NURSING HOME BOARD OF DIRECTORS AGENDA

County of Champaign, Urbana, Illinois
Monday, June 14, 2010 – 6:00pm

In Service Classroom, Champaign County Nursing Home
500 S. Art Bartell Road, Urbana

CHAIR: **Mary Ellen O'Shaughnessey**
DIRECTORS: **Jan Anderson, Peter Czajkowski, Jason Hirsbrunner, Lashunda Hambrick, Alan Nudo, Charles Lansford**

ITEM

I. **CALL TO ORDER**

II. **ROLL CALL**

III. **APPROVAL OF AGENDA/ADDENDUM**

IV. **APPROVAL OF MINUTES**
May 6, 2010

V. **PUBLIC PARTICIPATION**

VI. **OLD BUSINESS**

None

VII. **NEW BUSINESS**
a. Revised Meeting Calendar
b. Budget Timetable for FY 2011
c. IDPH Report (Buffenbarger & Noffke)
d. Management Report
e. Status Report on Objectives

VIII. **OTHER BUSINESS**

None

IX. **NEXT MEETING DATE & TIME**
a. July 12, 2010

XII. **ADJOURNMENT**

Attachments: Revised Meeting Calendar, Budget Timetable for FY 2011, Management Report, Objectives Update, Management Update, Implications for Skilled Nursing Facilities under Health Reform

Board of Directors

Champaign County Nursing Home
Urbana, Illinois
May 6 2010

Directors Present: Czajkowski, Anderson, O'Shaughnessey, Hambrick, Nudo, Hirsbrunner

Directors Absent/Excused: Lansford

Also Present: Busey, Scavotto, Buffenbarger, K. Noffke

1. Call to Order

The meeting was called to order at 6:00pm by Chair O'Shaugnessey

2. Roll Call

Busey called the roll of Directors. A quorum was established.

3. Agenda & Addendum

On motion by Anderson (second Hirsbrunner the agenda was approved (unanimous).

4. Approval of Minutes

On motion by Nudo (second Anderson), the Board approved the open session minutes of April 15, 2010. On motion by Nudo (second Anderson), the Board approved the closed session minutes of April 15, 2010.

5. Public Participation

There was no public participation..

6. Old Business

There was no old business.

7. New Business

a. IDPH Report

Buffenbarger and Noffke updated the Board on the status of the recent rash of IDPH complaints. The first two complaints, resulting in the Immediate Jeopardy citations and

totaling five deficiencies, have been cleared. A third complaint has not been cleared and could result in denial of payment for CCNH for Medicare and Medicaid admissions dating back to April 1. Buffenbarger presented the timeline and survey windows over which the complaints have occurred during the past few months. The current circumstance indicates that the earliest removal of the regulatory sanction is May 6; if that scenario holds, CCNH could lose as much as $200k between denial of payment and fines totaling $50k from both IDPH and CMS. However, there are facts that appear to be strongly in CCNH's favor and which will result in the filing of an appeal known as Informal Dispute Resolution. If CCNH prevails on the IDR, denial of payment would be for a minimal period of 2-3 days; fines and civil monetary penalties would continue with the financial impact being significantly less.

Extended discussion ensued about the survey process itself, the need for more staff training and the importance of a strong customer service orientation.

b. Management Report

Activity Director Gail Shivers has accepted the position of dementia director and the transition in Activities is under way. Once the supervisory changes in Activities are in place, Gail will move to dementia.

A replacement Marketing/Admissions Coordinator has been hired, the first using the predictive index program. The new Social Services Director started May 3.

The business office transition has gone smoothly. Statements are current through March. In particular, the Balance Sheet is now complete and reflective of the existing debt obligations. (Scavotto will change the March Balance Sheet to indicate that CCNH still owes the County $333k for an emergency loan.) Current operations through March indicate a slight operating gain of $26k. In April, CCNH will reflect the regulatory denial of payment as it represents a realistic contingency on operations. As a result, operating performance will suffer.

Going forward, higher census levels are the key to off-setting the impact of any payment denials.

Progress on objectives is behind expectations, largely due to the IDPH issues.

8. Other Business

There was no Other Business

9. Next Meeting Date

Tentatively Monday June 14, 2010, 6 pm.

Directors are to check their calendars and advise of any conflicts with this new date.

11. Adjournment

Chair O'Shaughnessey declared meeting adjourned at approximately 6:59 pm.

Respectfully submitted

Michael A. Scavotto
Recording Secretary

To: Board of Directors
Champaign County Nursing Home

From: M.A. Scavotto
Manager

Date: June 7, 2010

Re: Revised Meeting Calendar

With the change to meeting on Monday, the calendar of Board meetings is as follows:

Thursday, January 14, 2010

Thursday, February 11, 2010

Thursday, March 11, 2010

Thursday, April 15, 2010

Thursday May 13, 2010

Monday, June 14, 2010

Monday, July 12, 2010

Monday, August 9, 2010

Monday, September 13, 2010

Monday, October 18, 2010 (2nd Monday is a holiday)

Monday, November 8, 2010

Monday, December 13, 2010

All meetings are in the In-Service Classroom at the nursing home unless otherwise indicated. Meeting time is 6 p.m.

To: Board of Directors
Champaign County Nursing Home

From: M.A. Scavotto
Manager

Date: June 7, 2010

Re: Budget calendar for Fiscal 2011

I received the budget calendar from Deb and include it for your consideration. You will recall that our timing was off for Fiscal 2010 and we were not able to get the Nursing Board's review of the budget before the submission deadline. This plan looks workable to me, so expect discussion on the key budget assumptions to begin next month.

The Strategic Plan Deb refers to in 1.a. is the County's requirement that we submit a Mission Statement, Objectives, and Performance Indicators for each department.

NURSING HOME BOARD OF DIRECTORS – FY2011 BUDGET PLANNING PROCESS

1. ***July 12, 2010* – Management Proposal of Assumptions and Parameters for preparation of FY2011 Budget**
   - **a.** Review and Update of Strategic Plan
   - **b.** Non-Union Salary Administration
   - **c.** Private Pay Resident Rates
   - **d.** Assumptions/Parameters for Revenue Projections (Medicare rates, etc.)
   - **e.** Assumptions/Parameters for Budget Projections (ADC, staffing, etc.)

2. ***August 9, 2010* – Presentation of Management Recommendation for FY2011 Budget**

3. ***September 13, 2010* – Board of Directors Approval of Recommended Budget to be Forwarded to County Board for Approval**
   - **a.** ***Approval of FY2011 Budget***
   - **b.** ***Approval of FY2011 Non-Union Salary Administration***
   - **c.** ***Approval of FY2011 Private Pay Resident Rates***

To: Board of Directors
Champaign County Nursing Home

From: M.A. Scavotto
Manager

Date: June 7, 2010

Re: Management Report

I offer a special note regarding this management report. Please keep in mind that we are reducing Medicaid and Medicare revenues to reflect the impact of government sanctions under the current Denial of Payment status for CCNH. The matter is currently under appeal; if CCNH wins the appeal, it will be a pleasure to re-state the financial reports.

To keep the Denial of Payment in perspective, revenue reductions were approximately $(80)k Medicare and $(15)k Medicaid, for a total of $(95)k. Fines and penalties were booked at $50k.

As I write this update, census has been ranging from 195-200.

Here's what's happened on admissions and discharges.

	Oct-09	Nov-09	Dec-09	Jan-010	Feb	Mar	Apr
Admits							
Pvt Pay/Insurance	4	9	12	8	10	17	4
Medicare A	12	12	18	16	6	23	21
Medicaid	1	0	1	1		1	
Total	**17**	**21**	**31**	**25**	**16**	**41**	**25**
Discharges							
Pvt Pay/Insurance	8	15	11	13	17	13	11
Medicare A	10	6	11	7	5	6	9
Medicaid	2	4	4	1	1	1	3
Total	**20**	**25**	**26**	**21**	**23**	**20**	**23**

April's payer mix was 37 percent Private Pay, 50 percent Medicaid, and 13 percent Medicare. However, the Private Pay statistics contain 976 conversion days, many of which apply to prior months and which make meaningful comparison difficult. *CCNH*

does not admit Medicaid residents until they are Medicaid-eligible. These conversion days reflect residents who were admitted as Private Pay, have been paying as Private Pay, but have exhausted their funds and now must qualify for Medicaid.

April's results reflect a loss of $(143,408)k. Year-to-date, CCNH is reporting a loss of $(104)k which reflects both the government sanctions for April plus the full impact of the conversion days.

Private Pay revenues show the impact of the Medicaid conversions. Medicaid revenues were the highest CCNH has experienced since September of 2009:

	Dec 09	As Pct of Pt Revenue	Jan-10	As Pct of Pt Revenue	Feb-10	As Pct of Pt Revenue	Mar-10	As Pct of Pt Revenue	Apr-10*	As Pct of Pt Revenue
Medicare A	$210k	19%	$276k	24%	$164k	21%	$326k	27.4%	$283k	25.2%
Medicaid	$377k	34%	$430K	37%	$376K	37%	$388k	32.7%	$540k	48%
Pvt Pay	$454k	43%	$416k	36%	$392k	36%	$434k	36.4%	$253	22.5%

**April excluding impact of government sanctions*
Misc Revenue and Property Taxes excluded from calculation

Expenses were over budget by about $34k; Fines and Penalties of $50k were a large part of the problem. Agency costs were up for a second consecutive month. Most of the other expense items were within normal limits.

Average daily census is showing signs of stabilizing. The recent history has been:

CCNH Average Daily Census
Dec 2008 thru Apr 2010
without bedholds

Dec	190.9	Aug	182.4
Jan 09	198.4	Sep	181.5
Feb	195.8	Oct	183
Mar	188.4	Nov	179.2
Apr	186.9	Dec	187.7
May	188.6	Jan-10	188.5
June	178.9	Feb	185.2
July	179.8	Mar	192.1
		Apr	195.9

There is no question that census is better than when we first began the turnaround effort. If you start with August, it looks like CCNH is picking up some speed. CCNH is a large facility with high fixed cost load; as a result, it has a high break-even point and census remains the critical factor in improving CCNH's position.

Medicare days were 741 in April for an ADC of 24.7, including the Medicare Advantage days, which does not pay on a par with traditional Medicare. Based on CCNH's recent experience, March's Medicare A volume represents a spike, but one that we'll take willingly. Here's the pattern:

Dec	884	July	442	Feb 10	471
Jan 09	938	Aug	485	Mar	803
Feb	755	Sep	470	Apr	741
Mar	675	Oct	528		
Apr	540	Nov	448		
May	573	Dec	451		
June	396	Jan 10	644		

March's Medicare A revenues snapped our slump; April, without considering the government sanction, was better than many prior months, but not equal to March. Compare the results for Medicare A for the last 11 months versus the start of last fiscal year; we have been mired right around $200k and haven't been able to get back to earlier levels, which approximated $400k.

Medicare A Revenues

First 4 months		**Last 11 Months**	
Dec	$379k	May 09	$211k
Jan-09	$396k	June	$195k
Feb	$313k	July	$179k
Mar	$308k	Aug	$198k
		Sep	$196k
		Oct	$226k
		Nov	$218k
		Dec	$209k
		Jan-10	$276k
		Feb	$208k
		Mar	$434k
		Apr*	$283k*

*Without deduction for government sanction

As expected, Med B picked up in April reflecting $31k in revenues.

The Medicaid revenue pattern had been smoothing out. April's revenues reflect the receipt of a huge check for the 976 conversion days and that skews things badly, as you will see below. In my last report, for March, conversions amounted to 183 days, which is much more reflective of CCNH's normal pattern.

When looking over the table below, keep in mind that CCNH went to the Standard Rate on October 1, 2009:

Medicaid Revenues Compared

Month	Net Revenues	Chg	Days	Chg
April	$633k		2885	
May	$596k	(5.8)%	2941	1.9%
June	$497k	(16.6)%	2725	(7.3)%
July	$538k	8.2%	2791	2.4%
Aug	$511k	(5)%	2652	(5)%
Sep	$561k	9.8%	2818	6.3%
Oct*	$382k	(32)%	3160	12.1%
Nov	$416k^	8.9%	2837	(10.2)%
Dec	$377k	(9.4)%	2937	3.5%
Jan 10	$430k	14%	2839	(3.3)%
Feb	$376k	(13)%	2788	(1.8)%
Mar	$389k	3.5%	2982	7%
Apr#	$540k	38.8%	2935**	(1.7)%

**Medicaid revenues now recorded at net.*
^ Includes October's portion of certified costs
#Without deduction for government sanction
*** Without Medicaid conversion days*

CCNH's payer mix continues to move in a direction that is, overall, positive. The following table provides the comparisons in this significant change:

Comparative Payer Mix
CCNH

	Dec-07 thru June	Sep-08 thru Apr-10
Medicaid	62%	51.7%
Medicare	9%	10.6%
Pvt Pay	29%	37.7%
Totals	**100%**	**100%**

The Medicare per diem has been consistently over $400. In January the per diem was $442; in February the figure was $428. In March, despite the high volume, the per diem dropped to $407. Without the impact of the government sanctions, the Medicare per diem dipped to $383; with the sanction, and as reflected in the graphs the follow, the per diem was $274.

For the five months ended April 2010, the results of operations are posted below and include the impact of government sanctions.

Last Five Months w/Property Tax and Overhead Allocated Monthly

	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10
Medicare A	$ 209,875	$ 275,759	$208,224	$326,417	$202,660
Medicare B	$ 39,154	$27,840	$32,779	$23,882	$31,245
Medicaid	$377,223	$430,809	$376,710	$388,912	$525,733
Pvt Pay	$454,765	$416,163	$347,717	$434,007	$253,218
Adult Day-Private	$5,567	$6,209	$3,455	$4,666	$8,234
Adult Day-TXX	$14,146	$8,943	$9,740	$13,108	$12,949
Miscellaneous	$5,257	$6,881	$7,175	$7,002	$3,595
Property Tax	$81,437	$80,973	$80,973	$80,973	$80,973
All Revenues	$1,187,423	$1,253,577	$1,066,772	$1,278,967	$1,118,607
All Expenses	$1,212,081	$1,189,086	$1,082,184	$1,228,928	$1,262,798
Net Income/(Loss)	$(24,657)	$64,491	$(15,412)	$ 50,039	$(144,191)
Census	5632	5845	5185	5956	5876
Change		3.8%	-11.3%	14.9%	-1.3%
ADC	187.7	188.5	185.2	192.1	195.9
Change		0.4%	-1.8%	3.7%	2.0%
FTE	194.5	184.0	184.0	182.6	184

Cash position remains tight and this should come as no surprise as census targets have not materialized. At April 30, cash was at $611k. If we cannot exit from Denial of Payment, cash will get squeezed severely in the months ahead. Here's how we see things in the months ahead, assuming that Denial of Payment continues:

Month	Cash at 1st of Month	Lowest Cash Balance
May	$627k	$325k
June	$974k	$324k
July	$594k	$251k
Aug	$564k	$275k
Sept	$422k	$102k

July is an immediate concern because it contains three payrolls.

The following graphs provide a comparative statement of position for CCNH through April 2010.

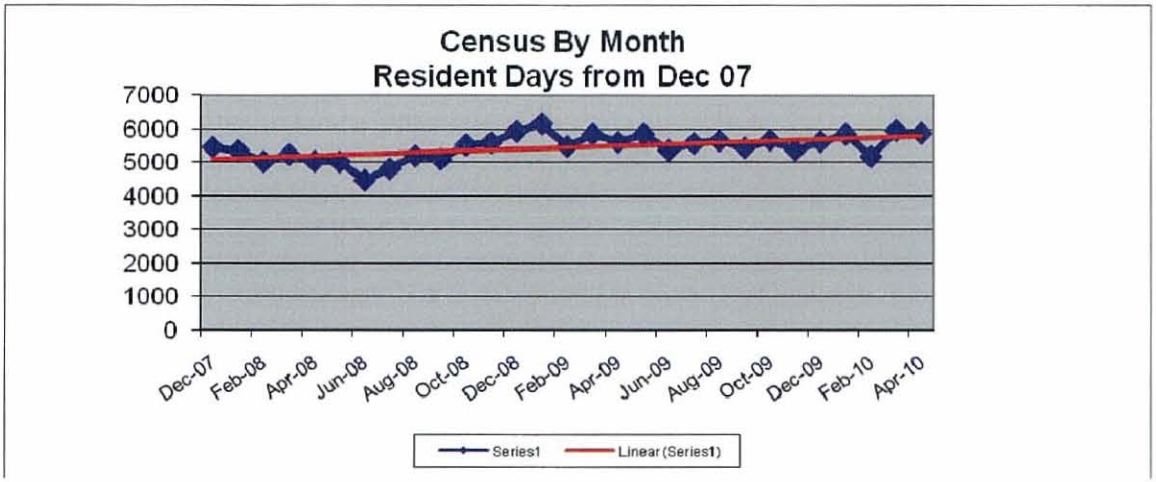
The solid line is a trend line for the displayed data and it should appear in red on your computers. (These graphs will display best when viewed on your screens.)

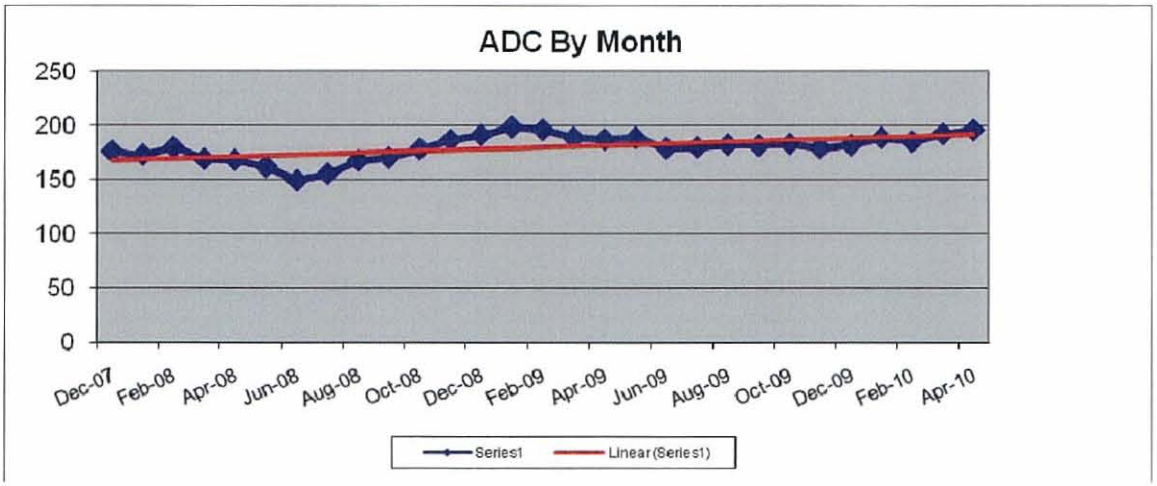
Census

Census continues to receive a lot of attention. Fiscal 2010 is off to a decent start with an ADC of 188.4 versus our target of 195. March has provided the strongest census this fiscal year with an ADC of 192.1.

Current Census by Payer by Month
(without bedholds)

Month	Pvt Pay	Medicaid	Medicare	Total
Aug -2008	1707	3140	341	5188
Sep	1587	3003	505	5095
Oct	1796	3069	607	5472
Nov	1704	3070	917	5691
Dec	1788	3246	884	5918
Jan-2009	1906	3306	938	6150
Feb	1773	2955	755	5483
Mar	2102	3064	675	5841
Apr	2183	2885	540	5608
May	2332	2941	573	5846
June	2248	2725	396	5369
July	2342	2791	442	5575
Aug	2517	2652	485	5654
Sep	2156	2818	470	5444
Oct	1985	3160	528	5673
Nov	2092	2837	448	5377
Dec	2244	2937	451	5632
Jan-2010	2362	2839	644	5845
Feb	1926	2788	471	5185
Mar	2171	2982	803	5956
Apr	2200	2935	741	5876





Revenues

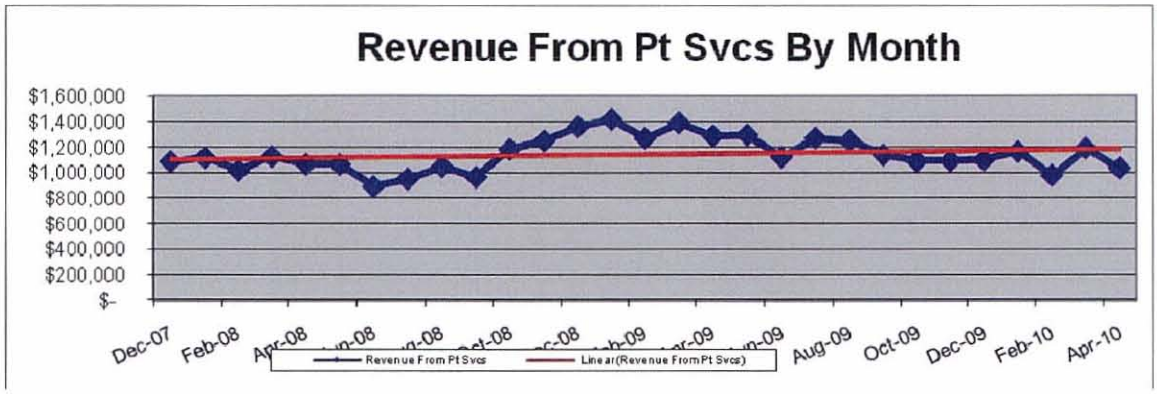
March's Medicare A activity reversed the sharp drop in Medicare volume that dates back to April 09. Excluding the impact of government payment sanctions, April's Medicare A revenue was $283k, not as good as March's level but a decent month for Fiscal 2010. Include the sanctions and the figure becomes $203k, representing a sizable hit but performance that is still better than June – September of 2009.

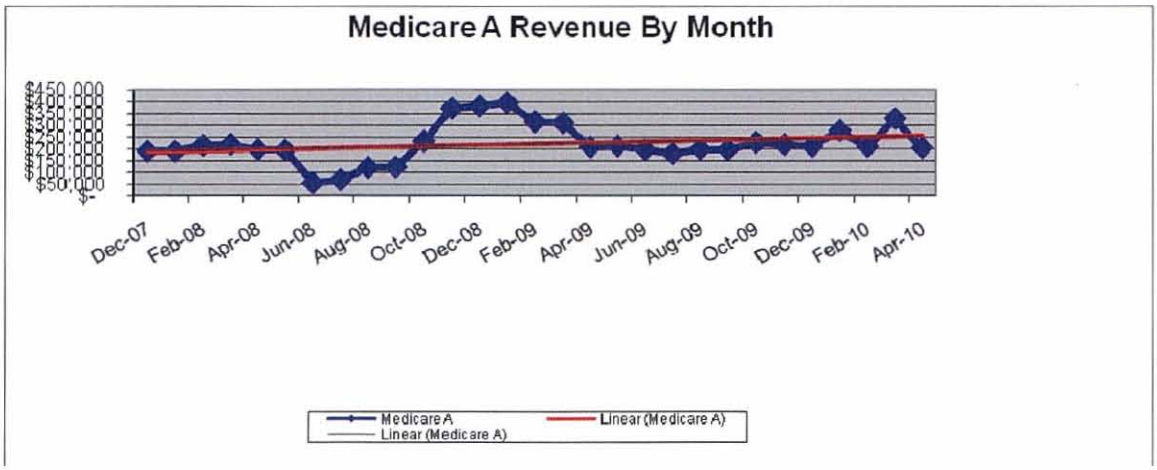
The Medicare per diem is a critical factor in building a better revenue base and we have significant improvements to make in our performance. For November and December, the per diem has been up - $486 and $465, respectively. January and February have followed suit with $442 and $428, respectively. March was disappointing at $407; as noted earlier,

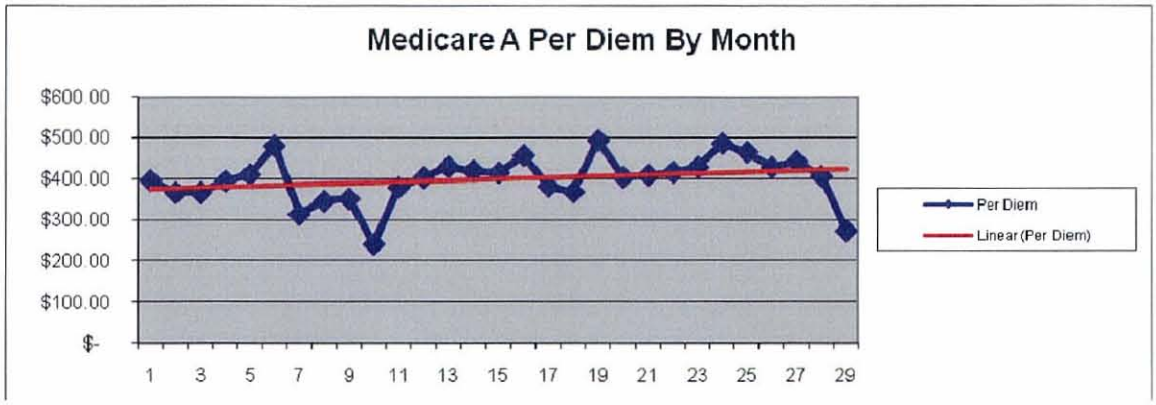
Medicare Advantage's per diem is considerably less than traditional Medicare; at approximately $375 per Advantage day, the overall average can drop fast. The April per diem came in at $381. (Including the sanctions, April's per diem was $281.)

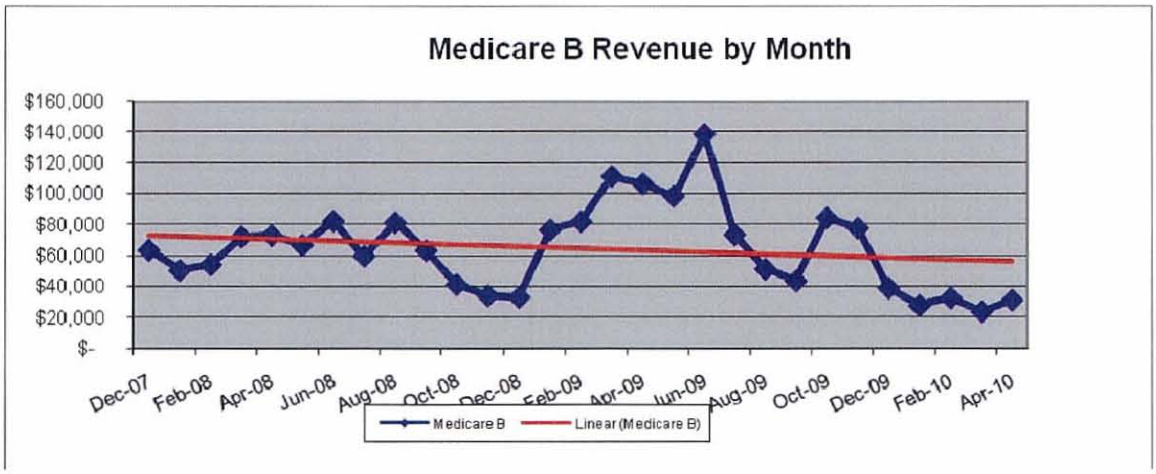
The trend line in Medicare A remains flat and that is a negative factor. Medicare census remains a critical ingredient to success and it also remains elusive. Also, take a look at the chart for Part B revenue; this classification continues to defy classification. The imposition of therapy caps played a huge role in reducing Med B revenues. However, with the recent removal of the therapy caps, Med B revenues bounced back in April.

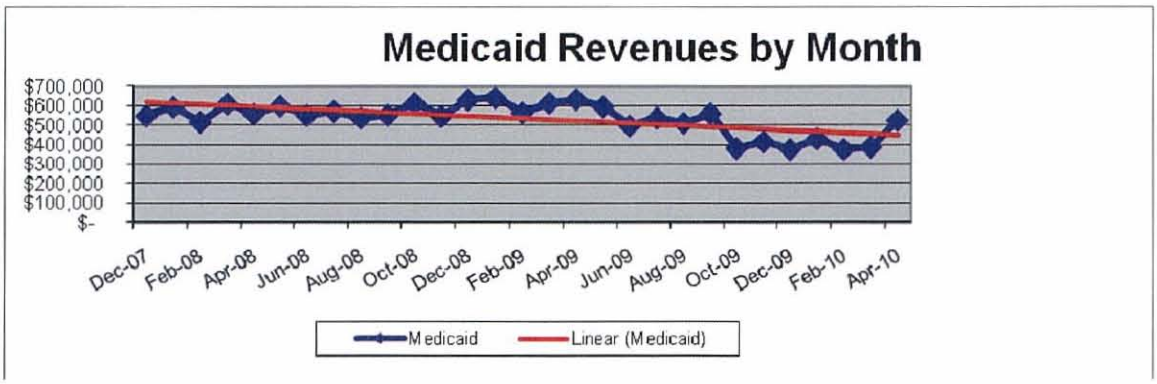
For the most part, Medicaid revenues continue to be stable. You will see from the graph that Medicaid revenues dived with the elimination of the old IGT program; however, our expenses also were reduced significantly. Generally, Medicaid revenues have been stable with some exceptions caused by conversions from Private Pay to Medicaid. This month, April, Medicaid is badly skewed because of an inordinately high number of Private Pay conversions.

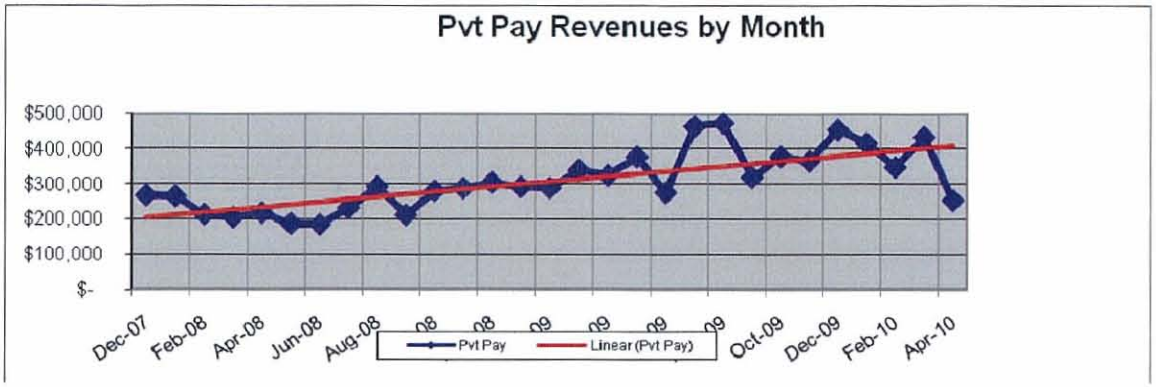


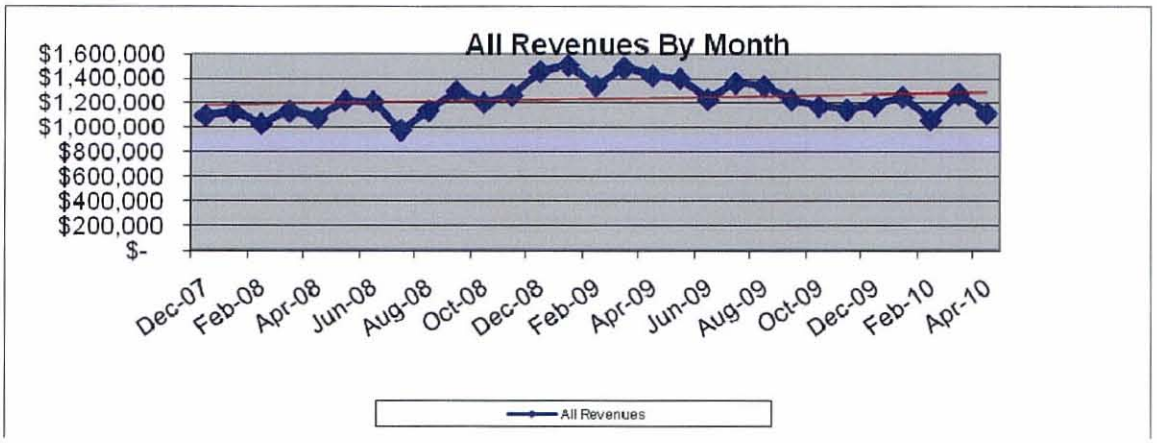



Medicare A Per Diem By Month
$600.00
$500.00
$400.00
$300.00
$200.00
$100.00
$-
1 3 5 7 9 11 13 15 17 19 21 23 25 27 29
Per Diem
Linear (Per Diem)


Medicare B Revenue by Month
$160,000
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$-
Dec-07 Feb-08 Apr-08 Jun-08 Aug-08 Oct-08 Dec-08 Feb-09 Apr-09 Jun-09 Aug-09 Oct-09 Dec-09 Feb-10 Apr-10
Medicare B
Linear (Medicare B)


Medicaid Revenues by Month
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$-
Dec-07 Feb-08 Apr-08 Jun-08 Aug-08 Oct-08 Dec-08 Feb-09 Apr-09 Jun-09 Aug-09 Oct-09 Dec-09 Feb-10 Apr-10
Medicaid
Linear (Medicaid)



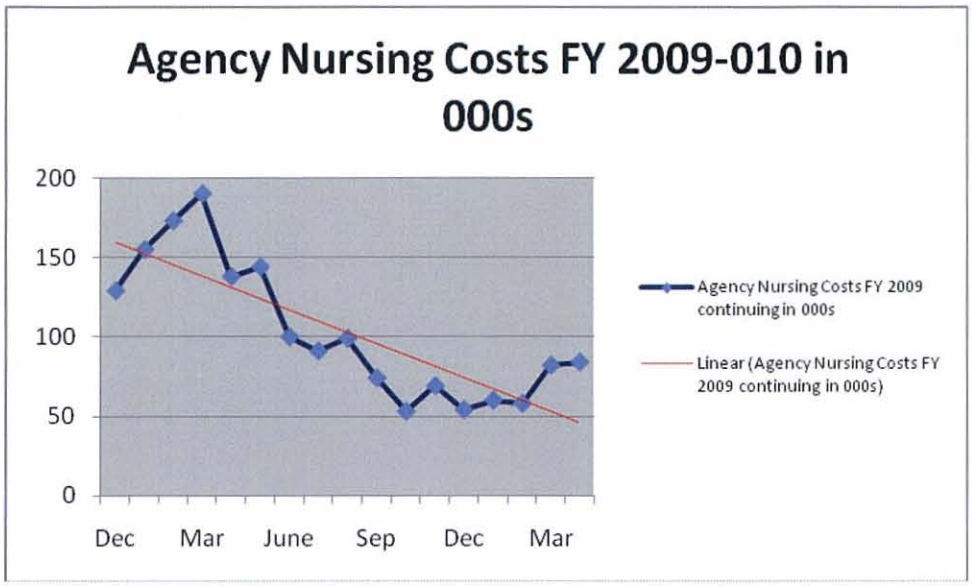


Expenses

CCNH's expense control continues to be pretty solid. In April, however, salaries were up over budget in several departments, especially in nursing. Nursing experienced increased usage of Part-Time Employees, No Benefit Full-time Employees and Overtime. It appears that a large part of the variance is due to how CCNH accounts for its TOPS (benefits) liability. CCNH adjusts its TOPS liability monthly, meaning that the increase in TOPS liability gets recognized as salary expense every month. Most business will adjust their TOPS liability annually rather than monthly. We'll be evaluating this and, unless I am missing something, a change is in the making. In actuality, this represents more of a budget problem in that the "budget" reflects salaries only and the "actual" reflects salaries plus TOPS earned during the month.

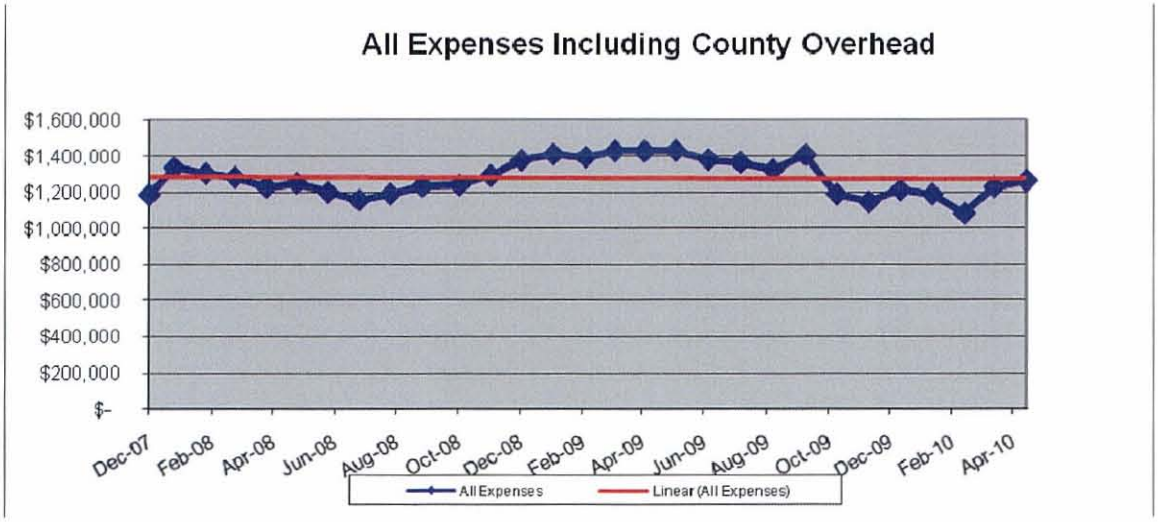
Professional fees were up with the inclusion of expenses for the Medicaid Cost Report. Agency expenses were up for the second consecutive month; they still continue to be below historical levels. We continue to use our own people – i.e., the PRN (No Benefit) group – but sometimes we have no choice in covering the resident load. Total expenses were over budget by $34k. Fines and Penalties were booked at $50k and these amounts

contributed significantly to the overage.



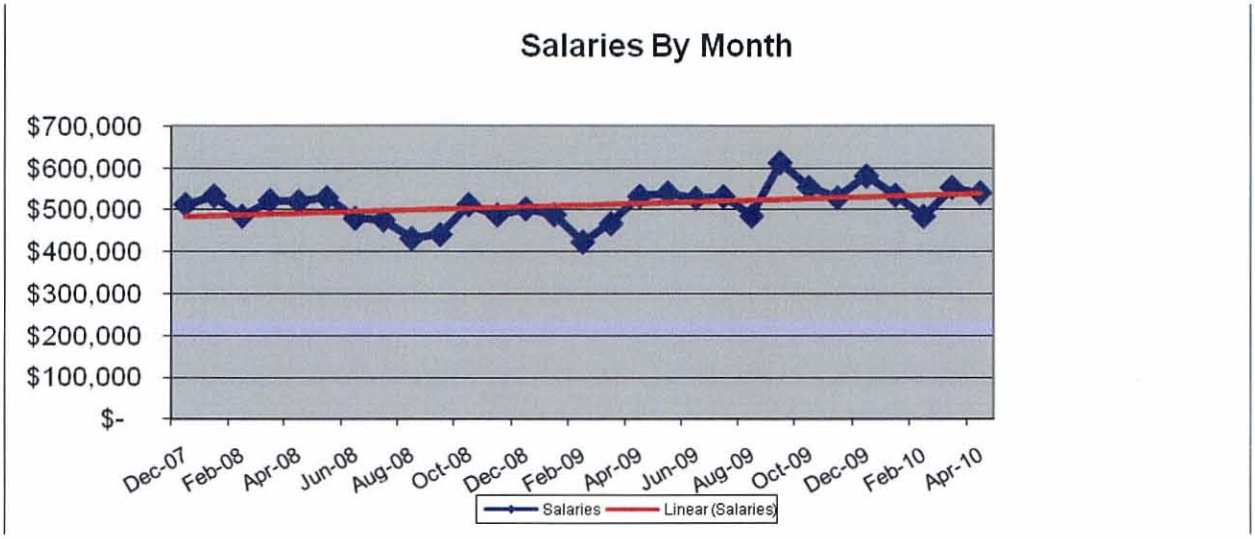
There are some big variable expense items that we watch closely. Examples are food, drugs, and medical supplies. Rehab costs are also variable, and they are set by contract. Utilities represent a fixed cost; there is not much we can do to dramatically alter the cost incurred for gas, electric, and water. Electric service was about $6k over budget in April.

With the exceptions noted above, particularly in salaries, expenses were within reasonable limits. The figures since October 09 reflect the elimination of the transfer expense associated with IGT program.

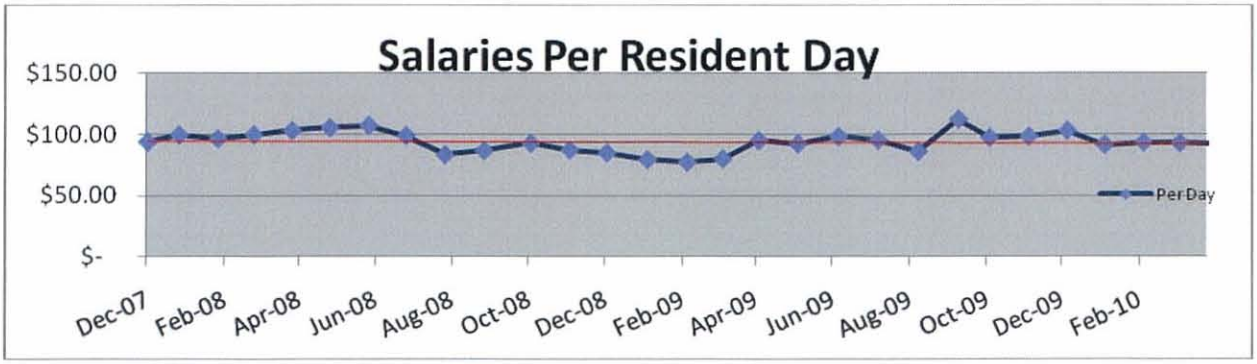


Salaries continue to be our biggest cost.

As we drop CCNH's dependency on agency staff, our own staffing costs are increasing. Graphically, the salary relationship is presented below.



It is no secret that we have been staffing up in the nursing department. You can see what happens when volume (census) dips in a healthcare facility. Fixed costs *per day*, which – I would argue -include a large portion of total salaries, increase when volume declines. For Fiscal 2010, salaries per day average $95.50; since January, the average is $92.52.



Summary

Census continues to be the big determinant of success. April's census results were excellent; yet they are over-shadowed by the Denial of Payment problem. We continue to experience wide swings in revenues by payer, and this results in inconsistency and continues to be a drain on sustained revenue improvement.

CCNH's cash flow is dependent upon government reimbursement;

To: Board of Directors
Champaign County Nursing Home

From: M.A. Scavotto
Manager

Date: June 7, 2010

Re; Organizational Objectives

Attached is a progress report on the current status of CCNH's objectives for Fiscal 2010. We have made decent progress on some items but, in general, have considerably more work to do.

Updates appear in red.

Objectives for CCNH

I. Quality of medical services

a. Integrate Medical Director into daily operations at CCNH; move as many residents as possible to direct supervision by Medical Director (consolidate medical direction)

Status – In progress. Medical Director is working well with Nursing to improve care processes. Moving residents to Medical Director's care has proven to be a slow process.

b. Develop a sub-acute service or its equivalent

Status – Developing nursing management skills at the floor level with unit
managers first. Our clinical oversight and skills need to improve.

c. Develop state-of-the-art dementia program; position CCNH as market leader in dementia (programming, media, community education, client service)

Recruit director

Status - Accomplished January 2010; re-started after an untimely death and new director in place June 2010

Develop program

Status – Director will start orienting and developing the program in July 2010

Promote program featuring education about dementia, caregiving

Status – Will follow the development of the program.

Use Adult Day Care as a gateway or feeder

Status – Will follow programming. Loosely in place now but no formal programs/plans are in place yet.

d. Improve IDPH regulatory position

Status – June 2010, improving nursing supervision is key; nursing supervision to be beefed up after Denial of Payment is lifted and as cash flow improves

No survey cycle problems

Status – we are not doing well in this area, June 2010

No G-level deficiencies or fines

Status– we are not doing well in this area, June 2010

Programmatic Quality Initiative: Commitment to Quality

Objective: Advance quality initiative from infancy to maturity
Method: Develop overall quality goals, separate action items into subcommittees, communicate goals and responsibilities with Department Leaders, measure and track progress.

Outcome	Action	Responsible	Completion Date
Develop quality goals	Define quality indicators with expected results.	Andrew B, Karen Noffke, Traci Heiden	7/31/10
Define sub-committee responsibilities	Draft responsibility statement. Separate quality indicators into sub-committee responsibilities.	Andrew B, Karen Noffke, Traci Heiden	8/31/10
Draft program parameters for each sub-committee	Define information used to derive quality indicator results. Develop meeting schedule and expected output including meeting minutes, completed measurement tools, actions to resolve variances from expected outcomes.	Andrew B, Karen Noffke, Traci Heiden	8/31/10
Draft measurement tools	Prepare tracking tools for each indicator.	Andrew B, Karen Noffke, Traci Heiden	9/30/10
Draft central tracking mechanism	Summary report for the central Quality Committee used during monthly review.	Andrew B, Karen Noffke, Traci Heiden	9/30/10
Launch meeting with Department Leaders	Present prepared information, responsibilities, assign sub-committee members, schedule meetings for FY10.	Andrew B	9/30/10
Program inception	Begin sub-committee and central Quality Committee reviews.	Andrew B	10/1/10

Quality indicator performance within established thresholds	Complete above. Monthly monitoring, review of quality indicators, refinement of variance reporting procedure, document steps of the Quality Process, develop Quality training manual to embed program in CCNH culture.	Quality Committee Andrew B, Karen Noffke, Traci Heiden	11/30/10

II. **Strategy**

a. Improve reputation and community image of CCNH

Consistent rankings of 4.5 or better on Pinnacle scores

Status- April 2010 Pinnacle survey shows Overall Quality, Nursing, Therapy, response to Problems improving; other areas show scores that are unacceptable. Overall, CCNH needs an overhaul in customer service. Support services are particularly disconcerting.

Management evaluations tied to customer satisfaction

Status – Rankings ranged from 3.87 to 4.49 over the last 12-months ended April 2010. Results are below our target.

Management performance objectives and subsequent evals will include customer satisfaction scores.

Status – No report yet

b. Strengthen CCNH position versus competitors

Measures of effectiveness:

ADC
Medicare load
Private pay mix

Status – Hired Marketing/Admission Coordinator on May 24, 2010. Conducting daily hospital rounds and will work with the Medical Director for a physician meet-and-greet at CCNH.

c. Improve coding capabilities for Medicare and Medicaid

Comparative reimbursement per diems

Quarterly Medicaid rate history for the nursing component

Status – MDS Coordinator is going to RAC-CT program through LSN on June 15th.
Medicaid rate increased from $129.53 in January to $137.02 in March as a result of an improvement in the nursing component.
Departments that participate in MDS coding are scheduled for a 9-part MDS seminar through LSN starting the week of June 9th.

Programmatic Strategy Initiative: Marketing

Objective: Develop a sustainable, fluid marketing plan; get census to 195 or better and maintain it

Method:

a. Hire a Marketing/Admissions Director, draft a marketing plan that includes communications and positioning.

Status – Hired Admissions Director May 24th. Marketing plan with communications and positioning to be drafted by July 1st.

b. Identify referral targets; track activities and effectiveness.

Status – done

c. Develop positioning statement for communications plan; adopt identity materials that complement the positioning statement; incorporate identity package into all CCNH communications

Status – no action yet – target date of August 1st.

d. Identify media placements and message; determine most effective means of communicating CCNH's position including Web opportunities

Status – no action yet – target date of August 1st.

e. TBD.... Research on public image and recognition

Status- no action yet

Measures of effectiveness:

ADC at 195 or better

III. Financing

a. Strengthen CCNH balance sheet

b. Develop cash reserves so that CCNH has a cash surplus of $1m (this will take some time)

c. Create a positive current ratio

Programmatic Financing Initiative: Integrate clinical and financial information to achieve maximum reimbursement

Objective: Identify those information support activities that promote coding effectiveness using the Minimum Data Set

Method: Develop a standard set of procedures that optimizes CCNH's ability to identify and respond to the most critical clinical needs of residents; capture those needs on the Minimum Data Set and measure CCNH's effectiveness.

Measures of effectiveness:

Number of default assessments
Number of logic errors that go uncorrected
Quarterly change in the Medicaid Standard Rate
Medicaid standard rate improved from $116.74 to $121 from Jan 2010 to March 2010.

IV. Policy

a. Implement corporate compliance including red flags identity theft program

b. Emphasize management development as a means of improving labor-mgt relations and productivity

Improved employee screening leading to lower turnover

More rigorous employee evaluations, training, and supervision

Reduced call-ins and higher productivity ratio

Fewer grievances; better in-house resolution of problems

Commitment to employee recognition

Programmatic Policy Initiative: Human Resources

Objective: Advance the skill level of CCNH supervisors through management development and on-the-job experience; specific emphasis shall be placed on verbal and written communication skills, documentation of events worthy of either discipline or recognition, and consistent, even-handed enforcement of CCNH policies.

Method: Provide development opportunities through supervisory workshops, in-service education sessions, practice sessions to build skills in documentation and in investigation, grievance and policy analysis, and CCNH-wide assessments of HR strengths and weaknesses. When feasible, add an experienced HR specialist to the management staff or provide the equivalent talent via a consultant.

Measures of effectiveness:
Nature of grievances filed and experience in handling them (attests to strength of management's documentation and investigation skills)

Status…Total grievance volume as decreased from a high point of 7 in February to 1 in May. The most prevalent type of grievance relates to shift issues, followed by elder abuse, employee behavior, and employee to employee or employee-supervisor conflict.

Consistency in documentation and in employee evaluation

Status…Documentation continues to improve our success at the Step III level. Of the 24 grievances this year, 2 have been overturned at Step III equating to a 92% management success rate.
Internal training on collective bargaining agreement, the Just Cause test, documentation, and evaluation are yielding tighter investigatory conclusions. Training conducted by Mary Ellen O'Shaughnessey on evaluations and partnering with employees to improve performance was very helpful.

Employee acquisition, retention and turnover by department (includes use of the Predictive Index)

Status- Predictive Index implemented May 2010

Key dashboard metrics

ADC: 195 goal; 186.9 actual Dec 2009 thru April 2010

	Mix Goal	Actual	ADC Goal	Actual	Per Diem Goal
Medicare	12%	10.6%	25	19.9	$425-$450 ($425*)
Medicaid	50%	51.7%	98	96.6	Trending up each qtr (Yes)
Pvt Pay	38%	37.7%	72	70.4	$180-$195 ($175)

*Excludes impact of Denial of Payment sanctions

Expense Control, cost per day target

Dec 09	$215	Average Dec 09 thru Apr 10 $210
Jan 10	$203	
Feb	$209	
Mar	$206	
Apr	$215	(fines & penalties at $50k)

Cash Balance

From Management Report for April 2010; balances forecast to include impact of Denial of Payment sanctions

Month	Cash at 1st of Month	Lowest Cash Balance
May	$627k	$325k
June	$974k	**$324k**
July	$594k	$251k
Aug	$564k	$275k
Sept	$422k	$102k

To: Board of Directors
Champaign County Nursing Home

From: M. A. Scavotto
Manager

Date: June 7, 2010

Re: Management Update

This is the twenty-third in a series of updates designed to keep you current on developments at CCNH.

1. **Census:** CCNH's mix continues to improve. At and ADC of 192 in March, we were much closer to achieving our goal of 195 than we have been since February 09. In April, ADC was 195.9. For Fiscal 2010, ADC is averaging 189.9. This is a good improvement that is overshadowed by our survey difficulties.

2. **Operations:** Issues with the balance sheet have been corrected and debt obligations to the County are now recorded accurately.

   I remain in contact with Carol Wadleigh at the County Auditor's office. I am scheduled to re-establish contact on June 15. The goal remains devising a software solution to financial reporting so that we can eliminate duplication of effort between the County Auditor and the nursing home.

   Gail Shivers has made the switch to dementia coordinator and has been attending the Rush dementia training program. Gail is enthusiastic about the assignment and recognizes its inherent difficulty. The new Social Services Director started May 3; Andrew reports that she is making a very positive impact. The Marketing/Admissions Director is also on board and adapting to CCNH.

   Our current difficulties with complaint surveys are serious. Once we get past the current denial of payment problem, I have every intention of bolstering supervision on the nursing units. This has a high priority. We continue to take an activist posture towards all incidents of resident abuse. As a result, there have been and will continue to be employee disciplinary actions, including terminations, for resident abuse. Training in resident abuse practices continues. We are also cataloging our incident history so we can get a better historical of the types of reportable incidents that occur at CCNH and the people who commit them. In the meantime, we continue to delegate nursing management functions to nursing supervisors in order to free up the DON for more policy-level activities within the nursing department; this is a work-in-progress and will be for several months.

Also, it's no secret that we are behind on our objectives; we intend to do better in the months ahead.

Regarding the IGT, we expect negotiations to begin in August. Our source on this is HFS itself. I'll keep you posted if and when anything actually develops.

Re-positioning rehab will continue. We have had initial discussion with Alliance Rehab and will have more. We have plenty of unused beds and are searching for ways to create a space much more conducive to rehab and to younger seniors undergoing more elective procedures.

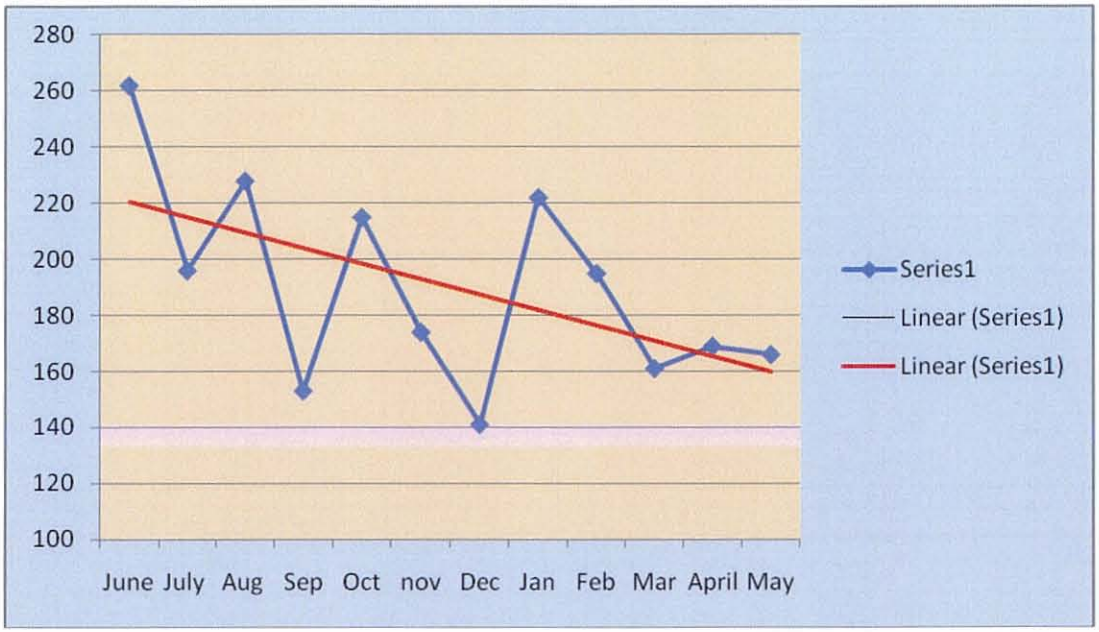
Upon admission, all residents execute a Resident Contract. These have recently been revised and will be put into service soon.

CCNH has been included in a Carle initiative spearheaded by its Quality/Risk Management Department. The group is evaluating ways to improve the medication reconciliation process between hospital and long-term care institution. It is nice to be included in this effort.

Included in this month's Board mailing is an attachment on the implications for skilled nursing facilities under health reform. You may want to have a session or two on this in the future. Corporate Compliance plans have been mandatory for a few years now, but they have never gained much traction in SNFs. The health reform act makes this point again by requiring all facilities to adopt a Corporate Compliance plan.

3. **Employees:** The unscheduled absence position is looking pretty good; CCNH is showing a big improvement that appears to be standing the test of time.

Unscheduled Absences January 2009 thru May 2010



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As always, give me a call (314-434-4227) or zap me via e-mail if you have questions or want to discuss anything.

Skilled Nursing Facilities Under Healthcare Reform
Patient Protection and Affordable Care Act (PPACA)
Enacted March 23, 2010

Benefits That Impact The Demand For Skilled Nursing Services

1. CLASS Act

The Act creates a voluntary, public long-term care insurance program called Community Living Assistance Services and Support (CLASS). The Secretary of Health & Human Services (HHS) must develop the details of the plan by October 1, 2012. It is expected that eligible individuals will be able to enroll sometime on late 2012 or in 2013.

Individuals pay premiums into a Federal long-term care insurance policy. Working adults will be automatically enrolled in the program unless they opt out. After five years, they have the option of using the benefits, estimated at about fifty ($50) per day, to defer the cost of skilled nursing care either in their homes or in institutions. Medicaid residents residing in nursing homes would be permitted to keep 5 percent of their cash benefit; those receiving benefits under home- and community-based waivers could keep 50 percent of their cash benefit.

Also, home and community based services get an incentive under reform. States will receive FMAP increases by shifting Medicaid beneficiaries away from nursing homes and into home- and community-based services (HCBS). States must re-balance their spending between nursing homes and HCBS by October 1, 2015. On the surface, SNFs can expect some reduction in inpatient resident activity; however, as discussed further below, the SNF is downstream from the hospital and SNFs should expect pressure to care for cases that currently require hospital admission.

2. Help close the donut hole in Medicare Part D.

Effective January 1, 2010 all Part D enrollees receive a rebate check in the amount of $250 once they enter the donut hole; the donut hole is currently between $2,830 and $6,440.

Effective July 1 2010, drug manufacturers will provide a 50 percent discount to Medicare enrollees for brand-name drugs and biologicals purchased in the coverage gap – i.e., the donut hole. Additional discounts will be phased in so that, by 2020, beneficiary responsibility will be reduced to 25 percent.

3. Reform encourages greater use of long-term care

States must include impoverishment protection in all waiver programs. This probably does not have a direct impact on SNF reimbursement; rather, it affects Medicaid eligibility determinations.

The reform act requires a major to limit readmits to hospitals. In actuality, this is a problem right now throughout the delivery system and SNFs play a large part in it whenever they send residents to the hospital. There are times when utilizing the hospital is necessary; there are other times, though, when stronger clinical management in the nursing home would benefit the system.

Under the reform act, hospitals with high re-admission rates will experience a cut in their reimbursement. One source (Health News Digest) estimates that 20 percent of Medicare hospital admissions result in readmissions within 30 days. That's a big number. Illinois ranks in the top five States with the highest readmission rates.

The immediate target of the new regulatory action is the hospital and the specific diagnoses will be skewed largely to heart failure and pneumonia. The modern hospital is geared to handle high-tech conditions; heart failure and pneumonia are low tech. One can make an excellent argument that these conditions can be handled appropriately in a SNF provided that clinical practices,

capabilities, and medical direction are appropriate. Consequently, this aspect of health reform represents an opportunity for skilled facilities.

4. RUGs- IV

CMS currently reimburses Medicare Part A on the basis of the RUGs-III classification system.

The RUGs- IV system is delayed until October 2 2011. The minimum Data Set (MDS) changes, known as MDS 3.0, are not delayed and are effective October 1 2010.

MDS 3.0 changes the use of concurrent therapies by allocating therapy minutes across all patients and eliminates the hospital look-back provisions currently in effect. The net effect of the changes will make it difficult to qualify for the X and L RUG classifications under the new rules. This appears to have little impact on the therapy company, but it will impact the SNF by limiting reimbursement. Because these changes are designed to be budget-neutral, the limitation on some reimbursement should be expected. Additionally, there are increased requirements to use licensed therapists as opposed to aides "under supervision", reimbursement for group therapy sessions is reduced, and the costs of providing therapy services will likely increase.

The changes create an incentive for SNFs to assess providing ventilator and tracheotomy care in order to move into or remain in the higher reimbursement classifications. The costs of providing the services are also higher, however; consequently, these types of decisions must take into account detailed clinical and financial factors.

5. Medicaid Expansion

Will add an estimated 16 million people nationally to the Medicaid rolls. By definition, Medicaid pays below costs. Eventually, expanded Medicaid obligations will fall back to the States.

6. Higher FMAP for States

Under the stimulus package, the Federal match amount for Illinois increased to 62 percent; this increased funding expires at the end of 2010. The health reform bill extends the higher FMAP levels another six (6) months. Illinois is actively lobbying for an extension of the higher FMAP. If the FMAP drops, it is expected to do so incrementally – the FMAP funding level would be 95 percent of the previous year in year 1 of the reduction, 90 percent in year 2, etc.

The FMAP increase is intended to finance newly-eligible Medicaid recipients.

Changes Likely To Impact Skilled Nursing Strategy & Operations

7. Transparency (Section 6101)

There are requirements to disclose ownership interests in nursing homes plus those persons or entities that exercise control over a facility. In other words, governing board members, partners, trustees, and managers.

Illinois already has a requirement to disclose ownership; the management aspect appears to be new for Illinois.

8. **Accountability Programs (Section 6102)**

Compliance

Within three years after the enactment of the act, the Secretary of HHS must determine how compliance and ethics programs have affected the quality of care. All skilled nursing facilities are required to have compliance programs now; however, compliance has not received much emphasis and we know of very few nursing facilities that have them. Compliance programs are an everyday fact-of-operations in hospitals.

Quality Assurance and Performance Improvement Program (QAPI)

By December 31 2011, the Secretary of HHS must establish and implement a QAPI program that will establish quality assurance and performance improvement standards and provide technical assistance on the development of best practices.

9. **Nursing Home Compare Website (Section 6103)**

The following provisions will be added to the CMS Nursing Home Compare website:

- Staffing data

- Links to State websites regarding State programs/final survey reports, plans of corrections

- The standardized complaint form, how it used, and how to file a complaint

- The number, type, severity, and outcome of substantiated complaints, number of adjudicated instances of criminal violations by a facility or employees that were convicted inside the facility involving abuse, neglect, exploitation, criminal sexual abuse, or that resulted in serious bodily injury, and the number of civil monetary penalties levied.

Illinois already provides much of this data through IDPH.

10. **Increased Regulatory Enforcement (sections 6111-14, 6121, 6201)**

Among the more pertinent elements of these provisions are requirements for dementia management and abuse prevention training. The expectation is that these programs become part of every employee's pre-employment training.

There are requirements for expanded background checks; Illinois facilities are already quite familiar with background checks.

11. **Reporting of Staffing Expenditures (Section 6104)**

Beginning two years after enactment, facility cost reports must provide details on "direct care staff" and indirect care, capital assets and administrative costs. This is already being done in Illinois.

Section 6106 requires facilities to electronically submit direct care staffing information (including agency and contract6 staff) based on payroll and other verifiable and auditable data. The information submitted will specify the employee category (such as RN, LPN, C.N.A., therapist, etc); will include resident census data and resident case mix; a regular reporting schedule; employee tenure and hours of care per resident day by category. Data submission will start by March 23, 2012.

Much of Section 6106 is already reported on the Illinois Medicaid Cost Report. However, the act does implement expanded reporting requirements and frequencies.

12. **Standardized Complaint Forms/Reporting**

The Secretary of HHs must establish a standardized complaint form for residents and/or those acting on a resident's behalf. It appears that there will be a standardized approach to complaints. Currently, each state has its own procedure.

13. **Value-Based Purchasing**

This promises to be complicated. Basically, the idea is for the government to apply accountability in its purchasing activities. For example, if a "never" event occurs in a hospital, the hospital will not be paid for the service; an example would be an operation on the incorrect patient or on the wrong body part. Under this provision, the Feds would determine what "never" events would apply to skilled nursing facilities.

Medication errors are an obvious target for emphasis; the Act also denotes a very specific requirement for better employee training in dementia and abuse. The idea is to infuse accountability by getting procedures and protocols correct, getting a process right the first time, and cutting down on obvious errors.

14. **Reimbursement**

Full Market Basket Updates are provided in 2010 and 2011; this is positive. However, in 2012 a productivity adjustment factor is introduced, which could result in decreases to future market basket updates. Also, other rules, such as those mentioned above with RUGs 3.0, serve to decrease the positive effect of a full market basket update.

Changes to PPS/RUG coding will impact all facilities and probably should not be considered part of healthcare reform as the contemplated changes have been well-known and anticipated in the industry. Specifically, and as introduced in item 3 above, SNFs should expect that it will be much more difficult to qualify for the intensive rehab services that are prevalent in nursing homes; the most visible service is orthopedics. Reimbursement will be shifting to chronic disease where the intensity of therapy is less. SNFs will be adjusting to serving more chronic and medically complex cases.

The specific impact of RUGs coding will be on the L and X classifications. Together, X and L days represent a large percentage of CCNH's total Medicare days. The challenge is to a) adapt to the regulatory reform by adjusting its assessment process and b) to seek out other forms of revenue enhancement. Both of these challenges can be met. It is vital to note that reimbursement under X and L is not being eliminated; it is being limited. Accordingly, serving new types of cases such as congestive heart failure must become the organization's objective. All homes – not just CCNH – face these challenges. The reform act places pressures on hospitals, too; as noted under 2, above, opportunities open up for skilled facilities to serve new markets.

Accountable Care Organizations may emerge under health care reform. If they do, we are likely to see capitation return in the form of bundled reimbursement.

There are two programs. First, a five-year demonstration provides for a single payment to be shared by hospital, physician group, skilled nursing facility, and a home health agency. Second, a three-year demonstration that allows providers of services and supplies to Medicare beneficiaries to belong to Accountable Care Organizations with a minimum of 5,000 beneficiaries.

The capitated form of reimbursement will drive activities from high-cost to lower-cost providers. Think in terms of hospital patients being directed to SNF, of today's SNF residents being directed to home care. This type of networking should be viewed as a strategic opportunity, especially where strong clinical and medical direction can be used to benefit a nursing facility.

15. **Independent Payment Advisory Board**

If Medicare expenditures exceed a target rate of growth, the IPAB is required to develop proposals that will reduce costs. IPAB recommendations are not advisory, they become law unless Congress adopts alternative cost savings proposals.

Proposals to reduce costs shall not include recommendations to ration health care, raise revenues, raise premiums, increase cost-sharing, or otherwise restrict benefits or eligibility. Since these exclusions do not leave much room for any other type of cost reduction approaches, the implication is that reduced provider fee schedules and payments are in sight.

Physicians and suppliers enjoy the benefits of the IPAB in 2015. Hospitals and nursing homes begin in 2020.

As noted above, there is nothing "advisory" about IPAB.

16. **Increase in Required Staffing Levels (State of Illinois)**

This provision is not Federal but reflects the new nursing home reform act just passed by the State of Illinois. Under the new act, minimum staffing increases from the current level of 2.5 direct nursing care hours per skilled day to 3.8 by July 1, 2013. There is an incremental ramp-up over a four year period. Intermediate care (ICF) increases from 1.7 hours per intermediate day to 2.5 by July 1, 2013.

This provision is definitely a cost-increaser for all skilled homes. The new law allows some hours to be counted that the current law prohibits – 100 percent of the Assistant Director of Nursing; 50 percent of the Director of Nursing; and 30 percent of the Social Services Director. All providers will need to assess their new operating position under the new regulations.

Other Provisions of Interest to Skilled Nursing

17. GAO Study and Report on Five-Star Quality Rating System (Section 6107)

The Act mandates a study on the CMS Five-Star Quality Rating System for nursing homes to include an analysis of how the system is being implemented; of problems associated with the system or its implementation; and of improvements that could be made.

18. Civil Monetary Penalties [CMP] (Section 6111)

In cases where a facility self-reports and promptly corrects a deficiency not later than 10 calendar days after a CMP is imposed, the amount of the penalty may be reduced by 50 percent. Reduction of penalties is prohibited for repeat deficiencies if the facility has already had a penalty reduced in the preceding year; for deficiencies resulting in a pattern of harm or widespread harm; for immediate jeopardy; or that result in the death of a resident.

19. National Independent Monitor Demonstration Project

The Act mandates a 2-year voluntary demonstration project by March 23, 2011, to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains. Participation criteria include evidence that some of the chain's facilities have safety and quality of care problems, or multiple facilities with a history of repeat safety and quality of care deficiencies. Participating chains will have 10 days from receipt of findings to submit a plan for corrective actions or why it will not take action. A report to Congress, including recommendations for establishment of a permanent program, is required within 180 days of the demo's completion.

20. Notification of Facility Closure (Section 6113)

Facility administrators must submit written notification of an impending closure to the Secretary, ombudsman, residents and their legal representatives or responsible parties. Notification must be no later than 60 days prior to closure, or in the case of termination, no later than the date determined by the secretary. No new residents may be admitted on or after the date of notification; the notice must include a plan for the transfer and adequate relocation of residents by a specified date. The State must ensure that before a facility closes, all residents of the facility have been successfully relocated. The Secretary may continue payment with respect to residents from the date of notification until residents are successfully relocated. Administrators who fail to comply will be subject to a civil monetary penalty of up to $100,000 and any other penalties that may be prescribed by law; may be excluded from participation in any Federal health care program.

This is already the policy in Illinois with the possible exception of the specified CMP; facility closures are monitored through the Certificate of Need program.

21. National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes (Section 6114)

The Act mandates 2 three-year demonstration projects to be implemented by March 23, 2011. First, for the development of best practices in facilities involved in culture change (including development of resources for funding to undertake culture change); second, for the development of best practices in facilities for use of information technology to improve care. The Secretary will award 1 or more grants to facility-based settings for the development of best practices with respect to the demonstration project involved. Both projects will consider the special needs of residents with cognitive impairment, including dementia.

22. Dementia and Abuse Prevention Training (Section 6121)

For Medicare/Medicaid facilities, the Act amends the nurse aide training requirements to include "...dementia management training, and patient abuse prevention training..." The Act clarifies the definition of Nurse Aide to include agency and/or contract staff.