehensive data. We used gross-domestic-product purchasing-power parities[6] to convert Canadian dollars to U.S. dollars, and we used SAS software for data analyses.[7]

INSURANCE OVERHEAD

We obtained figures for insurance overhead and the administration of government programs from the Centers for Medicare and Medicaid Services[8] and the Canadian Institute for Health Information.[9]

EMPLOYERS' COSTS TO MANAGE HEALTH CARE BENEFITS

For the United States, we used a published estimate of employers' spending for health care benefits consultants and internal administration related to health care benefits in 1996.[10,11] We used this figure to estimate 1999 costs on the basis of the growth in health care spending among employers in the private sector.[12] No comparable figures are available for Canada. We assumed that employers' internal administrative costs plus the costs of consultants (as a share of employers' health care spending[13]) are the same in Canada as in the United States.

HOSPITAL ADMINISTRATION

For the United States, we calculated the administrative share of hospital costs by analyzing data from fiscal year 1999 cost reports that 5220 hospitals had submitted to Medicare by September 30, 2001, using previously described methods.[14,15] For Canada, we and colleagues at the Canadian Institute for Health Information analyzed cost data for fiscal year 1999 (April 1, 1999, through March 31, 2000) for all Canadian hospitals except those in Quebec (which use a separate cost-reporting system), using methods similar to the ones we used to calculate costs in the United States. When questions arose about the comparability of expense categories, we obtained detailed descriptions of the Canadian categories from Canadian officials and consulted U.S. Medicare auditors to ascertain where such costs would be entered on Medicare cost reports. For both countries, we multiplied the percentage spent on administrative costs by total hospital spending.[8,9]

ADMINISTRATIVE COSTS OF PRACTITIONERS

We calculated the administrative costs of U.S. physicians by adding the value of the physicians' own time devoted to administration to estimates of the share of several categories of office expenses that are attributable to administrative work. We determined the proportion of physicians' work hours devoted to billing and administration from a national survey[16] and multiplied this proportion by physicians' net income before taxes.[8,17] We calculated the costs of administrative work by nurses and other clinical employees in doctors' offices by assuming that they spent the same proportion of their time on administration as did physicians. We calculated the value of this time on the basis of total physicians' revenues[8] and survey data on doctors' payroll costs from the American Medical Association.[17] We attributed all of physicians' expenses for clerical staff to administration.[17] Although administrative and clerical workers accounted for 43.8 percent of the work force in physicians' offices (unpublished data), we attributed only one third of office rent and

other expenses (excluding medical machinery and supplies)[17] to administration and billing. Accounting, legal fees (excluding the cost of malpractice insurance), the costs of outside billing services, and other such costs are subsumed in "other professional expenses,"[17] half of which we attributed to administration.

To estimate the administrative expenses of dentists (and other nonphysician practitioners), we analyzed data on administrative and clerical employment in practitioners' offices from the March 2000 Current Population Survey using previously described methods.[18] Administrative and clerical employees' share of office wages was 43 percent lower in the case of dentists' offices and 14 percent lower in the case of other nonphysician practitioners' offices than those of physicians' offices. We assumed that the administrative share of the income of dentists and other nonphysician practitioners mirrored these differences.

To calculate administrative costs in Canada, we obtained figures from a Canadian Medical Association survey on the proportion of physicians' time devoted to administration and practice management[19] and multiplied this proportion by physicians' net income before taxes.[9,20] To calculate the cost of nonphysician staff time, we used figures from Canadian Medical Association surveys of physicians' expenditures for office staff,[20,21] which did not distinguish between clinical and administrative staff. We analyzed special 1996 Canadian Census tabulations to determine administrative and clinical workers' shares of total wages in doctors' offices.[18] We attributed all of the administrative workers' share to administration and assumed that nonphysician clinical personnel spend the same proportion of their time on administration as did physicians.

To calculate the costs of office rent and similar expenses, we attributed one third of physicians' office rent, lease, mortgage, and equipment costs[20,21] to administration and billing. We attributed half of other professional expenses[20,21] to administration. To calculate the administrative expenses of nonphysician office-based practitioners in Canada, we used the same procedure that we used for the U.S. data and based the analysis on 1996 Canadian Census data.

NURSING HOME ADMINISTRATION

No published nationwide data on the administrative costs of U.S. nursing homes are available for 1999, and only Medicare-certified facilities (which are not representative of all nursing homes) file Medicare cost reports. However, California collects cost data from all licensed homes. Therefore, we analyzed 1999 data on 1241 California nursing homes,[22] grouping expenditures into three broad categories: administrative, clinical, and mixed administrative and clinical. We used methods similar to those employed in our hospital analysis[14,15] to allocate expenses from the "mixed" category to the clinical and administrative categories. To generate a national estimate, we multiplied the administrative share of expenditures by total nursing home spending.[8]

For Canada, we and colleagues at the Canadian Institute for Health Information analyzed data for fiscal year 1998 (April 1, 1998, through March 31, 1999) on administrative costs for homes for the aged (excluding Quebec) from Statistics Canada's Residential Care Facilities Survey, using methods similar to those we used for the U.S. data. We multiplied the share spent for administration by total nursing home expenditures in Canada.[9]

ADMINISTRATIVE COSTS OF HOME CARE AGENCIES

We analyzed data from fiscal year 1999 cost reports that 6633 home health care agencies submitted to Medicare. We excluded agencies reporting implausible administrative costs that were below 0 percent or above 100 percent and then calculated the proportion of expenses classified as "administrative and general."

For Canada, we obtained data on administrative costs in Ontario; the categories used appeared similar to those used in the U.S. data.[23] We totaled the administrative costs of Community Care Access Centres,[24] which contract with home care providers; home care providers (White G, Ontario Association of Community Care Access Centres: personal communication); and provincial government oversight of home care. We multiplied the proportion spent for administration by total home care spending throughout Canada.[25]

TOTAL COSTS OF HEALTH CARE ADMINISTRATION

To calculate total spending on health care administration, we totaled the administrative costs of all the categories detailed above. In analyzing the administrative share of health care spending, we excluded from both the numerator and the denominator expenditure categories for which data on administrative costs were unavailable: retail pharmacy sales,

medical equipment and supplies, public health, construction, research, and "other," a heterogeneous category that includes ambulances and in-plant services. These excluded categories accounted for $261.2 billion, 21.6 percent of U.S. health care expenditures, and $21.0 billion, 27.6 percent of Canadian health care expenditures.

TRENDS SINCE 1969

The analysis for 1999 relied on several sources of data that were not available for earlier years. To assess trends over time, using previously described methods,[18] we analyzed U.S. Census data on employment in health care settings from the March Current Population Survey for every fifth year since 1969 and the Canadian Census for 1971, 1986, and 1996.

RESULTS

INSURANCE OVERHEAD

In 1999 U.S. private insurers retained $46.9 billion of the $401.2 billion they collected in premiums. Their average overhead (11.7 percent) exceeded that of Medicare (3.6 percent) and Medicaid (6.8 percent). Overall, public and private insurance overhead totaled $72.0 billion — 5.9 percent of the total health care expenditures in the United States, or $259 per capita (Table 1).

The overhead costs of Canada's provincial insurance plans totaled $311 million (1.3 percent) of the $23.5 billion they spent for physicians and hospital services. An additional $17 million was spent to administer federal government health plans. The overhead of Canadian private insurers averaged 13.2 percent of the $8.4 billion spent for private coverage. Overall, insurance overhead accounted for 1.9 percent of Canadian health care spending, or $47 per capita (Table 1).

EMPLOYERS' COSTS TO MANAGE HEALTH BENEFITS

U.S. employers spent $12.2 billion on internal administrative costs related to health care benefits and $3.7 billion on health care benefits consultants — a total of $15.9 billion, or $57 per capita (Table 1). Canadian employers spent $3.6 billion for private health insurance and $252 million to manage health benefits, or $8 per capita.

HOSPITAL ADMINISTRATION

The average U.S. hospital devoted 24.3 percent of spending to administration. Hospital administration consumed $87.6 billion, or $315 per capita (Table 1). In Canada, hospital administration cost $3.1 billion — 12.9 percent of hospital spending, or $103 per capita.

NURSING HOME ADMINISTRATION

California nursing homes devoted 19.2 percent of revenues to administration in 1999. Nationwide, U.S. nursing homes spent $17.3 billion on administration, or $62 per capita (Table 1). Administration accounted for 12.2 percent ($882 million) of Canadian nursing home expenditures, or $29 per capita.

ADMINISTRATIVE COSTS OF PRACTITIONERS

In the United States, administrative tasks consumed 13.5 percent of physicians' time, valued at $15.5 billion. Physicians spent 8.3 percent of their gross income on clinical employees; the administrative portion (13.5 percent) of compensation of these employees was $3.0 billion. Physicians' costs for clerical staff averaged 12.3 percent of physicians' gross income, or $33.1 billion. The one third of physicians' office rent and expenses attributable to administration represented 4.6 percent of physicians' gross income, or $12.4 billion. Finally, the half of "other professional expenses" (a category that includes accounting and legal fees) attributable to administration accounted for 3.2 percent of physicians' income, or $8.6 billion. In total, physicians' administrative work and costs amounted to $72.6 billion — $261 per capita, or 26.9 percent of physicians' gross income.

The administrative costs of dentists and of other nonphysician practitioners totaled $8.6 billion and $8.8 billion, respectively. Overall, U.S. practitioners'

Table 1. Costs of Health Care Administration in the United States and Canada, 1999.

Cost Category	Spending per Capita (U.S. $)	
	United States	Canada
Insurance overhead	259	47
Employers' costs to manage health benefits	57	8
Hospital administration	315	103
Nursing home administration	62	29
Administrative costs of practitioners	324	107
Home care administration	42	13
Total	1,059	307

administrative costs amounted to $89.9 billion, or $324 per capita (Table 1).

Canadian physicians devoted 8.4 percent of their professional time to practice management and administration, valued at $592 million. They spent 6.1 percent of their gross income on clinical office staff. The administrative portion (8.4 percent) of compensation of these employees amounted to $53 million. Physicians' costs for clerical staff averaged 6.9 percent of their gross income, or $716 million. The one third of physicians' office rent and expenses attributable to administration totaled $193 million. Finally, the 50 percent of "other professional expenses" attributable to administration cost $116 million. In total, physicians' administrative work and costs amounted to $1.7 billion — $55 per capita, or 16.1 percent of their gross income.

The administrative and billing costs of Canadian dentists and of other nonphysician practitioners totaled $928 million and $660 million, respectively. Overall, the administrative expenses of Canadian practitioners totaled $3.3 billion, or $107 per capita (Table 1).

ADMINISTRATIVE COSTS OF HOME CARE AGENCIES

U.S. home care agencies devoted 35.0 percent of total expenditures to administration — $11.6 billion, or $42 per capita (Table 1). Administration accounted for 15.8 percent of Ontario's home care expenditures. Throughout Canada, home care administration expenses totaled $408 million, or $13 per capita.

TOTAL COSTS OF HEALTH CARE ADMINISTRATION

In the United States, health care administration cost $294.3 billion, or $1,059 per capita (Table 1). In Canada, health care administration cost $9.4 billion, or $307 per capita. If the difference of $752 per capita were applied to the 1999 U.S. population, the total excess administrative cost would be $209 billion. After exclusions, administration accounted for 31.0 percent of health care expenditures in the United States, as compared with 16.7 percent of health care expenditures in Canada.

TRENDS IN ADMINISTRATIVE EMPLOYMENT IN HEALTH CARE

In the United States, 27.3 percent of the 11.77 million people employed in health care settings in 1999 worked in administrative and clerical occupations (Table 2). This figure excludes 926,000 employees in life or health insurance firms, 724,000 in insurance brokerages, and employees of consulting firms.[26] In 1969, administrative and clerical workers represented 18.2 percent of the health care labor force (Table 2). In Canada, administrative and clerical occupations accounted for 19.1 percent of the health care labor force in 1996, 18.7 percent in 1986, and 16.0 percent in 1971. (These figures exclude insurance personnel). Although the United States employed 12 percent more health personnel per capita than Canada, administrative personnel accounted for three quarters of the difference.

Table 2. Administrative and Clerical Personnel as a Percentage of the Health Care Labor Force in the United States, 1969 through 1999.*

Year	Percentage of Health Care Labor Force
1969	18.2
1974	21.2
1979	21.9
1984	23.9
1989	25.5
1994	25.7
1999	27.3

* Calculations exclude insurance-industry personnel.

DISCUSSION

Administrators are indispensable to modern health care; their tasks include ensuring that supplies are on hand, that records are filed, and that nurses are paid. Many view intensive, sophisticated management as an attractive solution to cost and quality problems[27-29]; that utilization review, clinical-information systems, and quality-improvement programs should upgrade care seems obvious. However, some regard much of administration as superfluous, born of the quirks of the payment system rather than of clinical needs.

How much administration is optimal? Does the high administrative spending in the United States relative to that in Canada (or to that in the United States 30 years ago) improve care? No studies have directly addressed these questions. Although indirect evidence is sparse, analyses of investor-owned HMOs and hospitals — subgroups of providers

with relatively high administrative costs — have found that for-profit facilities have neither higher-quality care nor lower costs than not-for-profit facilities.[15,30-38] Internationally, administrative expenditures show little relation to overall growth in costs or to life expectancy or other health indicators.[39]

Several factors augment U.S. administrative costs. Private insurers, which have high overhead in most nations — 15.8 percent in Australia, 13.2 percent in Canada, 20.4 percent in Germany, and 10.4 percent in the Netherlands[40] — have a larger role in the United States than in Canada. Functions essential to private insurance but absent in public programs, such as underwriting and marketing, account for about two thirds of private insurers' overhead.[40]

A system with multiple insurers is also intrinsically costlier than a single-payer system. For insurers it means multiple duplicative claims-processing facilities and smaller insured groups, both of which increase overhead.[41,42] Fragmentation also raises costs for providers who must deal with multiple insurance products — at least 755 in Seattle alone[43] — forcing them to determine applicants' eligibility and to keep track of the various copayments, referral networks, and approval requirements. Canadian physicians send virtually all bills to a single insurer. A multiplicity of insurers also precludes paying hospitals a lump-sum, global budget. Under a global-budget system, hospitals and government authorities negotiate an annual budget based on past budgets, clinical performance, and projected changes in services and input costs. Hospitals receive periodic lump-sum payments (e.g., 1/12 of the annual amount each month).

The existence of global budgets in Canada has eliminated most billing and minimized internal cost accounting, since charges do not need to be attributed to individual patients and insurers. Yet fragmentation itself cannot explain the upswing in administrative costs in the United States since 1969, when costs resembled those in Canada. This growth coincided with the expansion of managed care and market-based competition, which fostered the adoption of complex accounting and auditing practices long standard in the business world.

Several caveats apply to our estimates. U.S. and Canadian hospitals, nursing homes, and home care agencies use different accounting categories, though we took pains to ensure that they were comparable. The U.S. hospital figure is consistent with findings from detailed studies of individual hospitals.[44-47] The California data we used to estimate the administrative costs of U.S. nursing homes resulted in a lower figure (19.2 percent of revenues) than a published national estimate for 1998 (25.2 percent).[48]

Our figures for physicians' administrative costs relied on self-reports of time and money spent. We had to estimate the time spent by other clinical personnel on administrative work and the share of office rent and expenses attributable to administration (together, these estimated categories account for 5 percent of total administrative costs in the United States). Physicians' reports and our estimates appear congruent with information from a time–motion study[45] and Census data on clerical and administrative personnel employed in practitioners' offices. Our estimates of employers' costs to administer health care benefits rely on a consultant's survey of

Table 3. Number of Enrollees and Employees of Selected Major U.S. Private Health Insurers and Canadian Provincial Health Plans, 2001.*

Plan Name	No. of Enrollees†	No. of Employees	No. of Employees/ 10,000 Enrollees
U.S. plans			
Aetna	17,170,000	35,700	20.8
Anthem	7,883,000	14,800	18.8
Cigna	14,300,000	44,600	31.2
Humana	6,435,800	14,500	22.5
Mid Atlantic Medical Services	1,832,400	2,571	14.0
Oxford	1,490,600	3,400	22.8
Pacificare	3,388,100	8,200	24.2
United Healthcare	8,540,000	30,000	35.1
WellPoint	10,146,945	13,900	13.7
Canadian plans			
Saskatchewan Health	1,021,288	145	1.4
Ontario Health Insurance Plan	11,742,672	1,433‡	1.2

* Data are from the Annual Reports filed with the Securities and Exchange Commission,[49] the Government of Saskatchewan,[50] and the Government of Ontario.[51]

† Numbers include administrative-services-only contracts as well as Medicare, Medicaid, and commercial enrollees; numbers exclude recipients of pharmacy-benefit management, life, dental, other specialty, and nonhealth insurance products.

‡ The estimate is based on wage and salary expenses and on the assumption that the average annual wage is $38,250.

a limited number of U.S. firms. Though subject to error, this category accounts for only 5 percent of administrative costs in the United States.

Cross-national comparisons are complicated by differences in the range of services offered in hospitals and outpatient settings. For instance, many U.S. hospitals operate skilled-nursing facilities, whose costs are lumped with hospital costs in the national health accounts. Similarly, the costs of free-standing surgical centers, more common in the United States than in Canada, are lumped with practitioner costs. Although these differences shift administrative costs among categories (e.g., from nursing homes to hospitals), their effects on national totals should be small.

Price differences also affect international comparisons, a problem only partially addressed by our use of purchasing-power parities to convert Canadian dollars to U.S. dollars. (Using exchange rates instead would increase the difference between the United States and Canada by 27 percent.) Canadian wages are slightly lower than those in the United States, distorting some comparisons (e.g., per capita spending), but not others (e.g., the administrative share of health care spending or personnel).

Our dollar estimates understate overhead costs in both nations. They exclude the marketing costs of pharmaceutical firms, the value of patients' time spent on paperwork, and most of the costs of advertising by providers, health care industry profits, and lobbying and political contributions. Our analysis also omits the costs of collecting taxes to fund health care and the administrative overhead of such businesses as retail pharmacies and ambulance companies. Finally, we priced practitioners' administrative time using their net, rather than gross, hourly income, conservatively assuming that when physicians substitute clinical for administrative time, their overhead costs rise proportionally; using gross hourly income would boost our estimate of total administrative costs in the United States to $320.1 billion.

The employment figures used for our time-trend analysis exclude administrative employees in consulting firms, drug companies, and retail pharmacies, as well as insurance workers, who are far more numerous in the United States than in Canada[49-51] (Table 3).

Despite these imprecisions, the difference in the costs of health care administration between the United States and Canada is clearly large and growing. Is $294.3 billion annually for U.S. health care administration money well spent?

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We are indebted to Geoff Ballinger and Gilles Fortin for their invaluable assistance in securing and analyzing data on Canadian administrative costs and the comparability of U.S. and Canadian cost categories.

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THE MORAL-HAZARD MYTH

by MALCOLM GLADWELL

The bad idea behind our failed health-care system.

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Tooth decay begins, typically, when debris becomes trapped between the teeth and along the ridges and in the grooves of the molars. The food rots. It becomes colonized with bacteria. The bacteria feeds off sugars in the mouth and forms an acid that begins to eat away at the enamel of the teeth. Slowly, the bacteria works its way through to the dentin, the inner structure, and from there the cavity begins to blossom three-dimensionally, spreading inward and sideways. When the decay reaches the pulp tissue, the blood vessels, and the nerves that serve the tooth, the pain starts—an insistent throbbing. The tooth turns brown. It begins to lose its hard structure, to the point where a dentist can reach into a cavity with a hand instrument and scoop out the decay. At the base of the tooth, the bacteria mineralizes into tartar, which begins to irritate the gums. They become puffy and bright red and start to recede, leaving more and more of the tooth's root exposed. When the infection works its way down to the bone, the structure holding the tooth in begins to collapse altogether.

Several years ago, two Harvard researchers, Susan Starr Sered and Rushika Fernandopulle, set out to interview people without health-care coverage for a book they were writing, "Uninsured in America." They talked to as many kinds of people as they could find, collecting stories of untreated depression and struggling single mothers and chronically injured laborers—and the most common complaint they heard was about teeth. Gina, a hairdresser in Idaho, whose husband worked as a freight manager at a chain store, had "a peculiar mannerism of keeping her mouth closed even when speaking." It turned out that she hadn't been able to afford dental care for three years, and one of her front teeth was rotting. Daniel, a construction worker, pulled out his bad teeth with pliers. Then, there was Loretta, who worked nights at a university research center in Mississippi, and was missing most of her teeth. "They break off after a while, and then you just grab a hold of them, and they work their way out," she explained to Sered and Fernandopulle. "It hurts so bad, because the tooth aches. Then it's a relief just to get it out of there. The hole closes up itself anyway. So it's so much better."

People without health insurance have bad teeth because, if you're paying for everything out of your own pocket, going to the dentist for a checkup seems like a luxury. It isn't, of course. The loss of teeth makes eating fresh fruits and vegetables difficult, and a diet heavy in soft, processed foods exacerbates more serious health problems, like diabetes. The pain of tooth decay leads many people to use alcohol as a salve. And those struggling to get ahead in the job market quickly find that the unsightliness of bad teeth, and the self-consciousness that results, can become a major barrier. If your teeth are bad, you're not going to get a job as a receptionist, say, or a cashier. You're going to be put in the back somewhere, far from the public eye. What Loretta, Gina, and Daniel understand, the two authors tell us, is that bad teeth have come to be seen as a marker of "poor parenting, low educational achievement and slow or faulty intellectual development." They are an outward marker of caste. "Almost every time we asked interviewees what their first priority would be if the president established universal health coverage tomorrow," Sered and Fernandopulle write, "the immediate answer was 'my teeth.' "

The U. S. health-care system, according to "Uninsured in America," has created a group of people who increasingly look different from others and suffer in ways that others do not. The leading cause of personal bankruptcy in the United States is unpaid medical bills. Half of the uninsured owe money to hospitals, and a third are being pursued by collection agencies. Children without health insurance are less likely to receive medical attention for serious injuries, for recurrent ear infections, or for asthma. Lung-cancer patients without insurance are less likely to receive surgery,

chemotherapy, or radiation treatment. Heart-attack victims without health insurance are less likely to receive angioplasty. People with pneumonia who don't have health insurance are less likely to receive X rays or consultations. The death rate in any given year for someone without health insurance is twenty-five per cent higher than for someone with insur-ance. Because the uninsured are sicker than the rest of us, they can't get better jobs, and because they can't get better jobs they can't afford health insurance, and because they can't afford health insurance they get even sicker. John, the manager of a bar in Idaho, tells Sered and Fernandopulle that as a result of various workplace injuries over the years he takes eight ibuprofen, waits two hours, then takes eight more—and tries to cadge as much prescription pain medication as he can from friends. "There are times when I should've gone to the doctor, but I couldn't afford to go because I don't have insurance," he says. "Like when my back messed up, I should've gone. If I had insurance, I would've went, because I know I could get treatment, but when you can't afford it you don't go. Because the harder the hole you get into in terms of bills, then you'll never get out. So you just say, 'I can deal with the pain.' "

One of the great mysteries of political life in the United States is why Americans are so devoted to their health-care system. Six times in the past century—during the First World War, during the Depression, during the Truman and Johnson Administrations, in the Senate in the nineteen-seventies, and during the Clinton years—efforts have been made to introduce some kind of universal health insurance, and each time the efforts have been rejected. Instead, the United States has opted for a makeshift system of increasing complexity and dysfunction. Americans spend $5,267 per capita on health care every year, almost two and half times the industrialized world's median of $2,193; the extra spending comes to hundreds of billions of dollars a year. What does that extra spending buy us? Americans have fewer doctors per capita than most Western countries. We go to the doctor less than people in other Western countries. We get admitted to the hospital less frequently than people in other Western countries. We are less satisfied with our health care than our counterparts in other countries. American life expectancy is lower than the Western average. Childhood-immunization rates in the United States are lower than average. Infant-mortality rates are in the nineteenth percentile of industrialized nations. Doctors here perform more high-end medical procedures, such as coronary angioplasties, than in other countries, but most of the wealthier Western countries have more CT scanners than the United States does, and Switzerland, Japan, Austria, and Finland all have more MRI machines per capita. Nor is our system more efficient. The United States spends more than a thousand dollars per capita per year—or close to four hundred billion dollars—on health-care-related paperwork and administration, whereas Canada, for example, spends only about three hundred dollars per capita. And, of course, every other country in the industrialized world insures all its citizens; despite those extra hundreds of billions of dollars we spend each year, we leave forty-five million people without any insurance. A country that displays an almost ruthless commitment to efficiency and performance in every aspect of its economy—a country that switched to Japanese cars the moment they were more reliable, and to Chinese T-shirts the moment they were five cents cheaper—has loyally stuck with a health-care system that leaves its citizenry pulling out their teeth with pliers.

America's health-care mess is, in part, simply an accident of history. The fact that there have been six attempts at universal health coverage in the last century suggests that there has long been support for the idea. But politics has always got in the way. In both Europe and the United States, for example, the push for health insurance was led, in large part, by organized labor. But in Europe the unions worked through the political system, fighting for coverage for all citizens. From the start, health insurance in Europe was public and universal, and that created powerful political support for any attempt to expand benefits. In the United States, by contrast, the unions worked through the collective-bargaining system and, as a result, could win health benefits only for their own members. Health insurance here has always been private and selective, and every attempt to expand benefits has resulted in a paralyzing political battle over who would be added to insurance rolls and who ought to pay for those additions.

Policy is driven by more than politics, however. It is equally driven by ideas, and in the past few decades a particular idea has taken hold among prominent American economists which has also been a powerful impediment to the expansion of health insurance. The idea is known as "moral hazard." Health economists in

other Western nations do not share this obsession. Nor do most Americans. But moral hazard has profoundly shaped the way think tanks formulate policy and the way experts argue and the way health insurers structure their plans and the way legislation and regulations have been written. The health-care mess isn't merely the unintentional result of political dysfunction, in other words. It is also the deliberate consequence of the way in which American policymakers have come to think about insurance.

"Moral hazard" is the term economists use to describe the fact that insurance can change the behavior of the person being insured. If your office gives you and your co-workers all the free Pepsi you want—if your employer, in effect, offers universal Pepsi insurance—you'll drink more Pepsi than you would have otherwise. If you have a no-deductible fire-insurance policy, you may be a little less diligent in clearing the brush away from your house. The savings-and-loan crisis of the nineteen-eighties was created, in large part, by the fact that the federal government insured savings deposits of up to a hundred thousand dollars, and so the newly deregulated S. & L.s made far riskier investments than they would have otherwise. Insurance can have the paradoxical effect of producing risky and wasteful behavior. Economists spend a great deal of time thinking about such moral hazard for good reason. Insurance is an attempt to make human life safer and more secure. But, if those efforts can backfire and produce riskier behavior, providing insurance becomes a much more complicated and problematic endeavor.

In 1968, the economist Mark Pauly argued that moral hazard played an enormous role in medicine, and, as John Nyman writes in his book "The Theory of the Demand for Health Insurance," Pauly's paper has become the "single most influential article in the health economics literature." Nyman, an economist at the University of Minnesota, says that the fear of moral hazard lies behind the thicket of co-payments and deductibles and utilization reviews which characterizes the American health-insurance system. Fear of moral hazard, Nyman writes, also explains "the general lack of enthusiasm by U.S. health economists for the expansion of health insurance coverage (for example, national health insurance or expanded Medicare benefits) in the U.S."

What Nyman is saying is that when your insurance company requires that you make a twenty-dollar co-payment for a visit to the doctor, or when your plan includes an annual five-hundred-dollar or thousand-dollar deductible, it's not simply an attempt to get you to pick up a larger share of your health costs. It is an attempt to make your use of the health-care system more efficient. Making you responsible for a share of the costs, the argument runs, will reduce moral hazard: you'll no longer grab one of those free Pepsis when you aren't really thirsty. That's also why Nyman says that the notion of moral hazard is behind the "lack of enthusiasm" for expansion of health insurance. If you think of insurance as producing wasteful consumption of medical services, then the fact that there are forty-five million Americans without health insurance is no longer an immediate cause for alarm. After all, it's not as if the uninsured *never* go to the doctor. They spend, on average, $934 a year on medical care. A moral-hazard theorist would say that they go to the doctor when they really have to. Those of us with private insurance, by contrast, consume $2,347 worth of health care a year. If a lot of that extra $1,413 is waste, then maybe the uninsured person is the truly efficient consumer of health care.

The moral-hazard argument makes sense, however, only if we consume health care in the same way that we consume other consumer goods, and to economists like Nyman this assumption is plainly absurd. We go to the doctor grudgingly, only because we're sick. "Moral hazard is overblown," the Princeton economist Uwe Reinhardt says. "You always hear that the demand for health care is unlimited. This is just not true. People who are very well insured, who are very rich, do you see them check into the hospital because it's free? Do people really like to go to the doctor? Do they check into the hospital instead of playing golf?"

For that matter, when you have to pay for your own health care, does your consumption really become more efficient? In the late nineteen-seventies, the RAND Corporation did an extensive study on the question, randomly assigning families to health plans with co-payment levels at zero per cent, twenty-five per cent, fifty per cent, or ninety-five per cent, up to six thousand dollars. As you might expect, the more that people were asked to chip in for their health care the less care they used. The problem was that they cut back equally on both frivolous care and useful care. Poor people in the high-deductible group with hypertension, for instance, didn't do nearly as good a job of controlling their blood pressure as those in other groups, resulting in a ten-

per-cent increase in the likelihood of death. As a recent Commonwealth Fund study concluded, cost sharing is "a blunt instrument." Of course it is: how should the average consumer be expected to know beforehand what care is frivolous and what care is useful? I just went to the dermatologist to get moles checked for skin cancer. If I had had to pay a hundred per cent, or even fifty per cent, of the cost of the visit, I might not have gone. Would that have been a wise decision? I have no idea. But if one of those moles really is cancerous, that simple, inexpensive visit could save the health-care system tens of thousands of dollars (not to mention saving me a great deal of heartbreak). The focus on moral hazard suggests that the changes we make in our behavior when we have insurance are nearly always wasteful. Yet, when it comes to health care, many of the things we do only because we have insurance—like getting our moles checked, or getting our teeth cleaned regularly, or getting a mammogram or engaging in other routine preventive care—are anything but wasteful and inefficient. In fact, they are behaviors that could end up saving the health-care system a good deal of money.

Sered and Fernandopulle tell the story of Steve, a factory worker from northern Idaho, with a "grotesquelooking left hand—what looks like a bone sticks out the side." When he was younger, he broke his hand. "The doctor wanted to operate on it," he recalls. "And because I didn't have insurance, well, I was like 'I ain't gonna have it operated on.' The doctor said, 'Well, I can wrap it for you with an Ace bandage.' I said, 'Ahh, let's do that, then.' " Steve uses less health care than he would if he had insurance, but that's not because he has defeated the scourge of moral hazard. It's because instead of getting a broken bone fixed he put a bandage on it.

At the center of the Bush Administration's plan to address the health-insurance mess are Health Savings Accounts, and Health Savings Accounts are exactly what you would come up with if you were concerned, above all else, with minimizing moral hazard. The logic behind them was laid out in the 2004 Economic Report of the President. Americans, the report argues, have too much health insurance: typical plans cover things that they shouldn't, creating the problem of overconsumption. Several paragraphs are then devoted to explaining the theory of moral hazard. The report turns to the subject of the uninsured, concluding that they fall into several groups. Some are foreigners who may be covered by their countries of origin. Some are people who could be covered by Medicaid but aren't or aren't admitting that they are. Finally, a large number "remain uninsured as a matter of choice." The report continues, "Researchers believe that as many as one-quarter of those without health insurance had coverage available through an employer but declined the coverage. . . . Still others may remain uninsured because they are young and healthy and do not see the need for insurance." In other words, those with health insurance are overinsured and their behavior is distorted by moral hazard. Those without health insurance use their own money to make decisions about insurance based on an assessment of their needs. The insured are wasteful. The uninsured are prudent. So what's the solution? Make the insured a little bit more like the uninsured.

Under the Health Savings Accounts system, consumers are asked to pay for routine health care with their own money—several thousand dollars of which can be put into a tax-free account. To handle their catastrophic expenses, they then purchase a basic health-insurance package with, say, a thousand-dollar annual deductible. As President Bush explained recently, "Health Savings Accounts all aim at empowering people to make decisions for themselves, owning their own health-care plan, and at the same time bringing some demand control into the cost of health care."

The country described in the President's report is a very different place from the country described in "Uninsured in America." Sered and Fernandopulle look at the billions we spend on medical care and wonder why Americans have so little insurance. The President's report considers the same situation and worries that we have too much. Sered and Fernandopulle see the lack of insurance as a problem of poverty; a third of the uninsured, after all, have incomes below the federal poverty line. In the section on the uninsured in the President's report, the word "poverty" is never used. In the Administration's view, people are offered insurance but "decline the coverage" as "a matter of choice." The uninsured in Sered and Fernandopulle's book decline coverage, but only because they can't afford it. Gina, for instance, works for a beauty salon that

offers her a bare-bones health-insurance plan with a thousand-dollar deductible for two hundred dollars a month. What's her total income? Nine hundred dollars a month. She could "choose" to accept health insurance, but only if she chose to stop buying food or paying the rent.

The biggest difference between the two accounts, though, has to do with how each views the function of insurance. Gina, Steve, and Loretta are ill, and need insurance to cover the costs of getting better. In their eyes, insurance is meant to help equalize financial risk between the healthy and the sick. In the insurance business, this model of coverage is known as "social insurance," and historically it was the way health coverage was conceived. If you were sixty and had heart disease and diabetes, you didn't pay substantially more for coverage than a perfectly healthy twenty-five-year-old. Under social insurance, the twenty-five-year-old agrees to pay thousands of dollars in premiums even though he didn't go to the doctor at all in the previous year, because he wants to make sure that someone else will subsidize his health care if he ever comes down with heart disease or diabetes. Canada and Germany and Japan and all the other industrialized nations with universal health care follow the social-insurance model. Medicare, too, is based on the social-insurance model, and, when Americans with Medicare report themselves to be happier with virtually every aspect of their insurance coverage than people with private insurance (as they do, repeatedly and overwhelmingly), they are referring to the social aspect of their insurance. They aren't getting better care. But they are getting something just as valuable: the security of being insulated against the financial shock of serious illness.

There is another way to organize insurance, however, and that is to make it actuarial. Car insurance, for instance, is actuarial. How much you pay is in large part a function of your individual situation and history: someone who drives a sports car and has received twenty speeding tickets in the past two years pays a much higher annual premium than a soccer mom with a minivan. In recent years, the private insurance industry in the United States has been moving toward the actuarial model, with profound consequences. The triumph of the actuarial model over the social-insurance model is the reason that companies unlucky enough to employ older, high-cost employees—like United Airlines—have run into such financial difficulty. It's the reason that automakers are increasingly moving their operations to Canada. It's the reason that small businesses that have one or two employees with serious illnesses suddenly face unmanageably high health-insurance premiums, and it's the reason that, in many states, people suffering from a potentially high-cost medical condition can't get anyone to insure them at all.

Health Savings Accounts represent the final, irrevocable step in the actuarial direction. If you are preoccupied with moral hazard, then you want people to pay for care with their own money, and, when you do that, the sick inevitably end up paying more than the healthy. And when you make people choose an insurance plan that fits their individual needs, those with significant medical problems will choose expensive health plans that cover lots of things, while those with few health problems will choose cheaper, bare-bones plans. The more expensive the comprehensive plans become, and the less expensive the bare-bones plans become, the more the very sick will cluster together at one end of the insurance spectrum, and the more the well will cluster together at the low-cost end. The days when the healthy twenty-five-year-old subsidizes the sixty-year-old with heart disease or diabetes are coming to an end. "The main effect of putting more of it on the consumer is to reduce the social redistributive element of insurance," the Stanford economist Victor Fuchs says. Health Savings Accounts are not a variant of universal health care. In their governing assumptions, they are the antithesis of universal health care.

The issue about what to do with the health-care system is sometimes presented as a technical argument about the merits of one kind of coverage over another or as an ideological argument about socialized versus private medicine. It is, instead, about a few very simple questions. Do you think that this kind of redistribution of risk is a good idea? Do you think that people whose genes predispose them to depression or cancer, or whose poverty complicates asthma or diabetes, or who get hit by a drunk driver, or who have to keep their mouths closed because their teeth are rotting ought to bear a greater share of the costs of their health care than those of us who are lucky enough to escape such misfortunes? In the rest of the industrialized world, it is assumed that the more equally and widely the burdens of illness are shared, the better off the population as a whole is likely to be. The reason the United States has forty-five million people without coverage is that its health-care policy

is in the hands of people who disagree, and who regard health insurance not as the solution but as the problem.

What are we purchasing from the private plans?

Passing the Buck
By Paul Krugman
The New York Times
April 22, 2005

Isn't competition supposed to make the private sector more efficient than the public sector? Well, as the World Health Organization put it in a discussion of Western Europe, private insurers generally don't compete by delivering care at lower cost. Instead, they "compete on the basis of risk selection" - that is, by turning away people who are likely to have high medical bills and by refusing or delaying any payment they can.

Yet the cost of providing medical care to those denied private insurance doesn't go away. If individuals are poor, or if medical expenses impoverish them, they are covered by Medicaid. Otherwise, they pay out of pocket or rely on the charity of public hospitals.

So we've created a vast and hugely expensive insurance bureaucracy that accomplishes nothing. The resources spent by private insurers don't reduce overall costs; they simply shift those costs to other people and institutions. It's perverse but true that this system, which insures only 85 percent of the population, costs much more than we would pay for a system that covered everyone.

Think about how crazy all of this is. At a rough guess, between two million and three million Americans are employed by insurers and health care providers not to deliver health care, but to pass the buck for that care to someone else. And the result of all their exertions is to make the nation poorer and sicker.

Why do we put up with such an expensive, counterproductive health care system? Vested interests play an important role. But we also suffer from ideological blinders: decades of indoctrination in the virtues of market competition and the evils of big government have left many Americans unable to comprehend the idea that sometimes competition is the problem, not the solution.

http://www.nytimes.com/2005/04/22/opinion/22krugman.html?hp

Comment: The debate today rages on as to whether we want to build on the current system, or replace it with a single, universal system. But why would we continue to support an industry that is consuming ever more of our health care dollars when its primary function is to devise methods of shifting the funding of health care from the insurance risk pool to patients and taxpayers? We are paying for a complex and expensive administrative system designed specifically to defeat the function that is the reason for its existence: pooling risk.

To quote further from Krugman's article: "According to the (World Health Organization), the higher costs of private insurers are 'mainly due to the extensive bureaucracy required to assess risk, rate premiums, design benefit packages and review, pay or refuse claims.' Public insurance plans have far less bureaucracy because they don't try to screen out high-risk clients or charge them higher fees."

Why then are we even considering the option of expanding our current system? It's broken beyond repair. Installing a new universal system would be cheaper and more effective. And we would all be healthier, both physically and financially.

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Health Savings Accounts and High-Deductible Health Plans: Why They Won't Cure What Ails U.S. Health Care

Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on health savings accounts (HSAs). The Committee is to be commended for focusing attention on the manifold problems confronting the U.S. health care system: steady growth in the number of uninsured Americans, rising health care costs and insurance premiums, wide variation in the quality and cost of care, and inefficiencies in care delivery and administration.

Some maintain that HSAs, coupled with high-deductible health plans (HDHPs), are an important part of the solution to our health system's cost, quality, and insurance problems. Asking families to pay more out-of-pocket, the reasoning goes, will create more prudent consumers of health care, driving down cost growth and improving the quality of care as providers compete for patients. And the tax incentives associated with HSAs will lure previously uninsured people into the individual market, reducing the numbers of families without health insurance.

But while it is comforting to believe that such a simple idea could help solve our health care problems, nearly all evidence gathered to date about HSAs and HDHPs points to the contrary. Indeed, there is evidence that encouraging people to join such health plans will exacerbate some of the very maladies that undermine our health care system's ability to perform at its highest level.

Many Americans Are Already Burdened by High Health Care Costs

- Americans already pay far more out-of-pocket for their health care than residents of other industrialized countries, and real per capita out-of-pocket spending has been steadily rising since the late 1990s.
- The Commonwealth Fund Biennial Health Insurance Survey found that in 2005, 60 percent of working-age adults with private insurance with annual household incomes of under $40,000 spent 5 percent or more of their income on out-of-pocket expenses and premiums, and 40 percent spent 10 percent or more.
- There is considerable evidence that high out-of-pocket costs lead patients to decide against getting the health care they need. The Commonwealth Fund Biennial Survey found that 44 percent of privately insured adults with deductibles of $1,000 or more avoided getting necessary health care or prescriptions because of the cost, compared with 25 percent of adults with deductibles under $500.
- There is also evidence that rising cost exposure leads people to accumulate medical debt, take on credit card debt, and reduce their savings. The Commonwealth Fund survey found that 40 percent of privately insured adults with deductibles of $1,000 or more had problems paying medical bills or had accumulated medical debt, compared

with 23 percent of adults with deductibles under $500.

Early Experience with HSA-Eligible HDHPs Reveals Low Satisfaction, High Out-of-Pocket Costs, and Cost-Related Access Problems

- The EBRI/Commonwealth Fund Consumerism in Health Care Survey found in 2005 that people enrolled in HSA-eligible HDHPs were much less satisfied with many aspects of their health care than adults in more comprehensive plans.
- People in these plans allocate substantial amounts of income to their health care, especially those who have poorer health or lower incomes.
- Adults in HDHPs are far more likely to delay or avoid getting needed care, or to skip medications, because of the cost. Problems are particularly pronounced among those with poorer health or lower incomes.
- Few Americans in any health plan have the information they need to make decisions. Just 12 to 16 percent of insured adults have information from their health plan about the quality or cost of care provided by their doctors and hospitals.

Patients' Use of Information Alone Is Not Likely to Dramatically Reduce Health Care Costs or Improve Quality

- It is unrealistic to expect that patient financial incentives, even if better information is available, will lead to dramatic improvements in quality and efficiency.
- Most health care costs are incurred by people who are very ill, often in emergencies. Ten percent of the sickest patients account for about 70 percent of all health care spending.
- Payers, federal and state governments, accrediting organizations, and professional societies are much better positioned to insist on high quality and efficiency.

HSAs Will Not Solve Our Uninsured Problem

- Economists Sherry Glied and Dahlia Remler estimate that under current law, fewer than 1 million currently uninsured Americans are expected to gain coverage as a result of HSAs. This is primarily because 71 percent of the uninsured are in a 10-percent-or-lower income tax bracket—and thus would benefit little from the tax savings associated with HSAs.

The Individual Insurance Market Is Not an Efficient or Equitable Solution to the Uninsured Problem

- The Commonwealth Fund Biennial Health Insurance Survey found that nearly 90 percent of adults who sought coverage in the individual insurance market in the last three years never ended up buying a plan.
- One-third (34%) of those who sought individual market insurance said they found it

very difficult or impossible to find a plan with the coverage they needed.
- Nearly three of five (58%) adults who sought individual market insurance found it very difficult or impossible to find a plan they could afford. The problem was particularly acute among people with health problems or low incomes.
- About one-fifth (21%) of adults who had ever sought coverage in the individual market were turned down by an insurance carrier, charged a higher price, or had a specific health problem excluded from their coverage.
- The individual market is also inefficient: the administrative costs of individual coverage consume an estimated 25 to 40 percent of each premium dollar, compared with 10 percent for group coverage.

What Needs to Be Done

We as a nation should focus on more promising strategies for expanding coverage, improving affordability, and improving quality and efficiency. These strategies include:

- Expanding group insurance coverage, with costs shared among individuals, employers, and government. This could be done by expanding employer-based coverage, eliminating Medicare's two-year waiting period for coverage of the disabled, letting older adults "buy in" to Medicare, and building on Medicaid and the State Children's Health Insurance Program (SCHIP) to cover greater numbers of low-income families, young adults, and single adults.
- Ensuring affordable coverage for families by placing limits on family premium and out-of-pocket costs as a percentage of income (e.g., 5% of income for low-income families).
- Greater transparency with regard to provider quality and the total costs of care.
- Pay-for-performance incentives to reward health care providers that deliver high quality and high efficiency.
- Development of "value networks" of high performing providers under Medicare, Medicaid, and private insurance.
- Better management of high-cost care and chronic health conditions.
- Improved access to primary care and preventive services.
- Investment in health information technology to facilitate the transfer of information among patients, providers, and payers.

Citation

S. R. Collins, Health Savings Accounts and High-Deductible Health Plans: Why They Won't Cure What Ails U.S. Health Care, Invited Testimony, Committee on Finance, Subcommittee on Health, United States Senate Hearing on "Health Savings Accounts," September 26, 2006

THE COMMONWEALTH FUND 1 EAST 75TH STREET, NEW YORK, NY 10021 PHONE: 212.606.3800 FAX: 212.606.3500 E-MAIL: CMWF@CMWF.ORG

ORDINANCE 06-25

TO AMEND CHAPTER 2.23 OF THE BLOOMINGTON MUNICIPAL CODE ENTITLED "COMMUNITY AND FAMILY RESOURCES DEPARTMENT" IN ORDER TO ESTABLISH THE COMMISSION ON THE STATUS OF BLACK MALES AS A PERMANENT COMMISSION

WHEREAS, Ordinance 01-03 created and established the Bloomington Commission on the Status of Black Males; and

WHEREAS, that ordinance contains a sunset provision which calls for the Commission to be reviewed every three years for the desirability of reauthorization; and

WHEREAS, as a result of such a review by the Commission and the administration, it has been deemed desirable to abolish the sunset provision and establish the Commission on the Status of Black Males as a permanent commission;

NOW, THEREFORE, BE IT HEREBY ORDAINED BY THE COMMON COUNCIL OF THE CITY OF BLOOMINGTON, MONROE COUNTY, INDIANA, THAT:

SECTION I. Bloomington Municipal Code 2.23.070(4) shall be amended by deleting it and replacing it with the following:

(4) Terms. The terms of all members of the commission shall be for two (2) years.

SECTION II. Bloomington Municipal Code 2.23.070(7) shall be deleted.

SECTION III. If any section, sentence or provision of this ordinance, or the application thereof to any person or circumstances shall be declared invalid, such invalidity shall not affect any of the other sections, sentences, provisions, or applications of this ordinance which can be given effect without the invalid provision or application, and to this end the provisions of this ordinance are declared to be severable.

SECTION IV. This ordinance shall be in full force and effect from and after its passage by the Common Council of the City of Bloomington and approval of the Mayor.

PASSED AND ADOPTED by the Common Council of the City of Bloomington, Monroe County, Indiana, upon this _____ day of _____, 2006

_____
CHRIS STURBAUM, President
Bloomington Common Council

ATTEST:

_____
REGINA MOORE, Clerk
City of Bloomington

PRESENTED by me to the Mayor of the City of Bloomington, Monroe County, Indiana, upon this _____ day of _____, 2006.

_____
REGINA MOORE, Clerk
City of Bloomington

SIGNED and APPROVED by me upon this _____ day of _____, 2006.

_____
MARK KRUZAN, Mayor
City of Bloomington

SYNOPSIS

This ordinance amends the Bloomington Municipal Code by abolishing the sunset provision on the Commission on the Status of Black Males and makes the Commission a permanent commission.

TO: **Mayor Mark Kruzan**
FROM: **Craig Brenner, Special Projects Coordinator**
DATE: **November 14, 2006**
RE: **Reauthorization of the Commission on the Status of Black Males**

The Commission on the Status of Black Males (CSBM) was established by a City of Bloomington ordinance on February 22, 2001. It was created in response to public request that the City study and address the issues and problems faced by African-American males. The Commission works to alleviate the problems that African-American men and boys experience in employment, education, criminal justice and health. It is modeled after the Indiana Commission on the Social Status of Black Males, which was created in 1993 to address the severe problems faced by African-American males statewide. Locally based commissions have been established across the state.

The Commission consists of seven Monroe County residents appointed by the Mayor, Common Council, Human Rights Commission, and the Dr. Martin Luther King, Jr. Birthday Celebration Commission. Commissioners include Larry Brown, Cedric Harris, William Knox, David Hummons, George W. Tardy, Jr., Paulette Patterson Dilworth, and Bev Smith. The CSBM is charged with developing action committees to address problems of African-American males, serving as a catalyst to promote positive public and private remedies to the problems, organizing and convening community forums and neighborhood-based focus groups to discuss the status of black males, and networking with similar groups throughout the state, sharing ideas, information, data and plans. The Commission submits written annual reports in February of each year. By ordinance the commission shall cease to exist after January 31, 2007, unless the Common Council passes an ordinance renewing or reestablishing it prior to January 31, 2007. After review by the Community and Family Resources Department and the administration, staff and Commission members recommend that the Commission be made a permanent commission due to its proven efficacy and the continuing issues faced by Black males. This change to permanency is also made in the interest of uniformity as no other City board or commission contains a sunset provision.

Attached is a copy of the commission's most recent annual report, dated February 13, 2006.

The Commission began 2006 by presenting the first annual award recognizing and affirming young African American males. The Mayor announced the award and called for nominations at the King Birthday celebration in January, and it was presented during Black History Month to Bloomington High School North Junior Matt Herndon.

During the past year, commission members continued to work closely with and attend meetings of the Monroe County Community School Corporation's Human Understanding and Diversity Forum, created in response to the commission's 2004 Town Hall Meeting on the topic of "Race, School Discipline, and Criminal Justice." After a year of study, including input from the public, faculty, staff, and members of the commission, the forum issued recommendations in December of last year to Dr. Maloy and MCCSC that address

the school corporation's policies and procedures. Since the departure of Dr. Maloy, the Forum has been on hold; however, MCCSC Interim Superintendent Jim Harvey will attend the December, 2006 meeting of the commission to discuss the Forum and other concerns expressed by the public at the Town Hall Meeting. Commission member Bev Smith, Human Resources Associate at MCCSC, is facilitating the Superintendent's involvement with the commission.

During 2006, the commission continued to address the goals of the community's Racial Justice Task Force, in particular the recommendations presented at the Town Hall Meeting by panelist and RJTF member Guy Loftman. The commission continues to believe that full implementation of these recommendations will have a positive impact on those involved with the criminal justice system in Monroe County, and it convened representatives of local law enforcement agencies, including City of Bloomington Police, at its April 12, 2006 meeting to work toward the placement of digital video cameras in all police vehicles.

The commission continues to work with the Indiana Commission on the Social Status of Black Males. During 2006, the Executive Director of the Indiana Commission on the Social Status of Black Males attended a commission meeting in Bloomington.

The commission was a co-sponsor of the October 3, 2006 Town Hall Meeting on Healthcare moderated by Dr. Edwin Marshall. The Town Hall Meeting was a huge success, and allowed Cook, Inc. to publicly announce its $600,000 donation to the new Volunteers in Medicine Clinic.

Many guests and representatives of community and governmental organizations attended Commission meetings during 2006, including representatives from the Monroe County Council, MCCSC, Monroe County Racial Justice Task Force, I.U. School of Education, Community Justice and Mediation Center, and Safe and Civil City Program. We continue to support and provided significant input into the conflict resolution training sessions by the Community Justice and Mediation Center, participating as trainers. The commission also supports and participates in the annual Juneteenth Celebration, Soul Food Festival, and Men of Color Leadership Conference held at Indiana University-Bloomington.

On November 10, 2006, the commission held a planning retreat at which it discussed specific initiatives planned for 2007. Some of this include instituting a mentoring program during the lunch hour in the public schools, supporting the 2007 Men of Color Conference at Indiana University by providing programming specifically aimed at high school students, continuing to work with Dr. Edwin Marshall on health issues of concern to Black males, and reaching out to the new Monroe County Prosecutor re. the Criminal Justice Task Force recommendations.

For detailed information on the activities of the Commission, please refer to the City's Web site at www.bloomington.in.gov/cfrd.

To: **Mayor Mark Kruzan**
Common Council of the City of Bloomington

From: **David Hummons, Chair**
Bloomington Commission on the Status of Black Males

Re: **Annual Report from the Commission on the Status of Black Males**

Date: **February 13, 2006**

The City of Bloomington's Commission on the Status of Black Males was created to address the problems faced by African-American males in the areas of health, employment, criminal justice, and education. The purposes and duties of the group include, in part, to serve as a catalyst to promote positive public and private remedies to address the multi-faceted problems confronting Black males in the community, to organize and convene community forums and focus groups to discuss the status of Black males, and to network with like-minded groups in the community and the state. The seven members of the Commission during 2005 included Commission Chair David Hummons (appointed by the Dr. Martin Luther King, Jr. Birthday Celebration Commission), William Knox (Common Council), Larry Brown (Human Rights Commission), Cedric Harris (Mayor), Paulette Patterson Dilworth (Mayor), Genevieve Williamson (Common Council), and George W. Tardy, Jr. (Mayor). With the recent resignation of Genevieve Williamson, there is one vacancy (Common Council). Staff support is provided by Liaison Craig Brenner and Program Assistant Lee Bowlen.

The Commission has completed its fifth year, making significant progress on several on-going initiatives. The 2004 Town Hall Meeting on the topic of "Race, School Discipline, and Criminal Justice" widely reported in *The Herald-Times*, and subsequent efforts by MCCSC Superintendent John Maloy resulted in creation of the MCCSC Human Understanding and Diversity Forum. After a year of study, including input from the public, faculty, staff, and members of the Commission, the forum issued recommendations in December to Dr. Maloy and MCCSC that address the school corporation's policies and procedures. A copy of the recommendations is attached to this report.

During 2005, we continued to address employment issues. Daniel Grundmann, Director of Employee Services for the City of Bloomington, attended our May meeting to discuss increasing the pool of applicants for city positions. We also continued to support the goals of the community's Racial Justice Task Force, in particular the seven recommendations presented at the Town Hall Meeting by panelist and RJTF member Guy Loftman (attached to this report). We continue to believe that full implementation of these recommendations will have a positive impact on those involved with the criminal justice system in Monroe County, and we decided that one of the most difficult recommendations – placing digital video cameras in all police

vehicles in Monroe County – deserved special attention. We are working to establish a committee consisting of representatives from the community to support this recommendation.

Having worked with Mayor Kruzan and the Bloomington Parks and Recreation Department during 2004 to rename Ninth Street Park in honor of Rev. Ernest D. Butler, we were pleased to be involved in the official ceremony in June of 2005.

We continue to work with the Indiana Commission on the Social Status of Black Males. During 2005, we participated in the 7th Annual African American Male National Conference: Education vs. Incarceration, in Indianapolis, where we presented two workshops to conference attendees from around the country on the topic "Developing a Local Commission: Best Practices." We have a good relationship with the new Executive Director of the Indiana Commission on the Social Status of Black Males, and he recently attended one of our meetings in Bloomington and discussed the Indiana Commission and ways we can work together.

Many guests and representatives of community and governmental organizations attended Commission meetings during 2005, including representatives from the Monroe County Council, MCCSC, Monroe County Racial Justice Task Force, I.U. School of Education, Community Justice and Mediation Center, and Safe and Civil City Program. We also supported and provided significant input into the design of conflict resolution training sessions by the Community Justice and Mediation Center, with one member of the Commission participating as a trainer, and we took part in the Juneteenth Celebration, Soul Food Festival, and Men of Color Leadership Conference held at Indiana University-Bloomington.

The Commission concluded 2005 by creating a new award to be presented annually during Black History Month that will recognize and affirm young African American males. The Mayor announced the award and called for nominations at the King Birthday celebration, and we will honor the first recipient later this month.

For detailed information on the activities of the Commission, please refer to the City's Web site at www.bloomington.in.gov/cfrd.

Addendum: Racial Justice Task Force Recommendations received from Guy Loftman.

1. Seek a built in TV camera and recorder in each BPD and MCSD squad car set to automatically come on when flashing lights are turned on.

2. Adjust bond schedule to allow $500 cash OR surety at initial release, not both. (Bond has already undergone major change since our initial study)

3. Make hearing date notice particularly obvious when people are in court. A separate, bright yellow colored paper with dates and times of mandatory appearances would be separately handed to the Defendant with express identification by court that those are the times to appear.

4. Seek backup notice address, phone and contact person for court and probation to minimize FTAs.

5. Don't require the defendant to appear personally at pretrial conferences.

6. Initiate a public education program on how the courts and criminal justice system work. Youth, especially should be informed of how to act if approached by police, if called to court or probation, and what to do if they believe they have been harassed or abused.

7. Initiate sliding fee for Pre-Trial Diversion Program.

ORDINANCE 06-26

TO AUTHORIZE THE ISSUANCE OF BONDS BY THE MONROE COUNTY REDEVELOPMENT COMMISSION PURSUANT TO IC 36-7-14-3.5

WHEREAS, the Monroe County Redevelopment Commission ("Commission") did on February 25, 1993, adopt a Declaratory Resolution establishing the Westside Economic Development Area ("Area"); and

WHEREAS, the City of Bloomington, Indiana ("City") has annexed part of the real estate within the Area ("Annexation"); and

WHEREAS, the Commission is considering adopting a resolution authorizing bonds in an aggregate principal amount not to exceed Five Million Dollars ($5,000,000) ("Bond Resolution") payable from Tax Increment and, to the extent Tax Increment is not sufficient, may impose a Special Benefits Tax for the purpose of paying the costs of the Project (each as defined in the Bond Resolution) ("Bonds"); and

WHEREAS, the County will use the proceeds of the Bonds to construct and develop the Indiana Life Sciences Education and Training Institute as a partnership between Monroe County, Ivy Tech Community College-Bloomington, Bloomington Economic Development Corporation, Bloomington Life Sciences Partnership, and local industry; and

WHEREAS, IC 36-7-14-3.5 requires the approval of the issuance of the Bonds payable from Tax Increment by the Common Council of the City;

NOW, THEREFORE, BE IT ORDAINED BY THE COMMON COUNCIL OF THE CITY OF BLOOMINGTON, INDIANA, THAT:

SECTION I. The Common Council hereby approves the issuance of the Bonds by the Commission.

SECTION II. This ordinance shall be in full force and effect from and after its passage and execution by the Mayor.

PASSED AND ADOPTED by the Common Council of the City of Bloomington, Indiana this ____ day of _____, 2006.

_____
CHRIS STURBAUM, President
Bloomington Common Council

ATTEST:

_____
REGINA MOORE, Clerk
City of Bloomington

PRESENTED by me to the Mayor of the City of Bloomington this ____ day of _____, 2006.

_____
REGINA MOORE, Clerk

SIGNED and APPROVED this ____ day of _____, 2006.

_____
MARK KRUZAN, Mayor
City of Bloomington

SYNOPSIS

This ordinance by the City of Bloomington approves Monroe County Redevelopment Commission's issuance of bonds payable with Tax Increment Finance (TIF) from Monroe County's Westside TIF District, a part of which has been annexed by the City. The City's approval for issuing new bonds is required whenever the City has annexed property within a County TIF district and the tax from that property will be used to repay TIF bonds. (See IC 36-7-14-3.5).

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November 14, 2006

Monroe County Redevelopment Commission
Attention: Mr. Clint Merkel
Courthouse
Bloomington, IN 47404

Gentlemen and Mesdames:

We have reviewed "The City of Bloomington and Monroe County, Indiana Agreement Regarding Tax Increment Finance (TIF) Revenues from The County's Westside TIF District". This agreement covers the TIF area which we commonly refer to as the Westside TIF. It is our understanding that the agreement covers the "property" as defined on Page Four of that agreement. It is also our understanding that the proposed project known as the Ivy Tech project does not fall within those boundaries. It should be noted that the proposed project is assumed to be a tax-exempt facility, and the County proposes to issue a 20-year bond payable from current TIF revenues, exclusive of the facility.

The new bond issue proposed to be issued by the County, and payable from TIF revenues from the Westside TIF District, at this time, does not appear to have any impact - either positive or negative - on the amount to be received by the City of Bloomington, now or in the future. In fact, when sizing the proposed bonds, the coverage requirement and the payment to the City were taken into account so as not to impact the City of Bloomington's annual payment from this area. In the event TIF revenues would be reduced by future events unknown to us at this time, we have not taken those events into account as of the date of this letter.

We hope this assists you as we move forward on this project.

Respectfully submitted,

Financial Solutions Group, Inc.

Gregory T. Guerrettaz

Indiana Life Sciences Education & Training Institute

Business Plan (DRAFT)

Executive Summary

Life Sciences: A Growth Industry: Life Sciences are a critical growth industry for Indiana, the United States and countries across the globe. The industry is expanding at double digit rates, fueled by major advances in the speed of drug delivery based on genomics technology, rational drug design and high throughput screening. Medical devices and diagnostics are becoming increasingly sophisticated and the manufacturing processes more complex. Additionally, the combination of drug and medical device combination products is bringing together science and engineering specialties unseen before producing vast collaborations with universities and industry.

Bloomington and Monroe County – A Unique Opportunity: Bloomington, Monroe County and the State of Indiana have a well established base of firms to build off of and can expect growth in life sciences over the next decade. Growth projections at 5 of our largest area firms call for over 1,200 new jobs to be created over the next five years. Average salaries in life sciences are well above the State average and provide benefits that are extremely attractive to prospective employees. There are many well established educational programs at our K-12 and higher education providers that serve the life sciences and our local life sciences firms are engaged in partnerships with our education and training providers that provide an exceptional community benefit.

Life Sciences Education & Training – A Growing Need: A significant need and unique opportunity exists for the development of a training facility and programs targeted at the life sciences sector. The opportunity for Bloomington/Monroe County and the region is not only to serve its growing biopharmaceutical and medical device firms with the necessary workers for their expansions, but also to build the capability into a strength and core competency in the region and the State of Indiana. In doing so, a ready source of trained talent will attract additional biotechnology, pharmaceutical, medical device firms and support the existing employment base we have today. This will further develop our local/regional economy in a significant way.

Proposed Education & Training Institute – A Solution: An Indiana Life Sciences Education and Training Institute is under development as an enabling investment for the growing life sciences industry in Bloomington, Monroe County, and the State of Indiana. This Institute has two critical elements, a well designed facility in which to provide training programs, and innovative life sciences training programs that serve immediate and future needs of local industry. The facility will be a partnership between Monroe County, Ivy Tech Community College-Bloomington, Bloomington Economic Development Corporation, Bloomington Life Sciences Partnership and local industry. The Institute will further develop education & training programs to provide skills for the emerging and existing life sciences workforce, and become a U.S. center of excellence for life sciences education and training.

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Business/Development Plan: The development of the facilities and Institute programs are underway, and we expect final plans by Fall 2006. The facility construction by Monroe County will take place in 2007 with expected opening in late 2007 or early 2008. The construction and operation of the facility will be part of a 20 year partnership between Monroe County Redevelopment Commission and Ivy Tech Community College resulting in Ivy Tech assuming ownership of the facility at the end of this period. An agreement in contract between Monroe County Redevelopment Commission and Ivy Tech Community College for 20 years will commence at the time of occupancy. Programs will be coordinated, developed and implemented by an advisory board, executive committee and the Institute Director throughout 2006 and 2007. Education and training activities are already underway in existing facilities and faculty will be leveraged at existing higher education institutions and from life sciences industry. Industry partners are working to provide necessary equipment, training direction, and fiscal resources to support the institute. The Institute Director will develop critical relationships with industry, academia and the community, and coordinate the sustainability of the Institute through programs, grants and other financial support measures. A $1.25M grant from the Indiana Department of Workforce Development has already been secured to assist in the formation of the Institute and support life sciences training programs.

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Indiana Life Sciences Education & Training Institute

Strategic Plan

1) **Case Statement/Value Proposition:** Life Sciences are a critical growth industry for Indiana, the United States and countries across the globe. The industry is expanding at double digit rates, fueled by major advances in the speed of drug delivery based on genomics technology, rational drug design and high throughput screening. Medical devices and diagnostics are becoming increasingly sophisticated and the manufacturing processes more complex. Additionally, the combination of drug and medical device combination products is bringing together science and engineering specialties unseen before producing vast collaborations with universities and industry. All in all, this environmental shift is changing the needs of our educational and workforce training programs.

   Indiana is strongly positioned to benefit from rapid expansions in the drug, device and other life sciences industries, particularly in the life sciences manufacturing arena. Eli Lilly & Company, Baxter BioPharma Solutions, Pfizer, Cook Group, Boston Scientific, Zimmer, DePuy, Biomet, Roche Diagnostics and many others have all expanded in size, facilities and employment base over the past several years. Indiana's biomedical manufacturing employment base is over 120,000 and growing quickly. New product, service and contract manufacturing firms are launching their businesses in our region to compete for business in the drug, device and biotech industries. In the Bloomington region alone, major growth at life sciences companies like: Cook, Inc., Baxter BioPharma Solutions, and Boston Scientific have grown our local employment base over 5,000 jobs. New startups have entered the market including: Cook Pharmica LLC and BioConvergence LLC. Between 1,200-1,500 new, high-paying jobs are expected in the next five years at our core area firms. (INSERT WAGE AND INCOME TAX FIGURES). We will need a coordinated effort of industry, academia, economic development and government in order to meet the demand for talent.

2) **Indiana Life Sciences Education and Training Institute:** A significant need and unique opportunity exists for the development of an education and training facility with programs targeted at the life sciences sector. The standardization and industrialization of life sciences manufacturing over the last 20 years now makes it possible to develop an effective, standardized curriculum. The opportunity for Indiana, and in a more focused fashion, the Bloomington/Monroe County region, is not only to serve its growing biopharmaceutical and medical device firms with the necessary workers for their expansions, but also to build the capability into a strength and core competency. In doing so, a ready source of trained talent will attract additional biotechnology, pharmaceutical, medical device firms and support the existing employment base we have today. This will further fuel and strengthen the core competencies of our region, and allow us to compete with life sciences centers across the US and abroad. The bottom line will be continued growth of jobs and investment in our local, regional and statewide economy. An Indiana Life Sciences Education and Training Institute is under development through bond authority from Monroe County Redevelopment Commission as an enabling investment for the growing life sciences industry in

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Bloomington, Monroe County, and the State of Indiana. This Institute has two critical elements, innovative life sciences training programs that serve immediate and future needs of local industry, and a well designed facility in which to provide training.

a) **Education & Training Program:**
   i) Mission: The Mission of the Indiana Life Sciences Education & Training Institute is to deliver life sciences education and training programs that will provide skilled workforce talent for area life sciences firms.
   ii) Skills Needed: There are a variety of skills needs for area life sciences firms in an ever-changing training environment, so flexibility is going to become an important part of our Institute plan. Since many of the positions at existing life sciences firms in the Monroe County region are already defined, we can make some important assumptions about skills needs.
      (1) Initially, a major need of all local businesses is to improve the skills of the *entry level* workforce. These positions are typically hourly, and require a high school degree with a well developed package of basic skills (reading, math…etc.) and soft skills (work ethic, teamwork, communications, problem solving…etc.). We need to align programs to serve this need with our community partners and add training programs that provide life sciences elements (regulatory skills, manufacturing process training…etc.). We will need to target the existing and future student base at local K-12 institutions, under employed, unemployed and potentially the retiree population to improve skills in our region.
      (2) Another major need will be to provide skills development for *supervisory/managerial* positions. This would include programs to develop management skills such as communications, project management, regulatory compliance, operations, and other core business needs of life sciences firms. Our target audiences here would be incumbent workers, transitional workforce, students at K-12 and higher educational institutions and the retiree population.
      (3) A diverse set of skills is needed at most major life sciences firms in the region. The Institute will work with employers to target industry-centered skills development programs through alliances with K-12, higher education and WorkOne in the region. A Strategic Plan will need to be created that aligns programs of instruction to provide a seamless pipeline of talent for the region.
   iii) Training Programs:
      (1) Demand Focus: The Institute will be responsive to the demands of the life sciences workforce. Fundamental tenants of the Institute will be to provide training programs that ensure *speed, convenience and low cost*. Life sciences employers will work with the Institute staff to develop programs that are unique to the industry and deliver skills on a timeframe that makes sense. It is our intention for the Indiana Life Sciences Education & Training Institute to become a recognized resource center for all curriculum and training resources available to our employers as well as serve as a portal of information for our communities, job seekers and policy officials. Some life sciences specific examples of likely training programs include, but are not limited to, life sciences manufacturing principles, operations in drug and device manufacturing, and FDA regulated practices. The Institute will also be designed to allow for classroom/laboratory

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instruction, hands-on training on equipment/processes. We will use all tools and technology necessary to reach our training goals including on-site training at life sciences companies, on-line training or distance learning for curriculum that is best delivered via the web and/or CD/DVD programs.

(2) Best Practices: In an effort to deliver the talent necessary for the regional life sciences firms, the Institute will study best practices with likeminded institutes around the U.S. and become a virtual center of excellence on life sciences workforce development. It is our hope that other areas of the country will look to our Institute as a best practice site in the near future.

(3) New Partnerships: New partnerships will be explored to create programs that impact our ability to provide trained talent for the area. Alliances with higher education institutions, trade associations, professional training centers and others will be an important part of the Institute offerings. Partnerships will lead to reduced overlap and focus resources where we can be most effective in provision of programs to benefit the industry. The Indiana Department of Workforce Development WorkOne Center will be a primary partner, as we will be closely collaborating on skills development activities.

(4) Partnership Development: We will include all education and training providers that serve the life sciences workforce in our region to drive the development of life sciences training that is in demand of our industry partners through Employer Learning Networks (ELNs). We will align the training options available with marketing and awareness of careers in life sciences to illustrate career ladders desperately needed by students, parents, teachers, guidance counselors, administrators, career services officers and the general public. These partnership agreements will be developed as needed through the ownership authority, will set us apart from other institutions around the US, and ensure that all stakeholders are represented in order to provide the best life sciences talent in the US.

(5) Strategic Skills Initiative: A $1.25M Strategic Skills Initiative (SSI) grant in support of the Institute from the Indiana Department of Workforce Development (DWD) to our Region 8 Workforce Board was awarded in July 2006 and will be integrated into the plans of the Institute. The grant awards will target funding for specific training programs that are critical to our ability to meet the demand of life sciences firms in our region. Since many excellent training programs already exist through the efforts of educational institutions across our region, we will need to be working with partners to ensure the success of the grant funds allotted. The Bloomington Economic Development Corporation, Bloomington Life Sciences Partnership and the Institute staff will be responsible for administering many aspects of the grant including the development of the Institute strategic plan. Other funding will go directly to Ivy Tech Community College-Bloomington, Indiana University Continuing Studies and others for specific training program development and/or implementation. SSI Grant solutions include:

(a) The BEDC will be responsible for a series of regional career fairs to provide opportunities for our workforce region to learn about opportunities at life sciences firms and about training options and programs to build skills necessary to compete effectively for jobs for current and future positions;

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(b) Career Readiness Assessments will be provided for 1,000 individuals at the career fairs and community forums. These will include specific skills needed by life sciences employers, as well as basic skills and soft skills levels. Assessments will provide necessary feedback on skills needs of each individual and can be used as a roadmap for programs and training. Life Sciences firms in the region and Work One will cost-share these assessments;

(c) Incumbent worker training will be provided for existing employees that need skills upgrades to achieve valued skills to employers. This will include:

(i) Soft skills training will be conducted by local providers through the HIRE Program for employees of existing life sciences firms over the two years of the grant. These employees have adequate basic skills, but need to upgrade their skills in critical thinking, communication, problem solving and how these skills are applied to life sciences environments;

(ii) A Biomedical Certificate Program will be created to serve specific needs of local employers, specifically technician level employees. While this will be created by industry leaders, regional education providers will most likely offer the actual training program upon completion. This will be of importance to existing employees and later to new students in the region;

(iii) A Life Sciences Operator Certification Program will be created to provide industry specific training on equipment and/or processes that are commonly used across biopharmaceutical and medical device industries. Training will take place in facilities where equipment can be easily accessed by the community, and partnering firms will assist with the procurement of equipment through loans, deals with suppliers or donations. Employers will gain economies of scale here through collaboration, not isolated internal training;

(iv) The Indiana University Certificate Program, "Managing in the Life Sciences", will be expanded to serve life sciences firms in the region. This new program will allow for 50 existing employees to receive supervisory/managerial training (project management, regulatory affairs, etc.), and receive a certificate at the end of the semester. This will address the critical shortage in the area of supervisory/management talent.

iv) Structure: The Institute and its programs will be governed by an Executive Committee and Advisory Board to ensure engagement and success of critical programs. Education and training programs will be developed by staff in partnership with training providers, industry advisors, workforce agencies, and a wide array of educational institutions from around the region. The Institute will become a U.S. center of excellence in life sciences education and training.

b) **Facilities:** The Indiana Life Sciences Education & Training Facility is in development through a combined effort of Monroe County Commissioners, Monroe County Redevelopment Commission, and Ivy Tech Community College. It will be used for life sciences education & training initiatives and become a national center of excellence for life sciences instruction. The facilities will be designed for an education & training purpose, so space will be designed with flexibility in mind.

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i) Management/Ownership: The facility will be built by the Monroe County Redevelopment Commission through bond financing provided by the Richland TIF (Tax Increment Financing) District for an amount not to exceed $5M, and be leased to Ivy Tech for $1/year for 20 years. Ivy Tech will lease the land to Monroe County for $1/year for a term of 20 years commencing at the time of operations. Ivy Tech will then operate the facility under terms of a lease agreement over the term of 20 years with Monroe County Redevelopment Commission. The facility will become an Ivy Tech facility at the end of the agreement with the Monroe County Redevelopment Commission. Ivy Tech Community College-Bloomington will be responsible for the facility operations.

ii) Layout/Design: Projected design of the 25,000 square foot facility includes:
   (1) Dedicated Ivy Tech Community College Space: Lab facilities for life sciences instruction for Ivy Tech Community College-Bloomington will consist of approximately 13,000 square feet. This space will also include classrooms for instruction and related support needs.
   (2) Administrative Space: Approximately 3,000 square feet of space will be developed into offices, rest rooms, and open areas for Institute staff, students, and faculty.
   (3) The Institute: The Institute's remaining space (Approximately 9,000 square feet) would be available for training suites, additional classrooms, and lab/development space for use in instruction and entrepreneurial development. These training facilities would be extremely flexible in order to meet the ever changing needs of the region. A working agreement with our technology incubator, inVenture, will allow for effective management and usage of these facilities per agreement with Ivy Tech Community College.

iii) Development Plan: (TBD by the architect selected for this construction project)

3) **Organizational Structure:**

a) Executive Committee: The Institute and its programs will be governed by an Executive Committee, to which staff will report, and provide guidance on programs, budgets and plans. It will also oversee accountability of the Institute as it matures. It will consist of representatives from key stakeholder institutions including, Monroe County, Ivy Tech Community College-Bloomington, Bloomington Economic Development Corporation, and a life sciences business representative.

b) Advisory Board: An Advisory Board will be created, consisting of representatives of education (K-12 and higher education), workforce development, economic development, government and life sciences industry professionals from across our region, Monroe County and the State of Indiana. Additionally, our regional partners will include economic development officials, elected officials, chambers of commerce and others from our EGR 8 counties (Owen, Monroe, Lawrence, Brown, Daviess, Martin, Greene, and Orange). It will provide advice and direction to the staff and Executive Committee, and be involved in key initiatives and programs to ensure engagement and success of critical programs. It will likely have 12-15 people from the different sectors serve on it.

c) Staffing Plan: The Institute will have a professional staff dedicated to the success of the Institute's programs and initiatives. Current plans include:

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i) Director: The Institute Director will be responsible for overall operational issues within the Institute.
ii) Administrative Assistant: Reports to Director and assists with all operational issues with the Institute.

4) **Budget:**
   a) Training Program
   b) Facility: Operations Costs: Funding Plan must be developed
   c) Income/Sustainability

Indiana Life Sciences Education &Training Institute

2 Year Budget Plan

Budget Description	Year 1	Year 2	TOTAL
Institute Programs Expense:			
Salary/Benefits			
Director	$100,000	$110,000	
Administrative Assistant	$45,000	$50,000	
Travel Expenses	$10,000	$5,000	
Office Equipment, Supplies and Operational Expenses	$10,000	$10,000	
Training & Instruction Expenses	$25,000	$25,000	
TOTAL:			
Facility Expense:			
Facility Construction (25,000 sq.ft x $200/sq.ft.):	$5,000,000		(Not to Exceed $5M)
Ivy Tech Dedicated Classroom and Lab (13,000)			
General Office/Administrative (3,000)			
Institute Flexible Space: Training/Lab (9,000)			
Operations Costs (5% of facility costs)	$125,000	$125,000	Ivy Tech
Reserves	$60,000	$60,000	
Contingencies	$25,000	$25,000	
TOTAL:			
Income:			
Grants SSI (Personnel-Institute)	$124,000	$48,000	
Richland TIF Financing	$5,000,000		(Not to Exceed $5M)
Industry Contributions			
Vendor Contributions			
Training Fees			
Naming Fees			
TOTAL:			

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5) Implementation:

a) Plan: Implementation of the Strategic Plan for the Institute will take place in 2 phases.
   i) Phase I will cover: Institute organization and operational plan, plan of execution for goals of the Institute for the first two years, facility development plan and a formal milestone review at end of year 2.
   ii) Phase II will cover: Institute 2 year initial program assessment, sustainability plan for the Institute, long range plan.

b) Timeline

6) Key Open Issues:

a) Action Plan for Operational Costs of Institute Programs
b) Agreements for Cooperative Use
c) Liability Concerns for Operation of Institute
d) Commercial Activity Issues (IT infrastructure…etc.)

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ORDINANCE 06-27

TO VACATE A PUBLIC PARCEL -
Re: Right-of-Way Running North /South
Along the East Side of 111 South Grant Street
(Trinity Episcopal Church - Rectors and Wardens, Petitioners)

WHEREAS, I.C. 36-7-3-12 authorizes the Common Council to vacate public ways and places upon petition of persons who own or are interested in lots contiguous to those public ways and places; and

WHEREAS, the petitioners, (Trinity Episcopal Church - Rectors and Wardens) have filed a petition to vacate a parcel of City property more particularly described below in order to add to the facility and make it more secure as well as more accessible to persons with disabilities;

NOW, THEREFORE, BE IT HEREBY ORDAINED BY THE COMMON COUNCIL OF THE CITY OF BLOOMINGTON, MONROE COUNTY, INDIANA, THAT:

SECTION I. Through the authority of I.C. 36-7-3-12, a portion of City owned property shall be vacated. The property, commonly known as a 20.24 foot wide by 127.60 foot long swath of street right-of-way along the east side of 111 S. Grant Street, which is the sideyard of the Trinity Episcopal Church and part of In-Lot No. 112 in the City of Bloomington, being more particularly described as follows:

> Commencing at a mag nail at the Southwest corner of In-Lot No. 112 in the City of Bloomington; thence NORTH 00 degrees 36 minutes 23 seconds EAST along the West line of said In-Lot a distance of 4.00 feet to the point of Beginning; thence continuing along said west line North 00 degrees 36 minutes 23 seconds east 127.65 feet to the Northwest corner of said In-Lot; thence leaving said West line and parallel with the North line of said In-Lot NORTH 89 degrees 52 minutes 38 seconds WEST 20.24 feet to the back of walk; thence along said back of walk SOUTH 00 degrees 34 minutes 19 seconds WEST, 127.60 feet; thence parallel to the South line of said In-Lot SOUTH 89 degrees 44 minutes 16 seconds EAST 20.16 feet to the Point of Beginning, containing 0.059 acres (2578.41 square feet) more or less.

SECTION II. Pursuant to I.C. 36-7-3-16, the following Utilities have submitted letters to the Common Council indicating that they are not occupying or using any part of this public way: City of Bloomington Utilities, SBC, Duke Energy, Insight Communications, and Vectren.

SECTION III. This ordinance shall be in full force and effect from and after its passage by the Common Council of the City of Bloomington and approval of the Mayor and the issuance of a building permit for construction of said improvements to the building.

PASSED AND ADOPTED by the Common Council of the City of Bloomington, Monroe County, Indiana, upon this _____ day of _____, 2006.

_____
CHRIS STURBAUM, President
Bloomington Common Council

ATTEST:

_____
REGINA MOORE, Clerk
City of Bloomington

PRESENTED by me to the Mayor of the City of Bloomington, Monroe County, Indiana, upon this _____ day of _____, 2006.

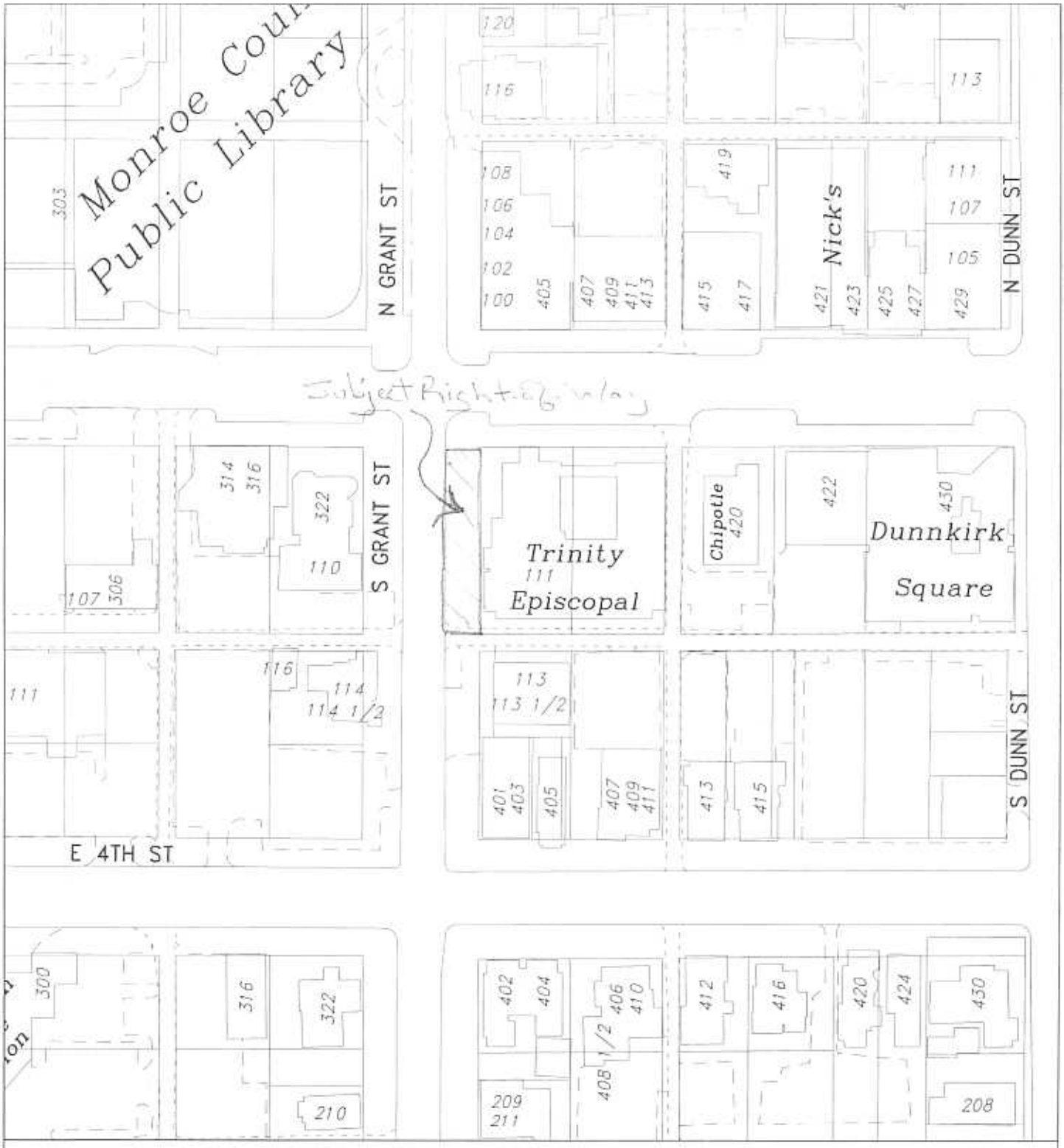
_____
REGINA MOORE, Clerk
City of Bloomington

SIGNED and APPROVED by me upon this _____ day of _____, 2006.

_____
MARK KRUZAN, Mayor
City of Bloomington

SYNOPSIS

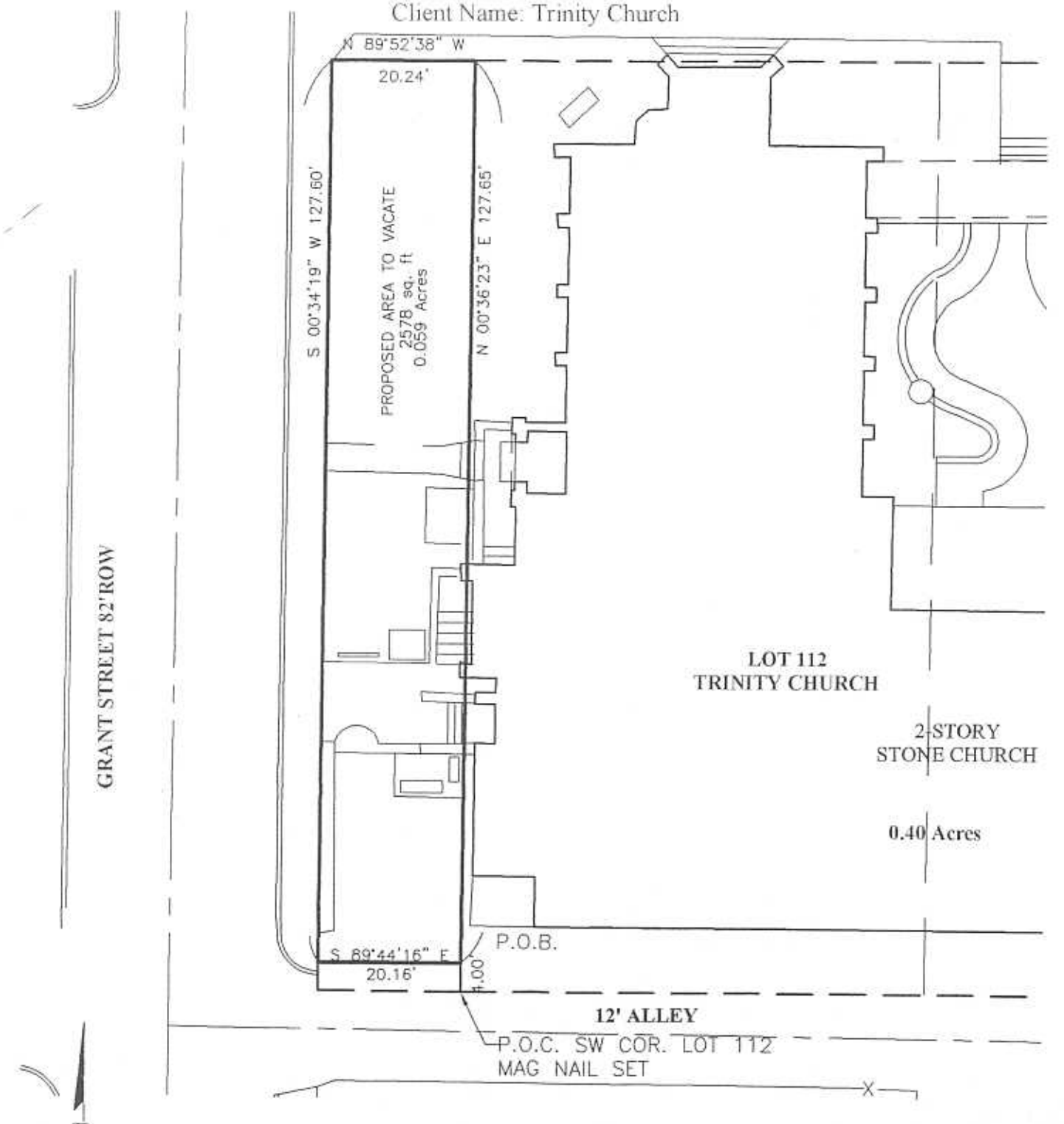
The petitioners, Trinity Episcopal Church - Rectors and Wardens, request vacation of a portion of the right-of-way running north/south along the east side of the church building at 111 South Grant Street.



For reference only; map information NOT warranted.

Bledsoe Riggert Guerrettaz
LAND SURVEYING · CIVIL ENGINEERING
1351 W. Tapp Road
Bloomington, IN 47403
Ph (812) 336-8277
Fx (812) 336-0817

EXHIBIT
PROPOSED VACATION OF RIGHT OF WAY
ALONG GRANT STREET
JOB No. 5399
Client Name: Trinity Church



SHEET 1 OF 2

CITY OF BLOOMINGTON
PLANNING DEPARTMENT
MEMORANDUM

DATE: November 13, 2006
TO: City of Bloomington Common Council Members
FROM: Lynne Darland, Zoning & Enforcement Manager
SUBJECT: Request for vacation of a street right-of-way
PETITIONERS: Trinity Episcopal Church (Rectors and Wardens)

LOCATION: The subject street right-of-way that the petitioner is proposing to be vacated runs parallel and north/south along the east side of Grant Street directly south of East Kirkwood. The property is bounded by East Kirkwood on the north, Grant Street on the west, Trinity Episcopal Church on the east and an improved alley on the south.

BACKGROUND: The petition request involves a 20.24 foot wide by 127.60 foot long swath of street right-of-way along the east side of S. Grant Street and consumes the green sideyard of the Trinity Episcopal Church. The right-of-way along Grant Street at this location is currently eighty-two (82) feet wide. A survey of the church property shows that there are church building encroachments into the right-of-way including the building, steps, benches and mechanicals.

The petitioner wishes to renovate portions of the church and also expand the building into the existing right-of-way. This will assist the church in allowing the entire facility to be handicapped accessible. The petitioner has been working with an architect and drawings are included in the packet of information. The entire property is zoned downtown (CD).

UTILITY INTRESTS: The following utility and city service organizations have responded to this request with no objections for the vacation of the existing right-of-way:

- **The City of Bloomington Public Works Department**
- **The City of Bloomington Utilities Department**
- **SBC Ameritech**
- **PSI Cinergy**
- **Insight Communications**
- **City of Bloomington Police Department**
- **City of Bloomington Fire Department**
- **Vectren**

The request for vacation was heard by the Board of Public Works (BPW) on October 31, 2006. The BPW voted to recommend vacation of the right-of-way. The petitioner worked with Duke Energy and CBU to insure that no right-of-way vacation or expansion of the church will interfere with any future work that may be needed for the Jordan River culvert project. None of the utilities have lines in the existing right-of-way proposed for vacation nor do they have any future plans to utilize this right-of-way. City police and fire had no objections to vacating this right-of-way.

CRITERIA: The criteria utilized to review a public ROW or easement vacation request are as follows:

1. Current Status - Access to Property.

This strip of right-of-way is located within an area that has been maintained as a green space and garden area for the church for many years. The right-of-way runs the length of the property line along Grant Street, excluding four feet at the south property line. The excluded four feet is needed to allow utilities work on the next section of the Jordan River Project. The loss of right-of-way does not impact accessibility to the church from Grant Street, Kirkwood, or the surrounding alleys.

2. Necessity for Growth of the City:

Future Status: No public utilization of this right-of-way is anticipated by the City. All public services can adequately be served through the remaining rights-of-way in the immediate area. The Board of Public Works and Engineering Department have reviewed this petition. Neither had concerns for future road widening or services in the future. The existing right-of-way is 82.5 feet. This is adequate to serve the area.

Proposed Private Ownership Utilization: The vacation of this strip of right-of-way will allow the petitioner to move forward with a development project wherein the church will be more handicapped accessible, including a new elevator and reworking of the hallways. This expansion will also allow for some security of the offices and nursery. No project has been filed with the Planning Department, but the church is working with an architect and the plans are in the final stages of development. The entire right-of-way would be deeded to the church if the vacation is approved.

Compliance with Regulations: The vacation of this right-of-way will not create any issues regarding compliance with local regulations.

Relation to Plans: The proposal is consistent with City Plans. Churches are permitted uses in the current Downtown (CD) zoning district, and also in the proposed Unified Development Ordinance that is under consideration at this time. The church is included in the *City of Bloomington Interim Report, Indiana Historical Sites and Structures Inventory, April 2004 edition*. The church is listed as 'notable' in this report meaning that the structure has above average historical importance. As a result, depending on the extent of the expansion, the church may be required to follow the demolition delay ordinance as required by the Bloomington Municipal Code.

The GPP calls for development in the downtown to foster the continued vitality of the downtown by stimulating new downtown development and redevelopment of underutilized parcels and buildings. The proposed expansion of the church follows the architectural desires of the city with continuity of the existing architecture, massing, vertical relief of the exterior walls, and the use of windows. The church building is also used for a variety of social service activities throughout the week and so is an active social gathering place in the heart of the city. Having a facility that is handicapped accessible is paramount to the success of the afore mentioned building uses.

RECOMMENDATION: Both staff and the Board of Public Works have recommended that the City vacate the right-of-way in question.

City of Bloomington
Office of the Common Council

Petition for Vacation of Public Right-of-Way

Ordinance:		06-27
Hearings:		
Council Chambers	**First Reading**	December 6, 2006
401 North Morton	**Committee of the Whole**	December 6, 2006 (unless cancelled)
7:30 p.m.	**Final Action**	December 20, 2006
Address of Property	111 South Grant Street	
Description of Proposed Vacation:	a 20.24 foot wide by 127.60 foot long swath of street right-of-way along the east side of 111 S. Grant Street which is the sideyard of the Trinity Episcopal Church and part of In-Lot No. 112 in the City of Bloomington	
Name of Petitioner	Trinity Episcopal Church - Rectors and Wardens	
Address	111 South Grant Street	
Phone	336-4466	
Consultant	Randy Lloyd	
Address	1720 North Kinser Pike	
Phone	330-0077	
Abutting Property Owners:	None	

This application must be accompanied by all required submittals as stated in the information packet for vacation of public right-of-way. Staff reserves the right to schedule hearing dates for petitions subject to complete submittals. Notices to adjacent property owners should not be mailed until hearing dates have been confirmed.

I (we) agree that the applicant will provide a list of and notify all adjacent property owners by certified mail at the applicant's expense.

I (we) further agree that the applicant will cause a legal notice of this application to be published in a paper having general circulation in Bloomington at the applicant's expense.

I (we) certify that all foregoing information is correct and that I (we) are the owners (legal agents for owners) of property adjacent to the proposed vacation of public right-of-way which is the subject of this application.

Signature: [signature] Rector's Warden

Date: November 21, 2006

Trinity Episcopal Church

Architectural Restoration and Renovation Committee

111 S. Grant St.
Bloomington IN
47408-4031

April 9, 2006

Dear Patrick,

Per conversations with Deputy Mayor James McNamara and you, please accept this letter as Trinity's official application for Pre-Petition Review of a proposed ROW vacation located along Grant Street.

As we discussed, Trinity, in celebration of our upcoming 100 year anniversary, is planning a restoration and renovation of our church facilities located at 111 S. Grant Street. Through an extensive planning process utilizing local architect Christine Matheu, we have developed an exciting restoration and renovation program that will permit Trinity to continue to serve and grow our congregation in its existing urban setting for the next 100 years. As I mentioned, Trinity's facilities are not completely accessible to many in our congregation and community. We sincerely desire to make Trinity a more inviting church to all members of our community. To accomplish this goal without significantly compromising our limited existing space requires us to build within an area of the City's ROW adjacent to the Trinity.

If granted a vacation of this ROW, Trinity would be able to add street level access, an elevator, and restrooms to better serve our congregation and the community. Additionally, the new construction would enable us to make our entire facilities accessible. This addition also is the lynchpin to our entire restoration and renovation plans. Without it, our ability to maintain our congregation and continue our mission would be severely compromised. Of course, the addition is designed to seamlessly fit with the historic nature of our church. It is worth noting that Trinity has maintained this section of ROW for several decades.

I have included all the information requested. If you have any questions, comments, or require additional information please contact me at my work address below:

Randy Lloyd
First Capital Investment Group
1720 N. Kinser Pike
Bloomington, IN 47404
812.330.0077
randy@firstcapitalusa.com

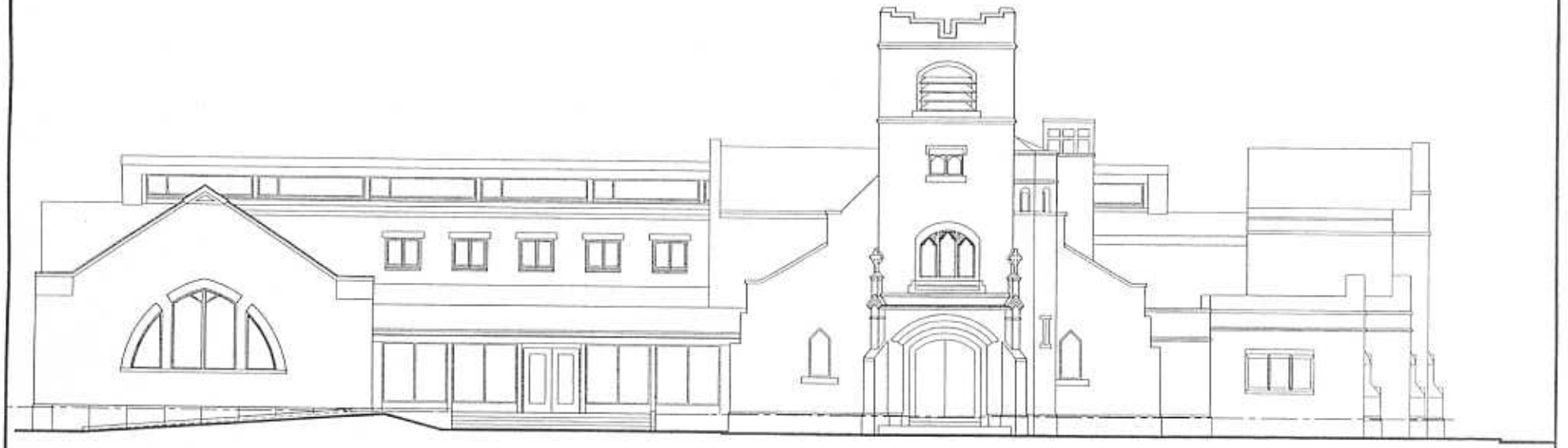
We look forward to working with you and the City of Bloomington on this critical issue. We sincerely believe these plans will allow us to remain a viable thread in our community's fabric for the next 100 years.

Sincerely,

Randy Lloyd,
Trinity Member
Architectural Restoration and Renovation Committee

cc: Father Don Jones
Trinity Vestry and Wardens
Restoration and Renovation Committee
Christine Matheu

Existing



TRINITY EPISCOPAL CHURCH

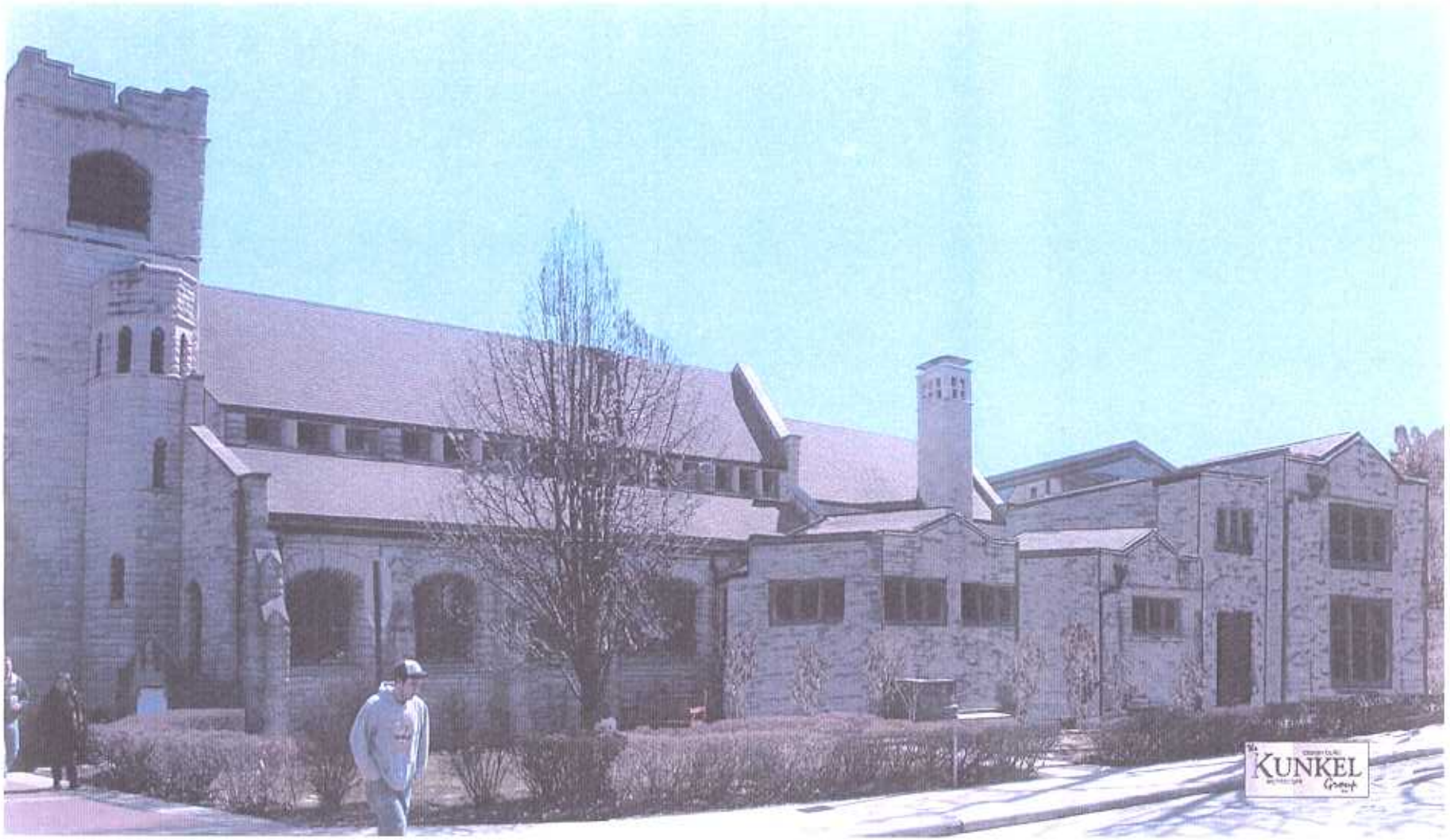
Christine Matheu Architect 205 N. College Ave. Suite 010 Bloomington IN 47404 Tel: 812 339 1235

NORTH ELEVATION

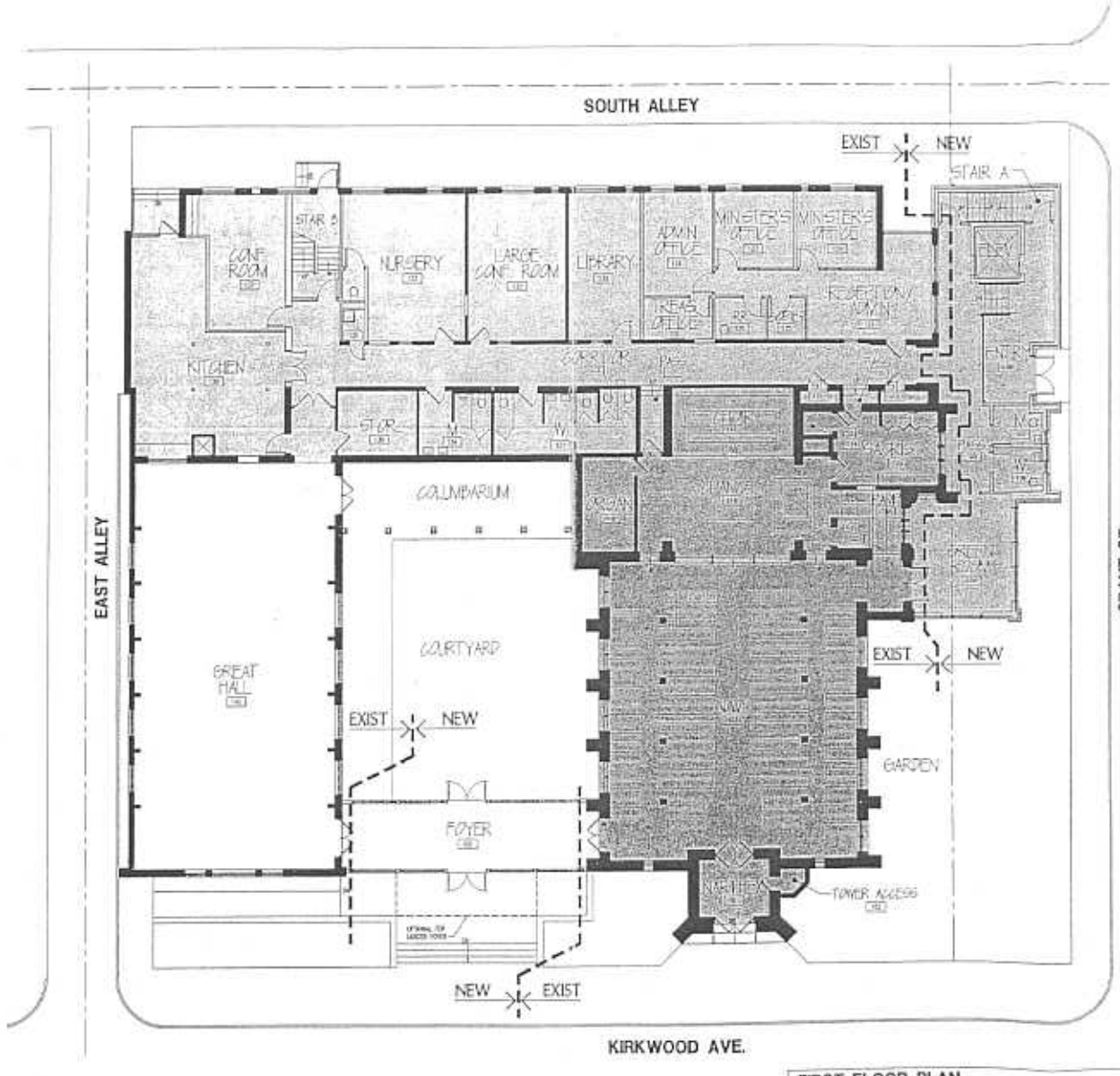
TRINITY EPISCOPAL CHURCH

Christine Matheu Architect 205 N. College Ave. Suite 010 Bloomington IN 47404 Tel: 812 339 1235

WEST ELEVATION



Proposed



FIRST FLOOR PLAN
SCALE: 1/8" = 1'-0"

1

Christine Matheu, Architect

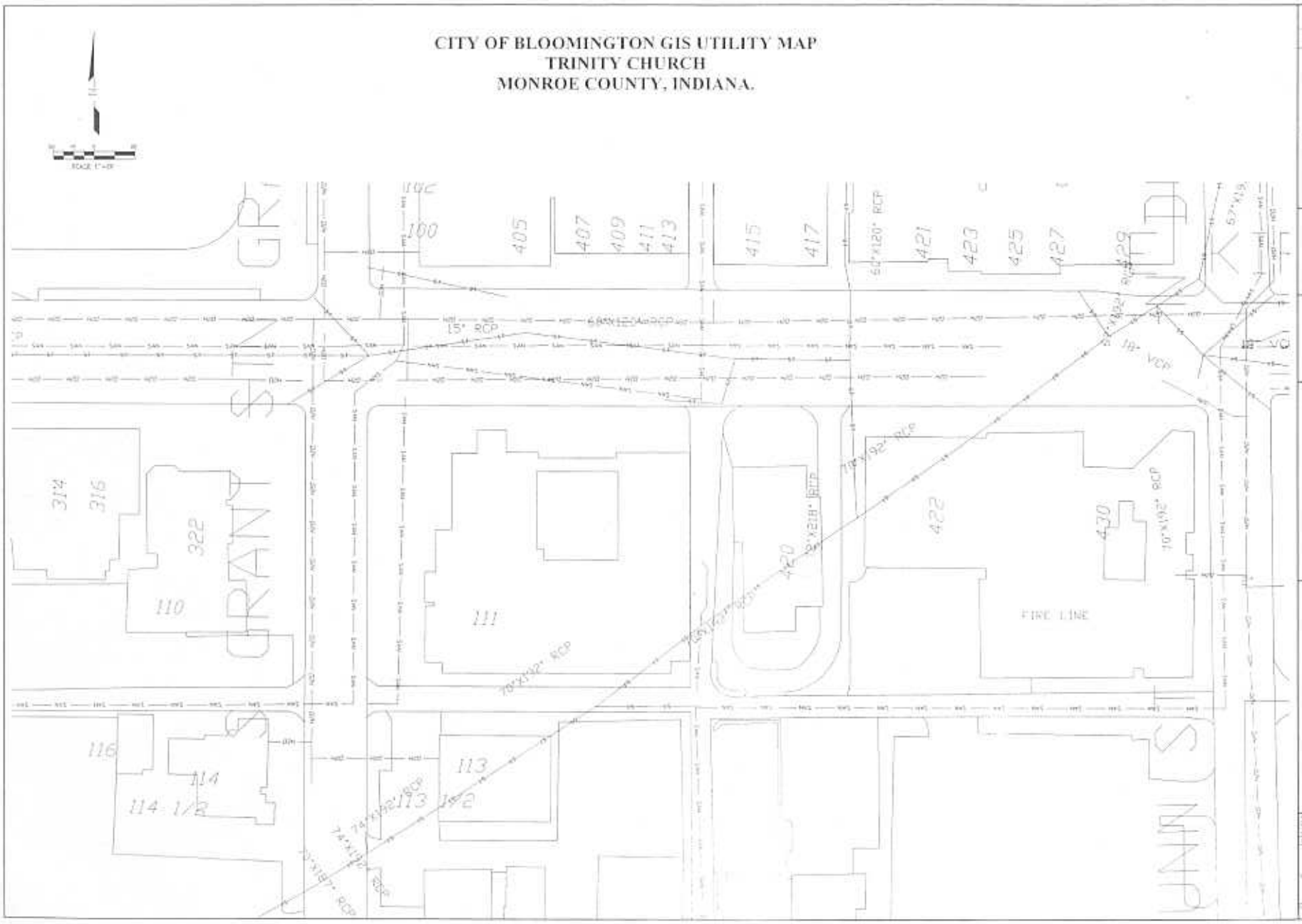
FEASIBILITY STUDY FOR THE TRINITY EPISCOPAL CHURCH RENOVATION & RESTORATION
111 SOUTH GRANT STREET
BLOOMINGTON - INDIANA 47408

ARCHITECT'S PROJECT NO: 0504
DATE: DECEMBER 21, 2006

FIRST FLOOR PLAN

SHEET NO
A201
STUDY DOCUMENTS

CITY OF BLOOMINGTON GIS UTILITY MAP
TRINITY CHURCH
MONROE COUNTY, INDIANA.



Bledsoe Tapp & Riggert, Inc.
Quality Land Surveying and Civil Engineering Services

TRINITY CHURCH
BLOOMINGTON, IN
FOR
MATTHEW

GIS UTILITIES

1 of 1

5399

Dear Reverend Jones,

City of Bloomington staff have been approached by your parishioner Randy Lloyd about Trinity Episcopal's plans to expand. I wanted to personally let you know that the City sees no issues with regard to the plan's design to encroach on the City's right-of-way.

More than that, I am excited about your plans to expand. I view Trinity as important to the general stability of Kirkwood Avenue and a major contributor to the vitality of our downtown. Your expansion represents a commitment that ensures that Trinity will continue to be the asset that we've long counted on as key component of Bloomington's community character.

Congratulations on this important new development.

Thank you,

Mark Kruzan
Mayor

ORDINANCE 06-27

TO VACATE A PUBLIC PARCEL - Re: Right-of-Way Running North /South Along the East Side of 111 South Grant Street (Trinity Episcopal Church - Rectors and Wardens, Petitioners)

Additional Materials in the Council Office

Responses from the Utility Companies and Safety Services including:

SBC,
Duke Energy,
Insight Communications, and
Vectren
Fire Department
Police Department
(Note: City of Bloomington Utilities and Insight Communications responded by phone)