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OFFICIAL NOTICE AND AGENDA

of a meeting of the **North Central Community Services Program Board** to be held at **North Central Health Care**, **1100 Lake View Drive, Wausau, WI 54403, Board Room** at **12:00 pm** on **Thursday, July 27th, 2017**

In addition to attendance in person at the location described above, Board members and the public are invited to attend by telephone conference. Persons wishing to attend the meeting by phone should contact Debbie Osowski at 715-848-4405 24 hours prior to the start time of the meeting for further instructions. Any person planning to attend this meeting who needs some type of special accommodation in order to participate should call the Administrative Office at 715-848-4405.
For TDD telephone service call 715-845-4928.

A QUORUM OF THE RETAINED COUNTY AUTHORITY COMMITTEE, COMPRISED OF APPOINTEES FROM LANGLADE, LINCOLN, AND MARATHON COUNTIES, MAY BE PRESENT AT THE NORTH CENTRAL COMMUNITY SERVICES PROGRAM BOARD MEETING; HOWEVER, NO VOTE OR ACTION WILL BE TAKEN BY THE RETAINED COUNTY AUTHORITY COMMITTEE.

1. Call to Order
2. Public Comment for Matters Appearing on the Agenda
3. Education: Crisis Assessment Response Team (CART) and Crisis/Behavioral Health PI Team Update – M. Barnes/L. Scudiere
4. Chairman's Report and Announcements– J. Zriny
    a. Update on Chief Executive Officer Recruitment Plan and Selection Timeline
5. ACTION: Approval of 6/29/17 NCCSP Board Meeting Minutes
6. Committee Reports
    a. Executive Committee Report – J. Zriny
        i. Review Draft Minutes of the 7/13/17 Meetings
    b. Finance, Personnel & Property Committee Report – B. Weaver
        i. Review Draft Minutes of 6/29/17 Meeting
        ii. Overview of 7/27/17 Meeting
        iii. June Financials – B. Glodowski
            1. CFO Report
            2. ACTION: Accept the June Financial Report and Financial Statements
    c. Nursing Home Operations Committee Report – J. Burgener
        i. Review Draft Minutes of the 6/23/17 Meeting
        ii. Overview of Joint meeting with Mount View Care Center Committee of 7/11/17
        iii. Overview of Mount View Care Center Financial and Operational Assessment Report and Recommendations
    d. Quality Committee Report – M. Loy
        i. Organizational Outcomes
            1. ACTION: Accept the Quality Dashboard as Presented
7. CEO Work Plan Review and Report – M. Loy
8. MOTION TO GO INTO CLOSED SESSION:
    a. Pursuant to Wis. Stat. Section §19.85(1)(g) for the purpose of conferring with legal counsel for the governmental body who is rendering oral or written advice concerning strategy to be adopted by the body with respect to litigation in which it is or is likely to become involved, for the purpose of conferring with legal counsel regarding a notice of claim for damages regarding the care of a patient under voluntary treatment on the CBRF unit.
9. RECONVENE to Open Session after approximately 15 minutes of deliberation in Closed Session
10. Policy Governance Discussion
    b. Review Draft End Statements
    c. Discussion of Committee Structures and the Work Committees Perform on Behalf of the Board
11. Discussion of Future Agenda Items for Board Consideration or Committee Assignment
12. Adjourn

Presiding Officer or Designee

NOTICE POSTED AT: North Central Health Care
COPY OF NOTICE DISTRIBUTED TO: Wausau Daily Herald, Antigo Daily Journal, Tomahawk Leader, Merrill Foto News, Langlade, Lincoln & Marathon County Clerks Offices

DATE: 07/21/17 TIME: 4:00 p.m. BY: D. Osowski

NCHC Chief Executive Officer Search

Executive Committee Vision

The RCA was created to have oversight for specific retained authorities of our Tri-County quasi-governmental health care services organization. One specific authority is the ability to participate in defining the position duties, qualifications and overall selection process of the Chief Executive Officer. The Executive Committee has considered the feedback from the RCA and is defining a vision forward that does not hold the opinion of the RCA superior to and potentially to the detriment of our own belief in what is in the overall best interests of the organization. North Central Health Care is neither exclusively a governmental agency nor a health care organization, it is uniquely both, which is precisely why it requires great skill in managing this tension beyond that of a governmental department of community programs. It is the belief of the Executive Committee that this organization needs to be run as an integrated healthcare system for the purposes of administering a community mental health, alcohol and drug abuse program and protective services and protective placement for the benefit of our government partners. This is in addition to administering many other programs including one of the State's largest skilled nursing homes and the coordination of affiliated partnerships such as the Medical College of Wisconsin's Psychiatry Residency Program. To successfully accomplish this charge in a complex matrix system of accountability, a CEO who can lead such a diverse organization in the gale forces of health care while understanding the symbiotic governmental relationships at the same time is absolutely essential.

It is the belief of the Executive Committee that moving in the direction of a more limited mindset as purely a governmental unit will erode the advantages this organization has created fiscally for our county partners while also potentially serving as a deterrent to overall access to service and quality improvement. A limiting hierarchy of bureaucracy typically involved in such organizations hinders quality performance and responsiveness over time as evidenced by the Veteran's Administration health system.

It is our belief that in order to meet the needs of the citizens in the tri-county area services need to be delivered through an integrated health care system that is responsive and accountable to its partners. There is no doubt that the owners of this organization are three Counties and the citizenry we collectively represent. We do not believe our vision runs counter to the best interests of both of these parties but will actually create the most value for our owners. The 51.42 board is in the process of implementing a policy governance form of oversight. This will hold this perspective and the chief executive officer accountable to the desired results but will allow him or her the flexibility to be proactive and responsive to changing needs. We are seeking an executive who is highly qualified in these regards and will help us fulfill our mission.

Chief Executive Officer Search Process

- The attached CEO Job description will be utilized for the search.
- The compensation plan currently in plan at NCHC will continue to be utilized. The attached position control and salary schedule for all NCHC employees is recommended to the RCA for consideration. All positions at NCHC are assigned to this plan and are administered according to the compensation policy and administration manual previously sent to the RCA as adopted by the NCCSP Board.
- The CEO compensation range is assigned to salary grade 28 which has a minimum salary of $156,716, a market target rate of $195,894 and a maximum rate of $235,073. The range is consistent with the philosophy and structure of all other positions at NCHC.
    - North Central Health Care's compensation philosophy is to pay at the 50th percentile or at the target market rate for all positions.

- The CEO range should accommodate sufficient choice in the recruitment process but still likely will present some limitation to the attraction of certain candidates or the loss of others.
- The range would have accommodated the final salary of the previous CEO incumbent at approximately $230,000 at the very upper end. If the target market rate was achieved in the recruitment, this would represent a salary reduction of 15%.
- The mid-point as a target is reflective of a trending forward of the historical compensation level of the CEO stretching back to at least the mid-1990's and would provide a sufficient differential of current compensation levels of direct reports.
- The range balances the difference between being a purely governmental agency and a health care CEO.
    - Other governmental agency compensation for similar roles, while not clear comparisons, of $120-$150,000 would represent a 25-40% discount to our CEO mid-point target of $195,000.
    - The market rate as determined by previous retained search firms and executive compensation analysis, of $260-$338,000, would represent an approximate 33-73% premium to our CEO mid-point target of $195,000.
- Adjusting our recommended range any lower would create compensation compression to the entire legacy pay plan which if implemented could drive turnover in key positions or inhibit successful recruitment challenges across the board when there has already been difficulty in the recruitment of key positions. In addition to the CEO position, industry surveys indicated Executive market rates to be 30% higher than the attached schedule being recommended.

- The search and selection process should be expedited as NCHC has been operating with an Interim CEO since February of 2016. A selection target of March 2018 would be extraordinary length of time for an Interim placement.
- The use of a national search firm is not recommended and we would request the RCA to consider whether an external search is even necessary given both the Board and NCHC Leadership's current level of satisfaction of the Interim CEO's portfolio of success over the last 18 months and direction for moving forward.

- Considerations if an external search is undertaken:
    - Maintaining stability of existing leadership team.
    - The need for a leadership transition plan for the current Interim CEO including a severance package to ensure stability if transition occurred at the CEO level.
    - The need for executive retention plans to maintain continuity and stability of the current executive management team as consideration for the risk associated with a continued period of uncertainty.
    - Over the last 18 months we have seen significant improvement in performance results with the current leadership team. Maintaining a focus and leading a team of over 700 employees during this most tenuous time speaks highly of the existing leadership.

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Chief Executive Officer

Job Code:	TBD	Program:	Administration
Reports To:	Retained County Authority (RCA) & NCHC Board of Directors	FLSA Status:	Exempt
EEO Code:	1.2	Last Revision:	June 30,2017

The following statements are intended to describe, in broad terms, the general functions and responsibility levels characteristic of positions assigned to this classification. They should not be viewed as an exhaustive list of all the specific duties and prerequisites applicable to the position.

Purpose of the Position

North Central Health Care (NCHC) is a quasi-governmental healthcare organization formed and owned by three Central Wisconsin counties - Langlade, Lincoln and Marathon. NCHC is governed by a board of directors appointed by representatives from these counties with a composition of elected officials, community appointees and at least one consumer of services.

Programs and services offered include outpatient, day treatment, community treatment, inpatient psychiatry hospitalization, residential treatment, outpatient and detoxification services for alcohol and drug dependency; and vocational, life skill training, early intervention, housing and care management services for developmentally disabled individuals. In addition, Marathon County's Mount View Care Center offers skilled nursing facility services at the main campus in Wausau with a licensed capacity of 220 residents. Mount View serves individuals in need of short term rehabilitation or post-acute care with complex physical needs, ventilator dependent care, long term skilled nursing care, or those in need of specialized nursing care for dementia, psychiatric and neurological diseases, or behavior problems.

The CEO is a visionary who can lead a complex organization, is a strong relationship builder and has a passion for working with those less fortunate and will serve as the highest administrative position for the organization.

Key responsibilities of the CEO are administering the policies and directives of both the NCHC Board of Directors and directives of the Retained County Authority (RCA) which represents the three counties.

Key accountabilities for the CEO are informing these bodies of progress in the coordination of major organizational activities and in the development and maintenance of effective service delivery systems for the communities it serves. The CEO assists these groups in their policy deliberations with data, information and advice. This position serves as an influential community leader in matters of Behavioral/Mental Health initiatives interacting with other community leaders, fundraising groups and the business community. Provides Thought, People, Results, and Personal Leadership for the organization and serves a role model for carrying out organization mission, vision and values.

Education and Experience Requirements

Required: Master's Degree in Health Care or Business Administration or related field

Experience in Health Care Management, Behavioral Health/Mental health and/or Human Services in an Executive Role

Experience supporting policy-makers in their governance.

Experience in building collaborative relationships, affiliations, networks with other organizations and/or Community Leaders.

Experience in overseeing large capital projects.

Possess and maintain a proper driver's license along with a good driving record as per NCHC standards.

Any combination of education and experience that provides equivalent knowledge, skills and abilities may be considered.

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Essential Duties and Responsibilities

- Maintains direct operational authority over all North Central Health Care programs through delegation of authority as deemed appropriate to Executives, Directors, and Managers.
- Participates as a member of various teams, committees, and taskforces to create innovative solutions associated with the provision of NCHC services.
- Plans, directs and reviews services and outcomes rendered by all programs for continuous improvement in meeting business priorities and community expectations.
- Responsible for keeping the Board apprised as to how overall operations and services are meeting the Board's expectations.
- Monitors ongoing monthly performance and makes appropriate adjustments to ensure budgetary and operational success.
- Maintains regular communication with the administrative officers and county boards of Langlade, Lincoln and Marathon counties to develop effective working relationships in supporting NCHC's mission.
- Directs the preparation of monthly and annual reports to report results to the Board of Directors.
- Ensures that all applicable legislation and government regulations are enforced and in compliance.
- Develops an operational plan in conjunction with the Senior Management team that establishes clearly defined performance standards, metrics and work plans that can be monitored to evaluate the organization's performance at any time.
- Directs the preparation and submission of an annual budget showing current financial status and anticipated overall revenue for Board approval.
- Directs the development of long-range financial plans including forecasts of anticipated requirements and revenues for approval of the Board of Directors.
- Develops, for Board approval, long-range strategic plans and targeted service improvements.
- Recommends changes in Board policies for approval by the Board of Directors.
- Model and carries out the organizations Mission, Vision and Core Values as overviewed below:
    - **Vision** *Lives Enriched and Fulfilled*
    - **Mission** *Langlade, Lincoln, and Marathon Counties partnering together to provide compassionate and specialized care for people with complex behavioral and skilled nursing needs*
    - **Core Values**
        - *Dignity: We are dedicated to providing excellent service with acceptance and respect to every individual, every day.*
        - *Integrity: We keep our promises and act in a way where doing the right things for the right reasons is standard.*
        - *Partnership: We are successful by building positive relationships by working across the organization and as a trusted County partner.*
        - *Accountability: We commit to positive outcomes and each other.*
        - *Continuous Improvement: We embrace change, value feedback, creativity and the advancement of excellence.*

Competencies

- Thought Leadership – Uses insightful judgement, thinks strategically, and is innovative in championing new ideas and initiatives that supports the mission of the organization.
- People Leadership: Influences others while engaging and inspiring commitment to a plan of action. Promotes collaboration and builds talent as well as relationships with the utmost integrity.

- Results Leadership: Ensures execution of business goals and drives for results. Focuses on the importance of Person Centered Service to the populations it serves.
- Personal Leadership: Inspires trust and is adaptable to learn and develop from experiences. Interacts well with others and maintains high level of integrity in all dealings.
- Demonstrated Business Acumen
- Demonstrated Financial Analysis Skills
- Knowledge of regulatory and accreditation standards along with federal, state and local codes relevant to the types of programs administered by NCHC.
- Thorough knowledge of the principles and practices of administrative organization and scientific management and their application to effective health care operation.
- Ability to inspire employees and partners to maintain a high degree of engagement and to lead by personal example.
- Ability to exercise good judgement in emergency situations.
- Annual competencies as required by North Central Health Care and/or various regulatory agencies based on entity and/or job title.

Core Value Standards of Behavior

It is expected that all employees will demonstrate behaviors that support excellence as defined by North Central Health Care's Core Value Standards of Behavior. It is particularly important that the organization's leader be a model of the values in action.

Physical and Working Environment

Normal mental and visual attention required. Normal office working conditions requiring continuous use of both hands. Sitting most of the time, may involve walking or standing for brief periods of time. Occasional bending, squatting, twisting, climbing stairs and may lift up to 10 pounds. Minimal exposures to workplace hazards including regular travel.

Acknowledgement

All requirements of the described position are subject to change over time where I may be required to perform other duties as requested by NCHC. Further, I acknowledge that this job description is neither an employment contract. I have received, read, and understand the expectations for the successful performance of this job.

Printed Name: _____ Signature: _____ Date: _____

In compliance with the American with Disabilities Act, NCHC will provide reasonable accommodations to qualified individuals and encourages both prospective and current employees to discuss potential accommodations with the employer. North Central Health Care is an Equal Opportunity Employer.

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NORTH CENTRAL COMMUNITY SERVICES PROGRAM
BOARD MEETING MINUTES

June 29, 2017 **12:00 p.m.** **Westwood Conference Center**

Present:

X	Randy Balk	X	Steve Benson	X	Ben Bliven
X	Jean Burgener	EXC	Holly Matucheski	X	Bill Metter
X	Bill Miller	X	Corrie Norrbom	X	Greta Rusch
X	Rick Seefeldt	EXC	Robin Stowe	X	Bob Weaver
EXC	Theresa Wetzsteon	X	Jeff Zriny		

Also Present: Michael Loy, Brenda Glodowski, Sue Matis, Laura Scudiere, Kim Gochanour, Sheila Zblewski, Lance Leonhard

Call to Order

- The meeting was called to order at 12:04 p.m.

Public Comment for Matters Appearing on the Agenda

- No public comments made.

Chairman's Report – J. Zriny

- An anonymous letter was received and forwarded to legal counsel for review. There were no alleged quality concerns but rather an employee with misinformation who didn't understand management decisions and made incorrect assumptions. Executive Committee recommended M. Loy have a conversation with NCHC Leadership Team regarding the letter and reinforce the complaint resolution and non-retaliation policy. The Leadership Team talked at length about managing expectations, how decisions are made, and that they can talk with M. Loy at any time who will listen and provide as much information to them as possible.
- There have been two joint meetings of the RCA and Executive Committee discussing the CEO Job description, search process, and compensation. Executive Committee will meet July 13 to finalize the search plans, job description, and forward to RCA for discussion on July 18. RCA continues to look at the CEO of NCHC as a county department position vs managing a health care organization. As we review Policy Governance we will look more closely at the role of the organization.

Approval of 5/25/17 NCCSP Board Meeting Minutes

- **Motion**/second, Weaver/Seefeldt, to approve the 5/25/17 NCCSP Board Meeting minutes. Motion carried.

Executive Committee Report – J. Zriny

- No additional questions or discussion.

Finance, Personnel & Property Committee Report – B. Weaver

- The memo provided by B. Glodowski highlights the positive reflection in financials. Expenses are down and census is up.

- The cost of state institutes has decreased significantly which can be attributed to daily communication with the state institutes to effectively manage the individuals there and stability of having a full-time psychiatrist back on the inpatient unit.
- We had budgeted a loss of about $650,000 in the nursing home with the intent to reduce the deficit throughout the year. Reducing the number of licensed beds by 20 early this year has had a positive impact on the deficit. This does not include the cost of the nursing home study that Marathon County asked us to incur. B. Weaver thanked staff for the major efforts that are working well.
- **Motion**/second, Burgener/Metter, to accept the Financial Report and May Financial Statements. Motion carried.

Nursing Home Operations Committee Report – J. Burgener

- Connie Gliniecke is on board as the DON. She had worked for NCHC a few years ago and we are fortunate to have her back.
- Census is doing well with a good payer mix but feel it could be better had the remodel happened.
- Financials have been the highlight. Changes that have had a positive affect have been: improved bed management, improved stand-up and stand-down meetings, admissions process, DON on board, being responsive to hospital planners, and stabilizing staff with wage increase and onboarding which has reduced open CNA positions from 40 to 14.

Quality Committee Report – M. Loy

- Executive Summary in packet indicates many positive elements in key indicators. Vacancy rate is our biggest opportunity which is highly correlated to Access to Behavioral Health Services. Patient experience is one of the strongest measures of the Dashboard. Nursing home readmission rate is flirting with exceeding target and we are seeing well managed finances in the organization.
- **Motion**/second, Metter/Benson, to accept the Quality Report. Motion carried,

Medical Staff Credentialing

- Medical staff is the delegated body by the NCCSP Board to review individual's credentials for privileges to practice at NCHC and recommends the following individuals for approval:
    - Appointment: Anne Dibala, M.D., Michael Lance, M.D., Robert Vickrey, M.D.
    - Reappointment: Jean Barabeau-Anaya, PAC, Terry Gander, PA-C, Debra Knapp, APNP, Debra Sanfilippo, PAC, Jennifer Svencer, PA-C, Shae Wheeler, PA-C
- **Motion**/second, Burgener/Rusch, to approve appointments as recommended. Motion carried.

Chief Executive Officer Recruitment Plan and Timeline

- Before the recruitment process can begin, whether utilizing a search firm or recruiting ourselves, the Executive Committee and RCA must come to an agreement on the job description and compensation of the CEO position. The major difference is whether the position is a 'county department head' or the CEO of a health care organization. Upon agreement a timeline will be established. The Executive Committee feels very strong that this position is a CEO of a health organization
- The job description is under revision. The word 'government' was added which alludes to the position being more county government. However, NCHC is very unique with the levels and types of services i.e. a psychiatric inpatient unit, the nursing home, outpatient services, community treatment, etc., and the complexity and level of responsibilities.
- Other organizations were researched but none found as a good comparison to NCHC. NCHC operates as a business, not a county department which is all tax levy supported, NCHC has revenue streams and bills for services; and now a Psychiatry Residency Program.

CEO Work Plan Update and Report – M. Loy

- The Board will spend a significant amount of time talking about Policy Governance at the retreat today and over the next six months.
- We have been working with Clifton Larson Allen on the nursing home report which will be released tomorrow. The general overview is that we have a huge asset that may need to be 'right sized' to make more beneficial to the community. There will be two meetings in July with the consultants i.e. July 11 at 7 p.m. to review the operational piece and a second later in July to review the strategic piece in how to operate the nursing home.
- The County Board has committed to vote on the pool in September, 2017 which requires a simple majority to proceed. The bonding vote, anticipate in the spring of 2018, needs ¾ vote. The project is estimated at $6 million for a new structure and the County Board has asked that $3 million come from the community giving only 5-6 months to raise $3 million. Estimated construction is about a year. The County Administrator felt this scenario would need to occur in order to have the votes to pass. We have met with the other area health organizations. Aspirus has offered to pledge $100,000 if the other two entities did the same. We will also pursue grants nationally and connect with the Veterans organizations, etc. but must have a positive initial vote prior to pursuing fund raising.
- Distributed: 2016 Annual Report and Commemorative 45 Year Anniversary Pins.
- Budget is in progress and will be ready for approval in August. A compensation plan which has been forwarded to the County should be back for our Board implementation in August.
- The RCA will be selecting an auditor for next year. RFP responses are due tomorrow. Selection should be completed in July. They are also reviewing the CEO Compensation and Recruitment plan, performance standards, and how the standards fits into NCHC and the dashboard.
- There was a Welcome event for the Psychiatry Residency Program this week with physicians from the community present. Success of this program is integral to the community. After an extensive matching process, three residents from 60 interviews out of 800 applicants were confirmed. Moving forward the Board would like to continue to receive reports on the progress of the program, the relationship between the residents and staff, where each resident is in their training (undergrad, med school, residency), etc. This intensive program requires our physicians to have residents with them on a daily basis for the rest of their careers and will increase costs with the investment involved.
- We are also working with the Medical College of Wisconsin in providing experience with family practice resident rotation. This is a partnership, an investment, and a privilege.
- The Board would like to invite Dr. Krall periodically for updates about the Residency Program.
- Dr. Dileep Borra has signed a letter of acceptance as a psychiatrist in Outpatient Services starting July 2018. His wife is also interested in a psychologist position in Outpatient services. We also have an offer out to a child psychiatrist with a goal to have 8 psychiatrists engaged with us within the year.
- Atty. John Fisher will provide an overview of a recently filed law suit with the three counties to the Board in closed session next month.

Discussion of Future Agenda items for Board Consideration or Committee Assignment

- Claim filed

Board Retreat – Policy Governance Discussion

- See attached

Motion/second, Bliven/Metter, to adjourn the Board Meeting and Retreat at 4:37 p.m. Motion carried.

dko

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NCCSP Board Retreat

July 29, 2017 **1:00 p.m.** **Westwood Conference Center**

Policy Governance Discussion

- Getting Started with Policy Governance by Caroline Oliver, NCHC Team Game Plan, and Balanced Scorecard Step Diagram were distributed.
- Three key questions are on the agenda for today:
  - What is our purpose?
  - Who do we serve?
  - What is the structure of the Board?
- Today is a mode of inquiry and discussion. The Board has an important role in delivering the best services and should decide on how it wants to govern moving forward. What can be done over the next five years to set NCHC up for success for the following 50 years?
- The CEO works with the Executive Team, Medical Staff, and Board. To maintain success, the Board also needs a direction and vision including working with the Retained County Authority Committee and the three county governments.
- Overall objectives of policy governance:
  1) Define end statements (from board perspective)
  2) Committee structure (purpose and structure)
  3) Executive limitations (clearly articulate what you don't want CEO to do)
  4) Board policies
  5) Board agenda and calendar
- A Policy Governance Manual will be developed which will identify the work of board and the executives, how we interact to move the organization forward, the adding of board members, the terms of board members considering the more frequent turnover of the county board member appointments.
- Ownership is two-fold:
  1) Legal (Langlade, Lincoln and Marathon Counties
  2) Moral (community)
  - Marathon County owns the facility and property but NCHC is a vendor to the county boards which provides services to the counties. The counties can purchase services from any provider but have chosen to purchase from NCHC as a provider.
  - As it is today financial equity is divided between the three counties.
- NCHC is an organization of organizations:
  - 51.42 (required):
    1) behavioral health
    2) community services via emergency and crisis services
  - Community Living (Adult Developmental Disability Services), (not required)
  - Mount View Care Center (county operations delegated to NCHC to manage), (not required)
  - Adult Protective Services, (required)
  - Aquatic, (not required)
  - Birth to 3, (required)
  - Demand Transportation (Marathon County only)

- Who represents the community and makes the decision on their behalf?
    - If financial support by the counties is part of NCHC then counties have a say in decisions. The Board exists and acts on behalf of the counties' as owners of NCHC.

Stakeholders

- County Government
- Medical Community
- State
- Federal Government – Medicare/Medicaid
- Insurance
- Care Management

End Statements

1. What benefit does our organization exist to produce?
    - Needs
    - Ability to afford services
    - Emergent needs (unplanned)
    - Nobody else can (or will) care for
    - Specialty
    - Benefit to individuals and families around MH, substance abuse
    - Benefit to community as a whole (sometimes not a realization as an upstream benefit i.e. B-3) or having a recovery friendly eco system.
        - law enforcement
        - legal system
        - schools
    - Substance abuse
    - Enhance quality of life issues for neighborhoods and citizens in a community at large
    - Meet needs for those with no resources i.e. populations that government looks at as 'last best hope'
    - A provider for 3rd party reimbursement.
    - Quality care in diverse areas
    - Positive Outcomes reputation
    - Multi-disciplinary addiction
    - People are savvy with investigating reputation, etc.
    - What do other providers look to NCHC to be able to do?

2) For Whom?
    - Populations of our counties

3) At what cost efficiency?
    - No way 'we' (Lincoln and Langlade Counties) can afford to do on their own
    - To maximize county financial contribution
    - We cannot discriminate based on payer source
    - There is a cost to not providing quality care.
    - NCHC was selected as a CCS regional provider because of the other services we provide in conjunction with the program.

4) We take care of people who can't take care of themselves and do it better than anyone else.

People

- Employee Engagement
- Premier provider employer
- Quality People
- Stability
- Dedication
- Collaborative
- Continuing education
- Pride (3 affirmations for every criticism)
- Competency
- Career Path Development – Professional Growth

Service

- Patient Satisfaction
- Exceed expectations
- Be the best
- Follow-up
- Compassionate Care
- Clarity of treatment plan
- Preparation
- Perspective
- Referral Source Satisfaction

Clinical

- Regulatory compliance
- Risk management
- Interdisciplinary (Population Health)
- Integrated (Seamless)
- Quality of Life
- Evidenced-based – screening / comprehensive assessments
- Best practice (center of excellence)
- Quality/financial/effectiveness
- Real Time Quality

Community

- Access
- Response and Responsiveness
- Public/Private Partnership
- Shared Information for Continuity of Care
- Awareness
- Respect
- Affiliations
- Perception
- Tell the Store
- Collective Impact
- Messaging/Advertising
- Connecting to resources

Financial

- Efficiency
- Growth
- Diversification
- Viability
- Value
- Adaptable
- Teaching-access

Feedback - What did you like about today's retreat/discussion and what would you change?

- Like discussion and what we need to look at.
- Would like the addition of small group discussion which would help drive conversation.
- Prepare a game plan so as not to get to a point we were previously.
- Ownership piece helps – to be mindful of the relationship with counties.
- Reading was helpful but was a lot.
- Get more out of discussion than just reading the materials.
- Incorporate additional discussion every other month after the Board meeting (45 min.)
- Liked getting back to basics, what we are, where we came from, who we are, how we are governed, and how we rely on the counties.
- More conversation of county being bad guy/good guy and appreciate what counties have to deal with.
- Process helps define who we are, where gaps were in own knowledge.
- Liked how the discussion unfolded. Have better sense of competencies and who board members are. Gained trust and respect of different viewpoints.
- Good to be mindful of breaks. In favor of small groups breakout sessions.
- Process good. Liked seeing Michael perform, learning clinical side, numbers, etc.
- Appreciated input from Lance.
- Appreciated Michael's preparation for today and did great job.
- Time well spent; didn't lose train of thought, engaging, no one got lost.
- Will be stronger because of today.
- Appreciated ability of better understanding of ownership, how we fit in, where board is in terms of everything else, the exercise, and getting to know people.

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NORTH CENTRAL COMMUNITY SERVICES PROGRAM BOARD
EXECUTIVE COMMITTEE

July 13, 2017 4:00 PM North Central Health Care – Board Room

Present:	X	Jeff Zriny	X	Jean Burgener
	EXC	Robin Stowe	X	Bob Weaver

Others present: Michael Loy, Sue Matis

Chairman Zriny called the meeting to order at 4:00 p.m.

Public Comment for Matters Appearing on the Agenda

- No public comment(s) made.

ACTION: Approval of 6/8/17 and 6/28/17 Executive Committee Meeting Minutes

- **Motion**/second, Burgener/Weaver, to approve the 6/8/17 and 6/28/17 Executive Committee meeting minutes; motion passed 3-0.

Policy Governance Review and Next Steps

- Committee members felt the Board Retreat went very well and are looking forward to seeing how it develops.
- Meetings will be held with Ken Day to prepare for upcoming Policy Governance education sessions for the Board. Mr. Day will be facilitating these educational sessions moving forward. The plan is to include 60-90 minutes at each Board meeting.

Finalize CEO Recruitment Materials for Retained County Authority Committee (RCA)

- The CEO Job description has been revised following the Committee discussion on 6/28 and will be provided to L. Leonhard, Chair of RCA, for the next RCA meeting July 18.
- The 7/18 RCA agenda will also include a review of performance standards, the audit RFP, and the compensation plan for the NCHC organization that was reviewed on 6/28.
- In regard to the CEO Search, the Committee agrees that they are not in favor of pursuing a national search for CEO. The current Interim CEO has been in the position for 18 months and has done an outstanding job evidenced by the positive turnaround in the organization. The RCA noted recently that they would like the CEO selection to be completed by March of 2018. The Executive Committee believes it will not be beneficial for NCHC to pursue a national search and delay the appointment until 2018. J. Zriny drafted a document regarding the CEO search plan stating the position of this Committee. Following review, the Committee agreed that this document will be attached to the revised CEO Job description and provided to L. Leonhard, Chair of the RCA for inclusion in the next meeting packet.
- A major hurdle before moving forward with the selection of CEO is agreeing on whether the position is a CEO of a complex health care organization or a department head of the county. The outcome will be directly reflected in the level of compensation for the position and ultimately the caliber of applicants for the position.

- The compensation plan for the entire organization must be agreed upon before any recruitment can take place.
- We will provide the RCA with our vision and what is needed to be successful. We can help determine the outcomes both short term and long term. The RCA is ultimately responsible for the outcomes of their decisions if they modify NCCSP Board's proposal.
- **Motion**/second, Burgener/Weaver, to accept the CEO Search document. Committee expressed concern about the potential for turnover at the executive level with the uncertainty and delays in this process and that the Board should be prepared. Motion carried. J. Zriny will provide L. Leonhard with the CEO search document and CEO Job description for inclusion in the next RCA meeting packet. M. Loy will provide the NCHC Compensation Plan to L. Leonhard also.

CEO Report

- Psychiatry Residency Program – Dr. Amy Butterworth began this week. With two physicians on the inpatient unit to support the residency program expect expenses for inpatient to be above budget. We are working on leveraging every revenue source to help with these additional expenses. Will also look at remodeling the unit to add office space for the doctors.
- Dr. Krall has been invited to the August Board meeting to provide an update. Hopefully one of the residents will be able to attend too.
- Dr. Immler has provided extensive coverage for us on the inpatient unit while we had been searching for a new Medical Director. He has also provided valuable insight and feedback and has indicated how well Dr. Dibala is doing.
- June financials show the 51.42 services with a positive variance and the nursing home down a bit. We are still confident we can close the gap on the budgeted deficit in the nursing home.
- At the end of June Wipfli completed a revenue cycle analysis for behavioral health services. It was felt there are opportunities for a better process from enrollment to payment. Some recommendations we are able to implement immediately.
- A plan to renovate the behavioral unit to streamline services is being developed. This will allow for better efficiencies and is estimated to free up operational costs which will repay the costs of the renovation quickly. A report will be provided by the end of the year.
- It is consistent when consultants come in, including those from Wipfli that we receive remarks about the compassion and commitment individuals have at NCHC to those we serve. NCHC has great staff and resources that others recognize and wanted the Committee to be aware.

Agenda for 7/27/17 Board Meeting

- Policy Governance Discussion facilitated by Ken Day
- Crisis/Behavioral Health Update - Matt Barnes
- Nursing home consultant report overview
- Case update
- Update on CEO selection/recruitment

Motion/second, Burgener/Weaver to adjourn. 4:56 p.m. Motion carried.

dko

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NORTH CENTRAL COMMUNITY SERVICES PROGRAM BOARD
FINANCE, PERSONNEL & PROPERTY COMMITTEE

June 29, 2017 11:00 AM Westwood Conference Center–Wausau

Present:	X	Randy Balk	X	Bill Miller	EXC	Robin Stowe
	X	Bob Weaver	X	Jeff Zriny		

Others Present: Michael Loy, Brenda Glodowski

Meeting was called to order at 11:00 a.m.

Public Comment for Matters Appearing on the Agenda

- No public comment(s) made.

ACTION: Approval of 05/25/17 Finance, Personnel & Property Committee Meeting Minutes

- **Motion**/second, Weaver/Balk, to approve the 05/25/17 Finance, Personnel & Property Committee meeting minutes. Motion carried.

May Financials – B. Glodowski

- Received the supplemental payment the end of May and in mid-June received the State receivable. May had a gain of over $334,000. The nursing home census improved from 182 to 184 and Medicare census averaged 18. Census on the inpatient unit has been decreasing slightly. A change in leadership can have an impact. Dr. Dibala has a strong desire to get individuals to a less restrictive area which reduces their stay on the inpatient unit. Will monitor for effectiveness in readmission rates.
- Revenue overall was slightly under target while overall expenses were below target by $327,000. Benefits and salaries are under budget. Health insurance costs have improved tremendously since last year and are currently below target. Benefits continue to do well. Through May the organization is $858,000 ahead of target.
- State institute expenses were very good in May and year to date they are just $12,000 above target. By end of June we anticipate being below target and may have another credit from the state institutes. As a reminder, we hired an RN to closely manage the cases at the state institutes, talking on a daily basis with them, which has proven to have had a positive impact on utilization. The main concern remains around youth and finding an alternative placement in the community and are working with Social Services for a solution.
- The nursing home saw a gain which helps our goal to eliminate the deficit by year end. The changes made last December have had positive results.
- The nursing home study report will be released tomorrow. They have some good insights and recommendations, however, some of the recommendations they noted were implemented last year already but there may be other opportunities for improvements. Their perspective is to continue in the nursing home business because we have a good asset.
- **Motion**/second, Miller/Balk, to accept the Financial Report and May Financial Statements. Motion carried.
- No discussion or questions regarding write-off's.

Budget Update - B. Glodowski

- The Wisconsin Retirement System is decreasing contributions by .2%.
- Currently working with insurance agents on health insurance costs for next year.
- The 2018 budget is being prepared and incorporates recommendations from the RCA. We are on schedule however, given the new timeline (earlier by two months) we must base some assumptions ahead of the budget year. We will also be developing a 2-year forecast.

CFO Report

- RFP responses for the audit firm are due 6/30/17.
- A review of the revenue cycle for mental health services is being done today and tomorrow.

Facility Asset Portfolio Composition, Ownership Status and Strategy for NCHC – M. Loy

- The changing dynamics in the three counties affects the properties that NCHC manages which are leased through the counties, the City of Wausau, and with landlords. Two years ago NCHC began paying insurance on all leased properties. To meet operational/regulation requirements we must maintain/update the facilities which in turn improves the property's value. The master facility plan will include how we manage our properties and how we move forward with the main campus.
- We are in the process of selling the Bellewood property. Bellewood was a 6-bed group home but the point of efficiency is 8-beds which led to leasing the Andrea Street location. We are also working with Marathon County to potentially sell Hillcrest to downsize the number of CBRF's we operate. The proceeds of these sales will be used for a youth crisis stabilization group home, which Marathon County has agreed to and would be owned by NCHC. The cost to renovate one of these properties is close to building new construction for this purpose. We have shared our proposal with the State. The State will issue an RFP and potentially 2-3 licenses. We hope the project will begin in mid-2018 if we are selected.
- We are currently working with Lincoln County and an architect on a major renovation to the building in Merrill where NCHC has offices which has been going very well.
- One of the challenges in managing properties with the current facility management arrangement is that now there is propensity not to provide all the needed maintenance of them due to the potential risk to Marathon County. If we continue to lease and outsource maintenance it puts us in difficult situations where NCHC staff has to perform duties that maintenance used to.
- When the Community Corner Clubhouse moved locations to North 3rd Avenue, we invested about $110,000 in renovations. The property is now worth $235,000 assessed value. Rent is $25,000 over an 8 year lease, which basically pays for the cost of the building.
- Following discussion on the pros and cons of managing a property portfolio, investing in properties, leasing, maintaining properties, whether or not NCHC continues providing residential services since it is not a mandated program, etc., the committee asked M. Loy to do the following:
    - Explore our own maintenance for the group homes.
    - Explore the option/negotiate the purchase of the Clubhouse building.

Discussion and Future Agenda Items

- None

Adjourn

- **Motion**/second, Miller/Balk, to adjourn the Finance, Personnel and Property Committee meeting at 11:45 a.m. Motion carried.

dko

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MEMO

TO: North Central Health Care Finance Committee
FROM: Brenda Glodowski
DATE: July 21, 2017
RE: Attached Financials

Attached please find a copy of the June Financial Statements for your review. To assist in your review, the following information is provided:

BALANCE SHEET

The nursing home supplemental payment was received in June, so that receivable is current. The State receivable is still showing a large balance in June due to payments not being received yet from the State as of the end of June. A payment was received in July. The investments have increased as another certificate of deposit was purchased.

STATEMENT OF REVENUE AND EXPENSES

The month of June shows a gain of $240,525 compared to a budgeted gain of $46,794, resulting in a positive variance of $193,731.

Overall revenue was below targets. The hospital census averaged 13 per day, which is below the target of 14. The nursing home census dropped compared to the prior month, showing an average of 182. The target is 203. The Medicare census remained consistent with the prior month, averaging 18 per day. The target is 20 per day. Outpatient areas are down some, which is normal in the summer months.

Overall expenses were below target by ($466,454) which offsets the revenue being down. Salaries and benefits remain below target, as do several other areas. State institutes were again below target, which has now closed the gap between actual and budget.

Year to date the organization continues to show positive results, showing an overall gain of $1,096,670 which exceeds target by $1,051,774.

If you have questions, please feel free to contact me.

Thank you.

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF NET POSITION
JUNE 2017

	Human Services	Nursing Home	Total	Prior Year Combined
Current Assets:				
Cash and cash equivalents	2,089,686	2,427,568	4,517,254	4,718,745
Accounts receivable:				
Patient - Net	2,987,348	1,937,760	4,925,108	6,004,372
Outpatient - WIMCR	695,000	0	695,000	505,000
Nursing home - Supplemental payment program	0	0	0	0
Marathon County	77,884	0	77,884	224,341
Appropriations receivable	0	0	0	0
Net state receivable	1,950,273	0	1,950,273	521,293
Other	534,906	0	534,906	376,911
Inventory	0	305,373	305,373	303,535
Other	582,603	430,796	1,013,398	1,032,411
Total current assets	8,917,701	5,101,496	14,019,197	13,686,608
Noncurrent Assets:				
Investments	11,292,000	0	11,292,000	9,800,000
Assets limited as to use	1,898,961	393,363	2,292,324	2,830,798
Contigency funds	500,000	0	500,000	0
Restricted assets - Patient trust funds	14,964	36,044	51,008	62,189
Net pension asset	0	0	0	4,846,938
Nondepreciable capital assets	281,609	872,720	1,154,329	810,660
Depreciable capital assets - Net	6,769,928	3,143,927	9,913,855	10,831,026
Total noncurrent assets	20,757,463	4,446,054	25,203,516	29,181,611
Deferred outflows of resources - Related to pensions	10,070,362	7,446,358	17,516,720	4,851,842
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	39,745,526	16,993,907	56,739,433	47,720,061

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF NET POSITION
JUNE 2017

	Human Services	Nursing Home	Total	Prior Year Combined
Current Liabilities:				
Current portion of related-party note payable	0	0	0	151,257
Accounts payable - Trade	799,297	591,027	1,390,324	1,548,868
Appropriations advances	0	0	0	0
Accrued liabilities:				
Salaries and retirement	922,655	682,242	1,604,897	1,547,593
Compensated absences	800,906	592,216	1,393,123	1,682,411
Health and dental insurance	458,770	339,230	798,000	857,000
Other Payables	209,729	155,080	364,809	455,083
Amounts payable to third-party reimbursement programs	229,576	0	229,576	255,920
Unearned revenue	92,635	0	92,635	135,146
Total current liabilities	3,513,569	2,359,795	5,873,364	6,633,278
Noncurrent Liabilities:				
Net pension liability	1,797,930	1,329,449	3,127,379	0
Related-party note payable	0	0	0	636,181
Patient trust funds	14,964	36,044	51,008	62,101
Total noncurrent liabilities	1,812,895	1,365,493	3,178,387	698,282
Total liabilities	5,326,463	3,725,288	9,051,751	7,331,561
Deferred inflows of resources - Related to pensions	3,821,383	2,825,657	6,647,040	84,873
Net Position:				
Net investment in capital assets	7,051,537	4,016,647	11,068,184	11,641,686
Unrestricted:				
Board designated for contingency	500,000	0	500,000	0
Board designated for capital assets	1,898,961	393,363	2,292,324	0
Undesignated	19,902,368	6,181,097	26,083,464	30,276,633
Operating Income / (Loss)	1,244,814	(148,144)	1,096,670	(1,614,692)
Total net position	30,597,680	10,442,962	41,040,642	40,303,627
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	39,745,526	16,993,907	56,739,433	47,720,061

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF REVENUES AND EXPENSES
FOR PERIOD ENDING JUNE 30, 2017

TOTAL	CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE	YTD ACTUAL	YTD BUDGET	YTD VARIANCE
Revenue:						
Net Patient Service Revenue	$3,389,557	$3,696,202	($306,645)	$21,677,659	$22,101,729	($424,070)
Other Revenue:						
State Match / Addendum	324,504	325,120	(616)	1,947,021	1,950,718	(3,697)
Grant Revenue	198,630	197,183	1,446	1,191,729	1,183,100	8,629
County Appropriations - Net	639,260	639,260	0	3,835,559	3,835,559	0
Departmental and Other Revenue	306,294	285,602	20,692	1,818,106	1,713,611	104,495
Total Other Revenue	1,468,687	1,447,165	21,523	8,792,416	8,682,988	109,427
Total Revenue	4,858,244	5,143,367	(285,123)	30,470,075	30,784,717	(314,642)
Expenses:						
Direct Expenses	3,406,893	3,801,920	(395,027)	21,998,401	22,905,518	(907,117)
Indirect Expenses	1,231,558	1,302,985	(71,427)	7,487,343	7,884,303	(396,960)
Total Expenses	4,638,452	5,104,906	(466,454)	29,485,744	30,789,821	(1,304,077)
Operating Income (Loss)	219,793	38,461	181,332	984,331	(5,104)	989,435
Nonoperating Gains (Losses):						
Interest Income	13,206	8,333	4,873	73,726	50,000	23,726
Donations and Gifts	7,526	0	7,526	33,690	0	33,690
Gain / (Loss) on Disposal of Assets	0	0	0	4,923	0	4,923
Total Nonoperating Gains / (Losses)	20,732	8,333	12,399	112,339	50,000	62,339
Income / (Loss)	$240,525	$46,794	$193,731	$1,096,670	$44,896	$1,051,774

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF REVENUES AND EXPENSES
FOR PERIOD ENDING JUNE 30, 2017

51.42./.437 PROGRAMS	CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE	YTD ACTUAL	YTD BUDGET	YTD VARIANCE
Revenue:						
Net Patient Service Revenue	$1,761,556	$1,923,932	($162,376)	$11,588,232	$11,424,320	$163,912
Other Revenue:						
State Match / Addendum	324,504	325,120	(616)	1,947,021	1,950,718	(3,697)
Grant Revenue	198,630	197,183	1,446	1,191,729	1,183,100	8,629
County Appropriations - Net	497,594	497,593	1	2,985,563	2,985,559	4
Departmental and Other Revenue	155,738	149,059	6,679	906,214	894,353	11,861
Total Other Revenue	1,176,465	1,168,955	7,510	7,030,527	7,013,730	16,797
Total Revenue	2,938,021	3,092,887	(154,866)	18,618,759	18,438,050	180,709
Expenses:						
Direct Expenses	2,057,906	2,349,959	(292,052)	13,764,037	14,156,963	(392,926)
Indirect Expenses	599,215	647,779	(48,565)	3,717,524	3,919,681	(202,157)
Total Expenses	2,657,121	2,997,738	(340,617)	17,481,561	18,076,645	(595,084)
Operating Income (Loss)	280,900	95,149	185,751	1,137,198	361,405	775,793
Nonoperating Gains (Losses):						
Interest Income	13,206	8,333	4,873	73,726	50,000	23,726
Donations and Gifts	7,162	0	7,162	28,967	0	28,967
Gain / (Loss) on Disposal of Assets	0	0	0	4,923	0	4,923
Total Nonoperating Gains / (Losses)	20,368	8,333	12,035	107,616	50,000	57,616
Income / (Loss)	$301,268	$103,483	$197,785	$1,244,814	$411,405	$833,408

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF REVENUES AND EXPENSES
FOR PERIOD ENDING JUNE 30, 2017

NURSING HOME	CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE	YTD ACTUAL	YTD BUDGET	YTD VARIANCE
Revenue:						
Net Patient Service Revenue	$1,628,001	$1,772,270	($144,269)	$10,089,427	$10,677,409	($587,982)
Other Revenue:						
County Appropriations - Net	141,666	141,667	(1)	849,996	850,000	(4)
Departmental and Other Revenue	150,557	136,543	14,013	911,893	819,258	92,634
Total Other Revenue	292,223	278,210	14,013	1,761,889	1,669,258	92,630
Total Revenue	1,920,224	2,050,480	(130,256)	11,851,316	12,346,667	(495,351)
Expenses:						
Direct Expenses	1,348,987	1,451,962	(102,974)	8,234,364	8,748,555	(514,190)
Indirect Expenses	632,344	655,206	(22,863)	3,769,819	3,964,622	(194,803)
Total Expenses	1,981,331	2,107,168	(125,837)	12,004,183	12,713,176	(708,993)
Operating Income (Loss)	(61,107)	(56,688)	(4,419)	(152,867)	(366,509)	213,642
Nonoperating Gains (Losses):						
Interest Income	0	0	0	0	0	0
Donations and Gifts	364	0	364	4,724	0	4,724
Gain / (Loss) on Disposal of Assets	0	0	0	0	0	0
Total Nonoperating Gains / (Losses)	364	0	364	4,724	0	4,724
Income / (Loss)	($60,743)	($56,688)	($4,055)	($148,144)	($366,509)	$218,365

NORTH CENTRAL HEALTH CARE
REPORT ON AVAILABILITY OF FUNDS
June 30, 2017

BANK	LENGTH	MATURITY DATE	INTEREST RATE	AMOUNT	Insured/ Collateralized
CoVantage Credit Union	578 Days	7/28/2017	0.85%	$300,000	X
People's State Bank	365 Days	8/21/2017	0.75%	$500,000	X
BMO Harris	365 Days	8/26/2017	0.80%	$500,000	X
Abby Bank	365 Days	8/29/2017	0.85%	$500,000	X
Abby Bank	365 Days	9/1/2017	0.85%	$500,000	X
Abby Bank	730 Days	10/29/2017	1.10%	$500,000	X
CoVantage Credit Union	730 Days	11/18/2017	1.10%	$500,000	X
PFM Investments	365 Days	11/29/2016	1.13%	$500,000	X
Abby Bank	730 Days	12/30/2017	1.10%	$500,000	X
CoVantage Credit Union	487 Days	1/1/2018	1.10%	$500,000	X
Abby Bank	365 Days	2/25/2018	1.10%	$500,000	X
Abby Bank	730 Days	3/15/2018	1.20%	$400,000	X
People's State Bank	395 Days	3/28/2018	1.05%	$250,000	X
CoVantage Credit Union	365 Days	3/30/2018	1.10%	$500,000	X
PFM Investments	365 Days	4/3/2018	1.16%	$500,000	x
PFM Investments	517 Days	4/30/2018	1.12%	$500,000	X
Abby Bank	730 Days	5/3/2018	1.20%	$500,000	X
BMO Harris	365 Days	5/28/2018	1.20%	$500,000	X
PFM Investments	365 Days	6/13/2018	1.50%	$492,000	X
Abby Bank	730 Days	1/6/2019	1.30%	$500,000	X
CoVantage Credit Union	679 Days	3/7/2019	1.61%	$500,000	X
People's State Bank	730 Days	5/29/2019	1.20%	$350,000	X
People's State Bank	730 Days	5/30/2019	1.20%	$500,000	X
Abby Bank	730 Days	7/19/2019	1.30%	$500,000	X
TOTAL FUNDS AVAILABLE				$11,292,000	
WEIGHTED AVERAGE	534.74 Days		1.124% INTEREST		

NCHC-DONATED FUNDS
Balance Sheet
As of June 30, 2017

ASSETS	
Current Assets	
Checking/Savings	
CHECKING ACCOUNT	
Adult Day Services	4,570.81
Adventure Camp	1,425.79
Birth to 3 Program	2,035.00
Clubhouse	25,564.60
Community Treatment	8,455.88
Fishing Without Boundries	4,439.00
General Donated Funds	60,701.09
Housing - DD Services	1,370.47
Langlade HCC	3,172.02
Legacies by the Lake	
Music in Memory	1,958.25
Legacies by the Lake - Other	3,791.75
Total Legacies by the Lake	5,750.00
Marathon Cty Suicide Prev Task	14,614.40
National Suicide Lifeline Stipe	3,176.37
Northern Valley West	2,921.82
Nursing Home - General Fund	3,833.59
Outpatient Services - Marathon	101.08
Pool	9,759.82
Prevent Suicide Langlade Co.	2,444.55
Resident Council	771.05
United Way	479.20
Total CHECKING ACCOUNT	155,586.54
Total Checking/Savings	155,586.54
Total Current Assets	155,586.54
TOTAL ASSETS	**155,586.54**
LIABILITIES & EQUITY	
Equity	
Opening Bal Equity	123,523.75
Retained Earnings	53,757.13
Net Income	-21,694.34
Total Equity	155,586.54
TOTAL LIABILITIES & EQUITY	**155,586.54**

North Central Health Care
Budget Revenue/Expense Report

Month Ending June 30, 2017

ACCOUNT DESCRIPTION	CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	YTD ACTUAL	YTD BUDGET	DIFFERENCE
REVENUE:					
Total Operating Revenue	4,858,244	5,143,367	30,470,075	30,784,717	(314,642)
EXPENSES:					
Salaries and Wages	2,252,440	2,506,014	13,687,599	15,119,629	(1,432,030)
Fringe Benefits	866,845	956,562	5,388,064	5,771,214	(383,150)
Departments Supplies	511,798	492,235	2,873,218	2,953,412	(80,194)
Purchased Services	401,725	364,450	2,920,097	2,231,699	688,398
Utilitites/Maintenance Agreements	406,306	372,653	2,375,745	2,235,915	139,829
Personal Development/Travel	10,822	37,985	154,018	227,909	(73,891)
Other Operating Expenses	104,023	108,966	670,019	653,793	16,226
Insurance	37,161	37,708	232,256	226,250	6,006
Depreciation & Amortization	135,907	139,583	817,430	837,500	(20,070)
Client Purchased Services	(88,577)	88,750	367,299	532,500	(165,201)
TOTAL EXPENSES	**4,638,452**	**5,104,906**	**29,485,744**	**30,789,821**	**(1,304,077)**
Nonoperating Income	20,732	8,333	112,339	50,000	62,339
EXCESS REVENUE (EXPENSE)	**240,525**	**46,794**	**1,096,670**	**44,896**	**1,051,774**

North Central Health Care
Write-Off Summary
June 2016

	Current Month	Current Year To Date	Prior Year To Date
Inpatient:			
Administrative Write-Off	($7,339)	$59,642	$134,844
Bad Debt	$220	$1,422	$10,516
Outpatient:			
Administrative Write-Off	$22,479	$102,890	$72,124
Bad Debt	$328	$1,814	$5,942
Nursing Home:			
Daily Services:			
Administrative Write-Off	$0	$724	$880
Bad Debt	$0	$11,970	$16,956
Ancillary Services:			
Administrative Write-Off	($531)	$13,685	$7,248
Bad Debt	$0	$321	($126)
Pharmacy:			
Administrative Write-Off	$0	$0	$0
Bad Debt	$0	$0	$0
Total - Administrative Write-Off	$14,608	$176,941	$215,096
Total - Bad Debt	$548	$15,527	$33,288

North Central Health Care
2017 Patient Days

Month		Budget	Actual	Variance	Budgeted Occupancy	Actual Occupancy	
January	Nursing Home	6,293	5,784	(509)	84.58%	77.74%	
	Hospital	434	502	68	87.50%	101.21%	
February	Nursing Home	5,684	5,267	(417)	84.58%	85.50%	***
	Hospital	392	441	49	87.50%	98.44%	
March	Nursing Home	6,293	5,703	(590)	84.58%	83.62%	
	Hospital	434	462	28	87.50%	93.15%	
April	Nursing Home	6,090	5,453	(637)	84.58%	82.62%	
	Hospital	420	480	60	87.50%	100.00%	
May	Nursing Home	6,293	5,698	(595)	84.58%	83.55%	
	Hospital	434	432	(2)	87.50%	87.10%	
June	Nursing Home	6,090	5,448	(642)	84.58%	82.55%	
	Hospital	420	400	(20)	87.50%	83.33%	
July	Nursing Home						
	Hospital						
August	Nursing Home						
	Hospital						
September	Nursing Home						
	Hospital						
October	Nursing Home						
	Hospital						
November	Nursing Home						
	Hospital						
December	Nursing Home						
	Hospital						
YTD	Nursing Home	36,743	33,353	(3,390)	101.39%	98.56%	
	Hospital	2,534	2,717	183	104.88%	112.46%	

*** Licensed beds decreased from 240 to 220

North Central Health Care
Person centered. Outcome focused.

NORTH CENTRAL COMMUNITY SERVICES PROGRAM BOARD
NURSING HOME OPERATIONS COMMITTEE

June 23, 2017 7:30 AM North Central Health Care – Board Room

Present:	X	Jean Burgener	EXC	Margaret Donnelly
	X	Bill Metter	X	Bill Miller

Also Present: Kim Gochanour, Brenda Glodowski, Sue Matis, Connie Gliniecki

Meeting was called to order at 7:35 a.m.

Public Comment for Matters Appearing on the Agenda

- No public comment(s) made.

Approval of 05/24/17 Nursing Home Operations Committee Meeting Minutes

- **Motion**/second, Metter/Miller, to approve the 05/24/17 Nursing Home Operations Committee meeting minutes. Motion carried.

Financial Report – B. Glodowski

- May ended with a gain of just over $38,000. Census was up to 184 from 182. Medicare average census was also up at 18 from 14.
- Overall expenses are down. The $23,000 expense in May was for half of the Clifton Larson Allen study. Benefits are down overall during May for the organization.
- We had budgeted a deficit of $624,000 and continue to strive to bring the deficit down so it is zero by year end.
- Connie Gliniecki was introduced as the new Director of Nursing. She is excited to be back and is busy reviewing systems, policies and procedures, and will be implementing changes.

Senior Executive Nursing Home Operations and Quality Report – K. Gochanour

- Nursing Home 5 Star Quality Report has been updated. We are currently listed at a 3 Star. Overall, quality measures is a 4 Star. We anticipate a positive change when the next update is completed in September. We continue to review all quality measures with specific focus on pain, psychotropic medication use (which is high due to the type of patients we care for but will review and verify need, documentation, and opportunities for improvement), and catheter use. Regardless of where our scores and Stars are, we must have an explanation for each catheter, psychotropic med, etc. Met with Aspirus and others in a post-acute care group. Aspirus has some tools that may help us with our review.
- Five CNA's have been hired this month, 2 housekeepers, and next month we will add 3 RN's and 3 additional CNA's. The night shift and Legacies have the greatest number of openings. We are struggling to hire nurses, which is not unusual for other area nursing homes as well. We are looking to utilize Certified Medication Techs (CMT). There may be an opportunity to offer a career ladder for CNA's for education to become a Med Tech. This would allow us to utilize both CNA's and nurses in a different capacity.

- As part of the medical community we need to be aware of what the medical community is paying. NCHC is different in that we serve a lot of the underserved individuals in the community. The committee asked Mr. Miller to remind the County Board about those we serve.
- The changes in onboarding and extended training has made a positive difference in that 'mandated' shifts are not used very often at this time.
- Survey window opens in July. We continue to complete chart audits, dining audits, etc. There is a new survey process that is more question-based and has greater emphasis on interviews and responses from residents than on tasks completed. Anticipate surveys to be more objective than subjective and will inform residents of the new process. With a new survey process under way, the Committee asked about having an education session at a future meeting, possibly with the entire Board.

Update on Mount View Care Center Committee Discussion – K. Gochanour

- A 'high level' call was done with CliftonLarsonAllen. Some recommendations they noted are things we have already begun working on i.e. MDS improvements. As a reminder, they received most data and information from us for 2016 and we have implemented changes over the last 6-9 months.
- It appears they believe renovation is needed but are determining optimum size from revenue and operations standpoint.
- Alluded to nursing home administration structure but no recommendations yet.
- No new revenue ideas at this point.
- Bed management was a suggestion. With the DON, C. Gliniecke, here now we can keep a close eye on bed management so that we can take every admission of those we can care for which may mean having to share rooms on a temporary basis at times.
- Final report is due July 1.
- There will be Joint meetings July 11 and 26 at 7 p.m. of the Nursing Home Operations Committee and the Mount View Care Committee. MVCC. Health and Human Services Committee will make any recommendations to the County Board in the fall. Consultants will be at the joint meeting July 11.
- There will not be a 'regular' meeting of the Nursing Home Operations Committee in July.
- If possible, the NHOC members would like to receive a copy of the consultant's report in advance of the joint meeting.
- B. Metter commented that staff have done an admirable job of laying out issues and bringing the consultants and county board members up to speed on the operations of the nursing home. Staff presented financials, regulatory requirements, staffing concerns in a meaningful manner and felt the information was received well.

Discussion and Future Agenda Items

- Additional clarification on the vent unit. We must maintain 1 respiratory therapist to 10 patients so we are able to have 20 patients at a time. We currently have 19. Medicaid is a good payer along with Medicare, VA, and private insurance. We do our best to admit those from our tri-county area first but also take admissions from other areas.
- Legacies has a capacity of 107; currently have 97-98 residents but like to be at a minimum of 100. Tendencies were to have residents long term but are now seeing short term stays with those diagnosed with dementia or behavioral systems of the disease and then individuals return to the community. Also seeing more Medicare and Medicaid than previously. We continue to work on efficiencies with the changes we are seeing but are receiving referrals usually when the disease is more advanced.

- How can our skilled nursing home better assist the community particularly through the many services of NCHC? For example: Adult Protective Services (domestic abuse of elderly), law enforcement, crisis center, the new Psychiatry Residency Program (rounds in the nursing home), community treatment, etc.
- Update provided on changes in area nursing homes. It is important to know what's going on in the community which also affects staffing:
    - Colonial Manor - Administrator is leaving, census about 50 with many empty beds, they seem to take high acuity if we can't take them.
    - Wausau Manor, Currently have Interim Administrator, a new DON, and State is currently there.
    - Rennes – Opened a 20 bed long term care unit which is consistently full
    - Pride (formerly Stoney River) – only taking Medicare patients, no replacement plans, when Medicare ends will ask individual to leave; will ask us to take individuals when they can't manage (usually due to symptoms of the disease). Dementia unit at Pride may have been purchased by another company.
    - Atrium (formerly Kennedy Park) – no information
    - Benedictine (formerly Marywood) - stays consistently full; perfect survey recently
    - Met with American Data who currently supports our electronic medical record for the nursing home. Concerned that they may not continue to update and keep the current system moving forward; they indicated they lost 75 clients last year. Point Click Care is what is widely used in the industry. Consultants have identified this in their report also.
- Will be looking at doing an MDS audit soon.
- Psychiatry Residency Program Open House – June 26th from 4-6 p.m.

Adjourn

Motion/second, Metter/Miller, to adjourn the Nursing Home Operations Committee meeting at 8:38 a.m. Motion carried.

dko

CliftonLarsonAllen

CLAconnect.com

June 2017

North Central Health Care - Mount View Care Center

Financial and Operational Assessment Report

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WEALTH ADVISORY | OUTSOURCING | AUDIT, TAX, AND CONSULTING

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GLOSSARY OF TERMS

- MDS- Minimum Data Set is a diagnostic tool that is part of the U.S federally mandated clinical assessment of all residents in a Medicare or Medicaid certified nursing home. The process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems

- QAPI- Quality Assurance (QA) is the process of meeting quality standards and assuring that care reaches an acceptable level. Performance improvement (PI) is continuously analyzing your performance and developing systematic efforts to improve it. (AHCA)

- ADL – Activities of Daily Living are routine activities that people tend do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking) and continence

- CMS – Center for Medicare and Medicaid Services

- RUG – Resource Utilization Groups are mutually exclusive categories that reflect levels of resource need in long-term care settings. RUGs flow from the Minimum Data Set (MDS) and drive Medicare reimbursement (and Medicaid reimbursement in some states) to nursing homes

- Medicare PPS – Medicare Prospective Payment System is used by CMS to set reimbursement rates that will be paid for each RUG category on a per diem basis

- EMR – Electronic Medical Record refers to an information system which captures data related to vital statistics and healthcare provided to an individual in a healthcare setting

- DON – Director of Nursing

- ADON – Assistant Director of Nursing

- RN – Registered Nurse

- LPN – Licensed Practical Nurse

- C.N.A. – Certified Nursing Assistant

PROCESS OVERVIEW

Organizational overview

Mount View Care Center (the "Organization" or "MVCC"), a nursing home managed by North Central Health Care ("NCHC") for the benefit of Marathon County and certain Wisconsin residents, recognizes the future financial challenges of a changing payer market and seeks to maintain its long-term commitment to its mission while providing excellent service to its community. The Organization is looking to improve the efficiency and effectiveness of its operations through the identification of potential process improvements and identification of opportunities to enhance revenue and reduce expenditures without affecting the quality of services they deliver. This process is important to position the Organization to successfully implement future strategies.

North Central Health Care's Mission and Vision are detailed below. It is critical to note that MVCC and NCHC has cared for residents of Central Wisconsin with complex needs for many years and many of these residents would not be able to receive care anywhere else in the area.

Our Mission: Langlade, Lincoln and Marathon Counties partnering together to provide compassionate and specialized care for people with complex behavioral and skilled nursing needs.
North Central Health Care has a deep history and relationship with our Central Wisconsin community. We are committed to our partnership with our three counties as we continually seek to provide the highest levels of accessible and specialized care for those we serve. Our person-centered service approach to the complex needs of those we serve and those we partner with are identical – we will meet you where you are at and walk with you on the journey together. Our programs and services provide compassionate and specialized care that is designed around each individual's abilities and challenges – creating a path to move forward together.

Our Vision: Lives Enriched and Fulfilled.
Each interaction we have with those we serve, our community partners and each other will lead to lives that are more enriched and fulfilled. We face the world with undeterred optimism and hope of possibility. Every day a new chance to make people's lives better. *The vast potential to make a difference in each individual's life is our greatest inspiration and measure of success*.
The NCHC Core Values will guide us in each interaction we have and allow us to carry out our Mission and Vision. Embodying our Core Values will allow North Central Health Care to:

…become the very best place for residents and clients to receive care,
…become the very best place for employees to work…*A Career of Opportunity,*
…continue to grow in our contributions to the communities we serve.

Engagement objectives

North Central Health Care engaged CliftonLarsonAllen LLP (CLA) to conduct an operations assessment to assist the organization in improving its efficiency and effectiveness, including:

- Perform an operational assessment to help identify opportunities for operational improvement.
- Assist in aligning Marathon County policy makers and the administrative staff on a strategic plan that will ensure efficiency and quality in MVCC's current operations and a road map to the future, that will meet the needs of Marathon County residents.

Engagement approach

The engagement approach consisted of comparing various financial and operating metrics of the Organization to other organizations within the geographic region, performing interviews with management and various department heads and preparing this report to document various observations and recommendations from the process. These observations and recommendations have been discussed with the Organization. The ultimate goal of the engagement is to convert the recommendations in this report to management initiatives in the following areas:

- Clinical Services: including staffing patterns, comparisons to budget and industry standards; job descriptions; reporting lines and responsibilities; clinical programming and staff development.
- Operations: including wage and benefit package costs; admissions practices; referrals and census management; operational performance indicators;
- Support services costs: such as dietary, housekeeping, laundry and maintenance.
- Revenue trends and primary market competition: rate analysis, case mix, documentation adequacy and timeliness; optimization analysis, staff knowledge of methodology and quality indicators.

The following data sources were utilized to benchmark the operations of MVCC against medians in the state, region and nationally. Following is a description of these data bases:

- CARF-CCAC (Commission on Accreditation of Rehab Facilities-Continuing Care Accreditation Commission) - represents data from the 2015 Financial Ratios & Trend Analysis of CARF-CCAC Accredited Organizations.
- CLA Proprietary Medicare Database - represents data pulled from the CMS database of Medicare cost reports that were filed. The data is specific to the county and primary market and compares the respective facility data to the county/state/CBSA as well as specific information from the Medicaid report for MVCC.
- CliftonLarsonAllen 31st Nursing Facility Cost Comparison - This report represents data from over 14,000 nursing facilities, including for-profit and not-for-profit in stand-alone and affiliated type organizations. Nursing staffing, administration and support ratios were used to benchmark MVCC operations.

Engagement scope

The engagement consists of the following phases:

- Phase I and II – Gathering information and creating the strategic framework through a baseline financial model – establishing “success” based financial performance targets
- Phase III - Financial and operational benchmarking
- Phase IV - On-site operational and clinical performance improvement assessment
- Phase V, VI and VII - Strategic planning and action register - create implementation plan with an update of the strategic action register and strategic planning financial model

This report covers Phase I, II, III and IV.

The following individuals and departmental representatives were interviewed as part of the assessment. All were very cooperative and readily shared their ideas to create efficiencies for the Organization.

- Michael Loy, Interim CEO
- Brenda Glodowski, CFO
- Kim Gochanour, Nursing Home Operations Executive (Administrator)
- Sue Matis, Human Resources Executive
- Kristin Woller, Assistant Administrator
- Cagney Martin, MV Staff Development
- Julie Lucko, Admissions Coordinator
- Jen Gorman, Food Service Director
- Natasha Sayles, Nurse Manager/ Interim DON
- Becky Schultz, Quality and Clinical Support executive
- Theresa Szews, Quality Director
- Tracy McDonnell, MDS Nurse
- Heather Schultz, MDS Nurse
- Nicole Goffin, MDS Nurse
- Cheryl Rye, Nurse Manager
- Silvia Tzinoglou, Nurse Manager
- Keith Benson, Scheduler

In addition, various management generated reports were reviewed, including:

- Organization chart
- Various staffing and productivity reports
- Resident census reports
- Financial reports
- Staffing and payroll information
- Select contracts
- Marketing information
- Floor plans

EXECUTIVE SUMMARY

Mount View Care Center has several competitive advantages which can be enhanced to better meet the needs of Marathon County in the future. The special programming provides much needed services to complex senior healthcare issues. The site location and beautiful outdoor setting is a unique asset that that can lift the spirits of residents and their families along with staff. Key quality measures are meeting high standards of care as well.

As the senior healthcare landscape continues to change, repositioning of the community is needed to deliver services appropriately and competitively. Renovation of the short term care and ventilator units along with key common areas is crucial to MVCC's future. An investment in technology that will help the staff be more efficient and effective is also needed. Potential residents and their families also expect technology options that help improve their quality of life through greater connection and choice. These renovations will allow MVCC to adjust the payor mix to create a more sustainable revenue stream.

The ventilator unit and Legacies dementia program are core competencies that are needed in the county and state. The configuration and size of these units are well suited for the market needs that are expected both now and in the near future. Short term care can expand with the renovations and will provide additional gross profit to help sustain the Medicaid population in other units. Long Term Care needs are declining overall and other options are available within the county as well.

Based on our review, the market can support a between 180 and 200 licensed beds related to the current services offered. An increase to 27 to 32 beds for short term care and a decrease in long term care beds to 20 to 30 can be pursued with the ventilator unit and Legacies program remaining at their current capacities. Final sizing of these units will depend on certain operational improvements and the renovations mentioned above. CLA will help MVCC determine the financial impact of these options through the CLA Intuition modeling in the final phase of this engagement.

Many aspects of the operation at MVCC have been or are in the process of being improved. The information and recommendations contained in this report provide opportunities for additional improvements in conjunction with the repositioning noted above.

Strategic Action Register

Findings	Recommendations
• Average Age of Plant Ratio is 27 years vs the National and Midwest benchmark median of 12.1 years. An average higher than 16 years often results in decreased occupancy results • Investment in technology upgrades, both operationally and clinically, appears to be	1. Renovations of the building are critical to the improvement in operating results and including capital costs allocated for increased use of technology systems that can enable more efficient care delivery. 2. A separate entrance and major upgrades should be considered for

a barrier to efficiency and quality improvements • Many short-term referrals understand the quality of care provided and reputation, however select elsewhere due to the age of physical plant • Medicaid capital rates are underutilized	the Post Acute Care Unit to attract a different payor mix increasing revenues and margin. 3. Medicaid payments will increase as a result of capital expenditures, which can offset debt payments.
• Marketing is perceived by staff to be more focused on public relations. High level review of marketing material indicated advertising budget of $68,500, less than .3% of revenues. • Admission process relies on nursing staff approval possibly resulting in greater rejection of referrals due to perceived complexity. • Beds designated for short-term rehab residents are frequently filled with long term care residents making them unavailable for short-term referrals. • MVCC holds 8% of Aspirus Medicare market share (3rd highest share) compared with leading competitor (Rennes) at 10%. • Medicaid population at 70% vs Midwest median of 57.2% • Medicare population at 10% meets Midwest median	4. Direct mail and direct advertising should be increased, focusing on individual services and the excellent quality measures of MVCC. As renovations move forward, highlighting the community appeal will be critical. 5. A Nurse Liaison should be considered to assess and accept referrals at the major hospital referral sources. This will increase efficiency of acceptance and the ability to increase Medicare short term stay admissions. 6. The Admissions process overall should be reviewed and transitioned away from direct care staff so that preferred referrals will not be declined due to inaccurate perceptions of MVCC capabilities. 7. Consider expansion of the Post Acute Care unit to increase Medicare residents and improve the payor mix. Vent unit beds would remain at 27 until referrals increase. Short term care beds should be increased targeting approximately 13% of residents or 27 – 32 residents.

	8. It is critical that the Post Acute Care unit be segregated with a separate entrance and that long term care residents are not allowed to remain in these beds. New processes for finding alternative placements may need to be developed.
• Based on our discussions with staff, the Medicare Resource Utilization Group (RUGs) process has significant improvement opportunities • Current average Medicare rate at $473 vs state median of $476 • Clinical assessment leadership and expertise is now in place • Additional technology such as wired kiosks for tracking care delivery more efficiently is needed	9. Continue education of staff on recording Activities of Daily Living (ADLs) and coding Minimum Data Set (MDS) sections for optimized rates. 10. Assess RUGs scores monthly to determine if they are accurately capturing all ADLs and services provided, resulting in increased daily rates. 11. Increase therapy scheduling and review based on the current acuity of the residents observed. Productivity reports and ongoing target setting and monitoring may be required of the therapy vendor. 12. A modern Electronic Medical Record (EMR) would allow for more mobile entry and tracking of care through easier methods to improve efficiency and reduce overtime.
• Overall costs are high compared to medians and competitors • 2016 employee benefits cost at 48% of salaries is significantly higher than non-governmental competitors in Marathon County where the median is 17%. LeadingAge Wisconsin medians for 2016 published this ratio at 19.9% for all	13. Direct care salaries and wage rates are in range of the market median. Support service wages are above the median and represent an expense reduction opportunity. 14. Direct care hours per resident day within certain departments are significantly over benchmarks, even after adjusting for the complexity of

Wisconsin nursing homes and 44% for governmental nursing homes • 2016 benefit costs were unusually high due to a large self insurance loss during that year, per discussion with management. 2015 employee benefits cost at 37% of salaries which did not have a large insurance loss adjustment and may be more indicative of ongoing costs. Additional 11% benefit cost in 2016 represents $1.48 million of $2.65 million loss for nursing facility. A portion of these costs include a noncash pension expense which is typically volatile due to the method of calculation under required governmental accounting standards • Majority of support service wage rates are higher than medians • Allocations were reviewed noting that they were reasonable and in many cases provided a departmental cost that was within range of available benchmarks	residents served. These hours may be reduced as noted in the sections below. 15. Employee benefit cost reductions would clearly help meet the organization's financial goal of operating at breakeven. Competitors have a distinct financial advantage here. MVCC will need to continually address this difference in order to create value from the expense. Turnover has improved significantly due to new onboarding and training and should continue, however, the benefits provided do not appear to be a key decision factor for the staff being hired at MVCC.
• Highest Hours Per Resident Day for direct care provided in the county at 5.22 • 5 star staffing rating based on most recent health survey was performed during a period in which state surveyors have been more critical of nursing home performance • Technology deficiencies causing additional overtime and inefficient workflow	16. Hours per resident day may be decreased as described within this report. Reductions will still allow for exceptional quality care if coupled properly with other initiatives to improve efficiency (i.e. improved technology such as kiosks, mobile data entry devices, and improved wireless connectivity along with improved process training.) 17. New health inspection surveys for competitors may trend downward and should be monitored. The 2016 issuance of a new CMS requirements of participation ruling will offer new

	areas to be reviewed by surveyors as well. Finding an effective mock survey process from a third party provider should be a priority until these requirements are fully operational.
• Nursing Administration at 202 (2016 average census) or 185 residents (current average census) is at the high end of the benchmark • Potential to reduce administration appears to be possible based on our observations coupled with better utilization of technology	18. If resident count drops below 170, reduction in administration staffing should be considered. 19. An Assistant Director of Nursing can be hired to administer the Post Acute and Long Term Care units (census of approximately 85.) A single program manager can be placed in charge of all three dementia environments (census of approximately 100.)
• Achieving median investment returns and capital contributions in the Midwest would provide $320,000 of additional funding per year.	20. Donations and contributions may be sought more deliberately by MVCC. Many county nursing homes hold fundraising events and appeals to bring awareness as to how residents are served and to raise funds for their long term mission. The strong volunteer base at MVCC may offer an opportunity to help plan and communicate key events and appeals.
• NCHC creation of a commission reviewed noting several concerns related to the ability to recoup enough from other counties who might join • Legal opinion restricts the ability to assess a fee per county resident and would require a set percentage or absolute amount of expected costs • Managing a commission would likely increase administration activities and can	21. A commission is not recommended to be created at this time as the rate of funding that is likely to be obtained will not provide enough funding for the care to be provided. 22. Counties throughout the country are struggling to manage health care costs both internally and externally. 23. The risk of creating a commission for MVCC is greater than the potential reward. We believe the

create other problems such as cost negotiation and fee collections

- Eight residents on May 30, 2017 originated outside the 3 counties.
- In 2017, Legacies has achieved an average census of 97 which included residents from other counties as follows: 3 from Langlade, 3 from Lincoln, 3 from Portage and 3 from other various counties
- In 2017, Long Term Care has achieved an average census of 37 which included residents from other counties as follows: 1 from Langlade, 1 from Shawano, 1 from Racine, and 1 from Oneida. One additional resident was from Minneapolis as their family lives here and are paying privately for services.

administration and legal challenges associated with this structure across county lines is significant. Negotiations and meetings related to fee structures, collection of those fees and obtaining approvals with various governmental entities will take more time and distract NCHC and MVCC from the renovations needed and the changes in healthcare delivery that need to be implemented.

24. MVCC has a greater opportunity to increase residents and adjust costs to meet its mission through the initiatives noted above.

Revenue enhancement and cost reduction opportunities

CLA identified opportunities for financial improvement of approximately $4.7 million which are summarized below. Medicare census increase as noted below is contingent upon the renovation of the nursing home including integration of new technology and management information systems.

The summaries below were prepared from the financial benchmarking and operational and clinical analyses performed and detailed in the following sections of this report:

Revenue Enhancement Opportunities	Unit	Number of Units	Average Value per Unit	Potential Margin Improvement
Begin Fundraising Campaign (Direct Mail Appeal, Gala, etc.)	Year 1 Estimated	1.00	$ 25,000	$ 25,000
Increase Medicare Census by 7 short term care (non-ventilator residents)	Resident Days	2,555	$ 61.83	$ 157,976
Decrease Medicaid Census by 9 non ventilator residents	Resident Days	3,285	$ 5.31	$ 17,443
Increase Medicare Rate by 10% over county median of $476 per day	Resident Days	9,738	$ 50.60	$ 492,743
(current rate at $473 per day) through MDS coding and care planning improvements				
				$ 693,162
Marketing Cost Offsets:				
Nurse Liaison - wage rate $30 per hour plus 37% benefit cost				$ (85,488)
Estimated Additional Advertising Costs at approximately .2% of revenue				$ (50,000)
				$ (135,488)

Expense Reduction Opportunities	MVCC	County/ Wisconsin Median	Potential Improvements at the median
Pharmacy costs per Medicare day are $7.43 above state median	$ 46.98	$ 39.53	***$ 53,513***
Dietary costs per inpatient day are $5.52 above benchmark	$ 25.81	$ 17.19	***$ 565,584***
Net Expenses per Inpatient Day			
Plant Operations	$ 13.89	$ 9.21	$ 345,932
Housekeeping	$ 6.94	$ 6.11	$ 61,351
Laundry	$ 2.60	$ 2.37	$ 17,001
Total Inpatient Operating Expense Per Resident Day			***$ 424,284***
	Annual Hours Reduced	**Average Rate**	**Potential Improvement**
Potential Staffing Adjustments			
Legacies Hours Per Resident Day reduced from 4.52 to 3.35	41,912	$ 20.52	$ 860,029
Long Term Care Hours Per Resident Day reduced from 4.10 to 3.49	13,390	$ 20.52	$ 274,753
Post Acute Care Hours Per Resident Day reduced from 6.19 to 5.31	14,208	$ 20.52	$ 291,540
Respiratory Therapist staffing reduced from 8.6 FTEs to 6.0 FTEs	5,408	$ 25.14	$ 135,957
Nursing Administration Hours reduced by 1 FTE (program manager)	2,080	$ 31.00	$ 64,480
Total Staffing Adjustment Savings			***$ 1,626,759***
Employee Benefit Reduction to 37% of Salaries			***$ 1,480,000***
Resident days			
Total Legacies Resident Days 2016	35,822		
Total Long Term Care Resident Days 2016	21,950		
Total Ventilator Resident Days 2016	7,841		
Total Short Term Care Resident Days 2016	8,304		
Medicare Part A days 2016	7,183		

CLA calculated several of the opportunities for improvement above using the Medicare Cost Report median data. Recognizing that medians are not necessarily realistic targets for the facility, they are offered as areas that merit further review in setting realistic targets. As a target, 50% - 75% of the total potential is suggested.

Key Clinical strategy opportunities

- Realign MDS coordinators to report to the Administrator or another non-clinical leader rather than the Director of Nursing and empower them to continuously review and improve the MDS education and recording processes throughout the Organization in order to optimize rates for the work performed.

- Investigate the reason for the high distribution of Rehab RUGs categories while therapy costs per day are well below the median. Based on the acuity observed, nursing tasks do not appear to be being recorded or reimbursed fully and therapy minutes may be increased.

- Track staffing related to the ventilator units separately from the short term rehabilitation units on the Post Acute Care wing to better understand the costs and profitability of these resident payment streams.

- Reduce direct care hours of staffing to be closer to the median in each unit to improve profitability. Due to complexities observed, hours should be able to be reduced while maintaining quality but reaching the median may be an unrealistic target.

- Consider using Medication Technicians in order to relieve licensed nurses from performing this task.

- Continue the onboarding and training process to retain C.N.A.s and create new learning experiences to retain licensed nurses. Survey staff both formally and informally to identify misperceptions (i.e. the belief of staff that pay rates considerably lower than other facilities when they are actually above the county median) that are affecting staff and develop communications to eliminate misperceptions that are found.

OBSERVATIONS AND FINDINGS

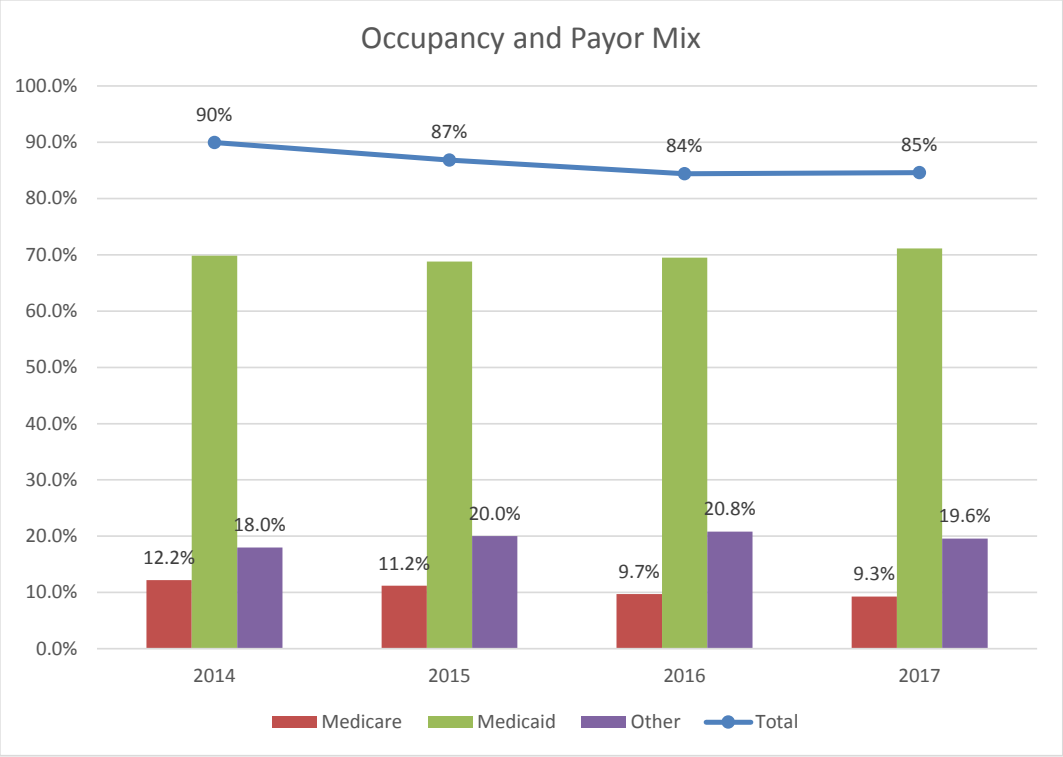
General observations

- Marathon County has been providing some form of nursing services since the late 1880's and was previously referred to as the Rib View Sanitarium.
- The current nursing home has been managed and operated by North Central Health Care since 1973. Prior to 1973, the nursing home was managed by a Board of Trustees.
- The lakeside setting of the community is beautiful and well maintained and represents an asset that could not be duplicated. The value of the campus location is not recorded in the financials and its full potential has not been realized.
- The nursing facility itself has not been updated for many years. The site location can be optimized through additional use of the outdoor space and a modernization of the current internal facilities. Additional residents would be more attracted to Mount View Care Center with even basic renovations.
- Those residents of Marathon County who are aware of the Mount View Care Center and the services provided understand MVCC's value and mission. Staff believe that the unwritten mission of helping senior patients and residents with the most complex health issues and those who will not be served elsewhere is understood by this group and continuing to get the message out to more community members can enhance utilization.
- MVCC provides a specialized array of services including respiratory therapy, music therapy, specialized dementia care and therapy, and specialized ventilator dependent care and therapy. These services are delivered in conjunction with standard nursing home services such as physical, occupational and speech therapy, transitional post-acute care, and long term care.
- The dementia programs are well known in the state and have been awarded a grant to train other state organizations on the program developed at MVCC.
- Based on discussions with staff, MVCC typically has 30-40 residents who are in protective placement requiring the County to provide care for these residents through the County's own facilities or by paying for services at third party providers.
- The CLA review focused on costs as the significant driver of potentials for improvement
- Occupancy overall is strong at 92% in 2016 compared to the county median of 76% and the state median of 80.2% while being one of the largest nursing communities in the state with 220 beds currently.
- Due to the high occupancy and some transitions in care, a bed lock scenario has evolved at MVCC. Bed lock occurs when preferable potential residents request a bed in the nursing facility and there are no beds available that would match the skill level and environment required by the potential resident. Managing this situation requires a facility to segregate beds appropriately to admit residents that maintain a payor mix that will allow the facility to sustain its operations.
- Due to the fact that NCHC is a large organization overall with many service lines and many shared services, it is important to note that the allocation of these costs are a key component that will drive results at each service line. Allocations are more difficult to properly determine as an organization gets larger and staff adjust their work habits to serve many service lines on any given day.
- MVCC serves a very high percentage of Medicaid residents at 70%. Two competitors serve a similar percentage of Medicaid residents and their 5 star ratings and results are similar to MVCC.

- MVCC provides one of the highest staffing ratios, somewhat driven by the complexity of care in the ventilator unit, among its peers. The only peer with a higher staffing ratio does not accept Medicaid with 23% of its service days being billed to Medicare A compared to 10% for MVCC.
- Long Term Care occupancy has dropped significantly in recent years most likely due to other available options in the Wausau market. Long Term Care will continue to be needed, but is likely to decline regionally and nationally.
- Overall costs are higher than the benchmarks on a per resident day basis.
- Employee benefits costs are significantly impacting results in 2016 at 48% of payroll costs as compared to the median of all nursing homes in Marathon County at 17%. If benefit costs were reduced to 28% of revenue, net income would improve by approximately $2.5 million which would have allowed MVCC to break even in 2016. $1.48 million could be saved annually if the benefit rate remained flat at the 2015 rate of 37%. The Wisconsin median for employee benefit cost percentage published by LeadingAge Wisconsin separates out governmental homes with a median of 44.4%. The large difference between these medians provides financial advantage for competitors. Ensuring that this additional cost to MVCC is creating value is critical.
- A review of the key quality metrics revealed that MVCC is beating national and state averages in the following key areas:
    - Hospital Readmissions
    - Emergency Department Visits
    - Successfully Discharged to the Community
- MVCC also ranks in the top quartile in these areas among their peers.
- Nursing Administration is close to the benchmark but may be reduced. The structure of the facility would allow a Director of Nursing to manage the Long Term Care, Short Term Care and Vent Units without requiring an additional program manager.

Occupancy and payor mix comparison

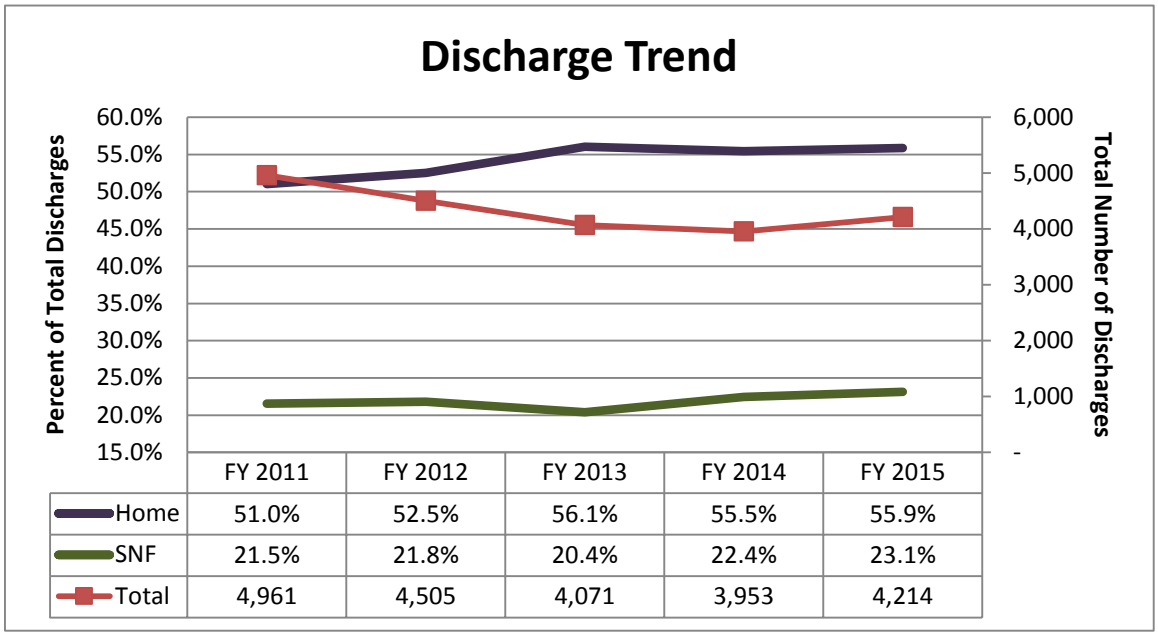
Overall occupancy has fallen over the past two years and is slightly lower than the Midwest average (84.7% per the CLA 31st Annual Skilled Nursing Facility Cost Comparison Report.) At the beginning of 2017, total licensed beds were reduced from 240 to 220 reflecting the future expectation of reduced bed needs in the area.



We also noted that while Other census days (private pay and insurance) have stayed relatively constant, Medicare census days have declined being replaced by Medicaid census days. Based on our discussions with staff, this change is partially related to Medicare referrals that were not admitted due to staffing and workflow concerns along with an increasing length of stay for Medicaid residents, which has produced a bed-lock environment at MVCC. Results still track closely to Midwest median census percentage of 10.1% for Medicare, while Medicaid is significantly higher than the Midwest median of 57.2%.

Hospital discharges and referrals

MVCC's main referral hospital is Aspirus Wausau. Referrals for the ventilator unit originate state-wide, as MVCC is one(1) of only five(5) vent units in Wisconsin. Referrals from Aspirus are strong and, while discharges to home have been flat in recent years, discharges to Skilled Nursing Facilities (SNFs) have increased. This appears to be the result of more complex cases being treated at Aspirus. We noted that overall discharges from Aspirus have been more volatile in recent years as residents begin to utilize hospital care differently. MVCC can use this information to capitalize on their ability to manage complex cases and increase their revenues and Medicare resident percentage.



	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Home	51.0%	52.5%	56.1%	55.5%	55.9%
SNF	21.5%	21.8%	20.4%	22.4%	23.1%
Total	4,961	4,505	4,071	3,953	4,214

Other discharge destinations in 2015 were other acute care facilities (17%) and deaths (5%.)

The most common diagnoses groups discharged to SNFs from Aspirus per the 2015 Medicare claims data are noted below:

Diagnosis Code	Description	Total Payments	Unique Patients
V5789	**Care involving other specified rehabilitation procedure**	**$7,963,090**	**701**
Top 3 SNF Facilities	Rennes Health and Rehab Center of Weston/Wausau	$1,338,118	129
Visited (Based on	Wausau Manor	$1,193,496	114
Total Payments)	Stoney River - Marshfield	$776,950	84
V5413	**Aftercare for healing traumatic fracture of hip**	**$434,364**	**34**
Top 3 SNF Facilities	Atrium Post Acute Care of Stevens Point (FKA: Stevens Point Care Center)	$67,236	
Visited (Based on	Colonial Manor Medical and Rehabilitation Center	$56,230	
Total Payments)	Rennes Health and Rehab Center of Weston/Wausau	$46,276	
V573	**Care involving speech-language therapy**	**$330,003**	**52**
Top 3 SNF Facilities	**North Central Health Care**	$330,003	29
Visited (Based on			
Total Payments)			
V5721	**Encounter for occupational therapy**	**$269,574**	**37**
Top 3 SNF Facilities	**North Central Health Care**	$253,102	36
Visited (Based on	Atrium Post Acute Care of Wisconsin Rapids (FKA: Wisconsin Rapids)	$16,472	
Total Payments)			
V5481	**Aftercare following joint replacement**	**$267,855**	**37**
Top 3 SNF Facilities	Rennes Health and Rehab Center of Weston/Wausau	$76,411	
Visited (Based on	Eastview Medical & Rehabilitation Center	$59,134	
Total Payments)	Stoney River - Marshfield	$31,748	
51883	**Chronic respiratory failure**	**$109,201**	**701**
Top 3 SNF Facilities	Wissota Health & Regional Vent	$58,491	129
Visited (Based on	**North Central Health Care**	$45,236	114
Total Payments)	Atrium Post Acute Care of Weston	$5,475	84
51884	**Acute and chronic respiratory failure**	**$211,617**	**11**
Top 3 SNF Facilities	**North Central Health Care**	$148,253	
Visited (Based on	Strawberry Lane Medical and Rehabilitation Center	$18,397	
Total Payments)	Eastview Medical & Rehabilitation Center	$11,487	

Based on the data above, it would appear Aspirus considers certain diagnoses to be best served by MVCC, however, rehabilitation procedures, related to the top two diagnosis groups, are typically discharged elsewhere.

MVCC captures 8% of the Medicare spending at SNFs referred from Aspirus Wausau and rank very close to the second and first highest SNF referral source. We have designated the top six SNFs in the chart below as the peer group for additional analysis later in this report. MVCC has been able to maintain a relatively high and competitive market share in comparison to other SNFs in the area as they continue to focus on complex cases.

	Provider	% of Spending Captured	% of Patients Captured	Peer Group?
1	Rennes Health and Rehab Center of Weston/Wausau	10%	10%	Yes
2	Wausau Manor	9%	9%	Yes
3	**North Central Health Care**	8%	6%	Yes
4	Colonial Manor Medical and Rehabilitation Center	6%	4%	Yes
5	Stoney River - Marshfield	5%	6%	Yes
6	Benedictine Living Community of Wausau (Marywood Convalescent Center)	**5%**	**5%**	Yes
7	Atrium Post Acute Care of Weston	4%	3%	
8	Eastview Medical & Rehabilitation Center	4%	3%	
9	Rennes Health and Rehab Center of Rhinelander (FKA: Lillian Kerr Healthcare Center)	4%	5%	
10	Homme Home For The Aging	3%	3%	
11	Atrium Post Acute Care of Wisconsin Rapids (FKA: Wisconsin Rapids)	3%	2%	
12	Atrium Post Acute Care of Stevens Point (FKA: Stevens Point Care Center)	3%	2%	
13	Pine Crest Nursing Home	2%	3%	
14	Portage County Health Care Center	2%	2%	
15	Strawberry Lane Medical and Rehabilitation Center	2%	1%	

The area SNFs have excess capacity, which represents a risk that must be evaluated in the strategic planning process:

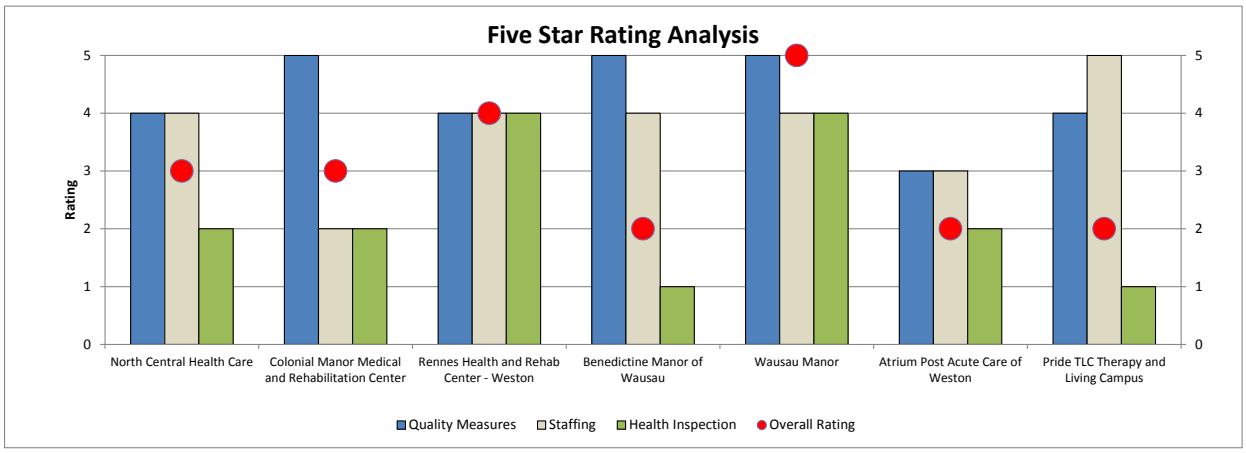
Nursing Community	Ownership Type	Certified Beds	Occupancy	CCRC	Overall Star Rating
WAUSAU MANOR	For profit - Corporation	68	53	FALSE	★★★★★
RENNES HEALTH AND REHAB	For profit - Corporation	84	80	FALSE	★★★★
MOUNT VIEW CARE CENTER	Government - County	220	198	FALSE	★★★
ATRIUM POST ACUTE CARE WESTON	For profit - Partnership	128	41	FALSE	★★★
COLONIAL MANOR	For profit - Corporation	150	66	FALSE	★★
BENEDICTINE MANOR	Non profit - Church related	82	59	FALSE	★★
PRIDE TLC THERAPY	For profit - Partnership	35	19	FALSE	★★

None of the area competitors are CCRCs and three of the six competitors are at a 2 star rating.

Quality and Medicare Five Star analysis

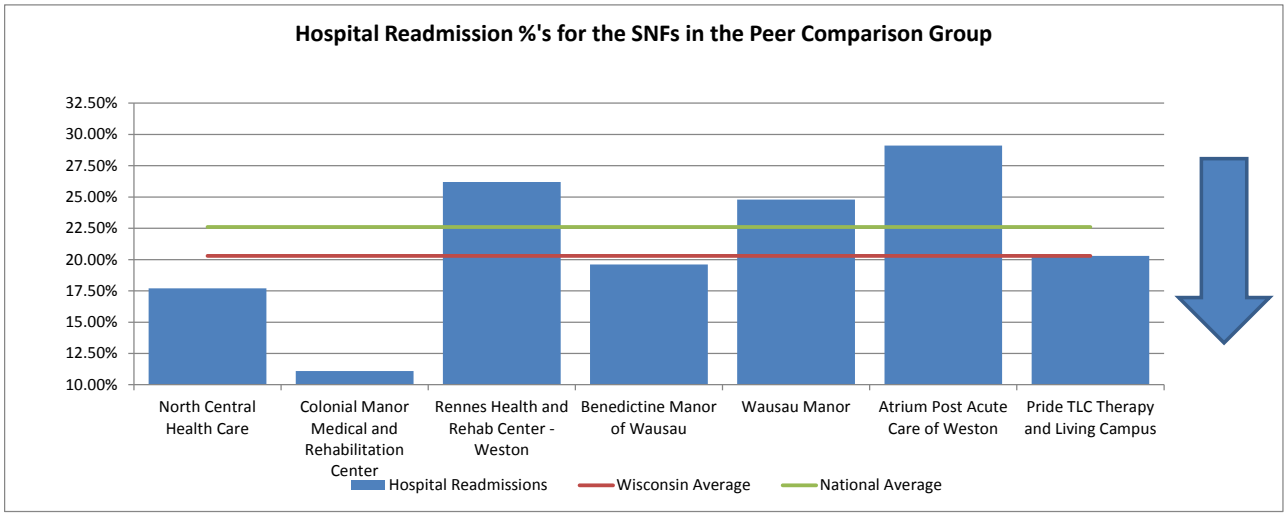
The key competitor peer group in Wausau and the Marathon County area are all experiencing lower rated health inspections, which is a trend that CLA has seen occurring throughout Wisconsin. Quality measure performance has been the main strategy used by most other organizations to increase their overall star rating. For example, between April and May 2017, Wausau Manor increased their overall rating from 4 to 5 stars by

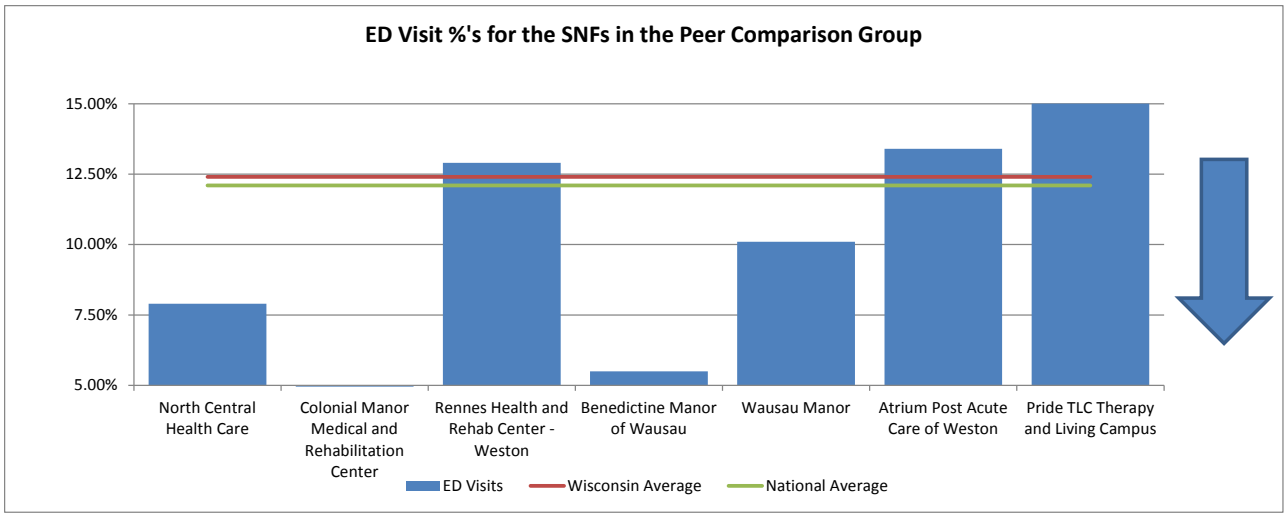
achieving a 5 star rating in their quality measures. This will become a key factor for all SNFs as the labor market continues to tighten.

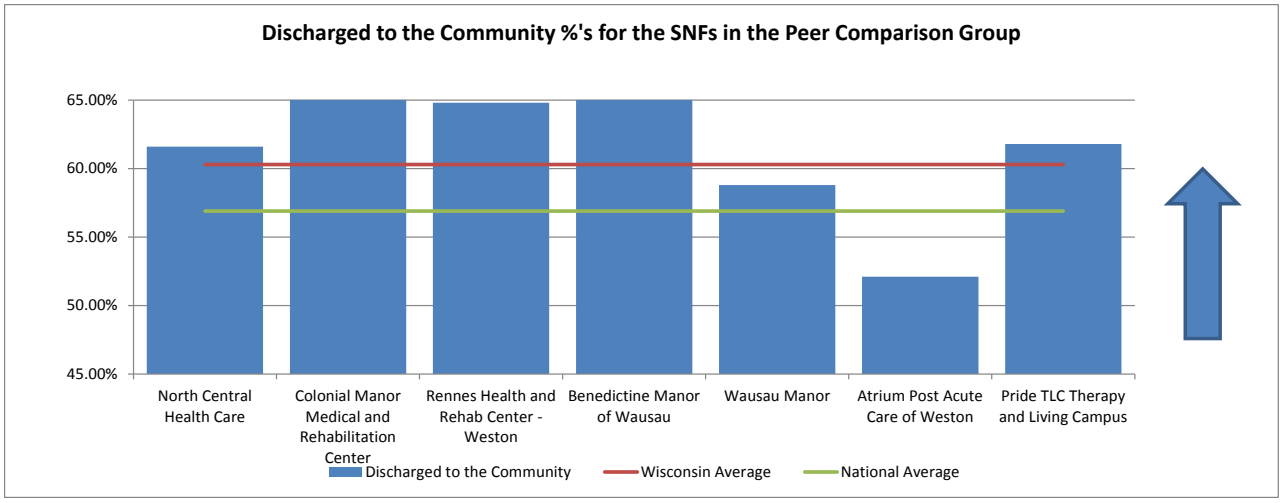


As can be seen in the chart above, MVCC is still positioned well in the market according to the 5 star rating system. It should be noted that all competitors other than Rennes Health and Rehab and Wausau Manor have a health inspection rating of 2 stars or less. Rennes and Wausau Manor have upcoming inspections this summer while most of the others were inspected after October 2016, so it is possible that their 4 star ratings may be challenged over the next several months.

Key quality measures to focus on include those noted below. The desired trend is indicated by the arrow to the right of the charts:







In each of these cases, MVCC is performing above most of its competitors as well as the national and state averages. Continued focus on these measures should be maintained and improved where possible. Ongoing discussions with Aspirus and other referring hospitals should also be a key focus.

Quality Measures which need improvement to reach state averages and to increase the overall Quality Measure star rating relate to long stay residents. Due to the population served at MVCC, it is understood that some of these measures will not be able to be lowered significantly and MVCC management should determine which measures can be improved most effectively. These measures include long stay residents who:

- Received an antipsychotic medication
- Have/had a catheter inserted and left in their bladder
- Have a UTI
- Self-report moderate to severe pain

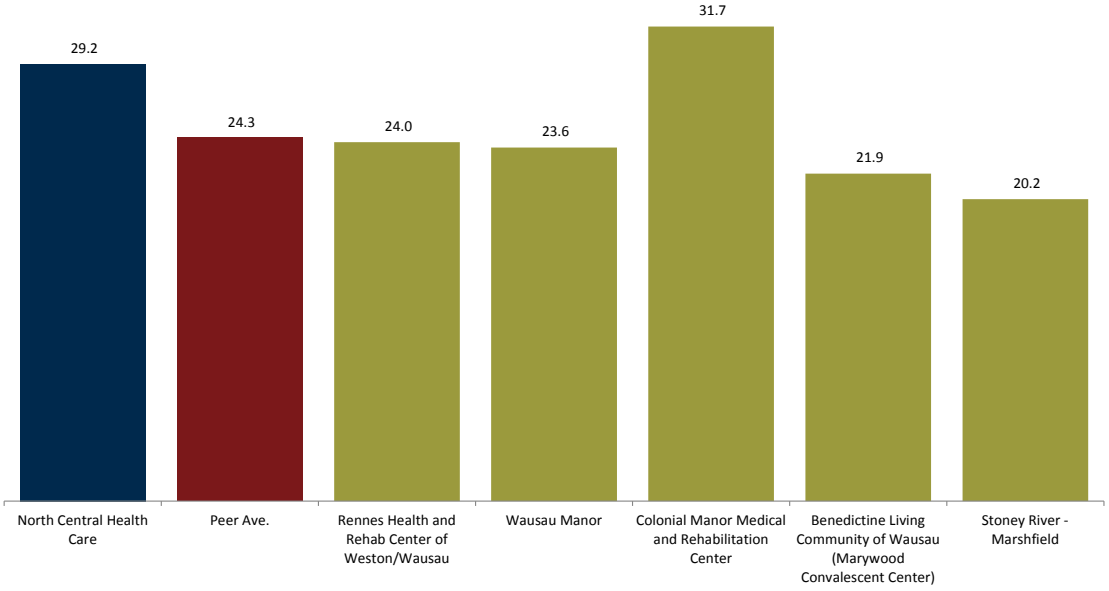
CLA also noted that the percentage of long stay residents who have depressive symptoms was extremely low at .70% compared to the national and state averages of approximately 5.50%. This measure may indicate undocumented behaviors observed and proper coding would produce higher reimbursements than what are currently being paid as well.

Length of stay analysis

MVCC has a longer length of stay as compared to other SNFs in its peer group, however, it is comparable to the Wisconsin state average Medicare stay of 29 days. As value based purchasing continues, it is likely that this average length of stay will continue to decline.

vs. Other Peer SNF Referral Sites

Average SNF Length of Stay per Unique Patient



Referrals

Referrals from hospitals and other health care providers have increased from a monthly average of 62 in 2016 to an average of 85 in 2017. Due to the bed locked status of MVCC, however, only 36% were admitted in 2016 and 32% in 2017. Some of these declines could have impacted the total revenue if patients with higher Medicare reimbursement rates were not admitted (due to staffing issues or beds not being available.)

ASSESSMENT OF FINANCIAL STRUCTURE

Medicare and Medicaid cost report analysis

CLA utilizes a Proprietary Medicare Database aggregating data from the CMS Medicare cost reports that were filed in the previous reporting year. The data used here is specific to Wisconsin and Marathon County and compares the respective facility data to state and MVCC's peer group as well as SNF specific information for the respective facilities. Data is aggregated as follows:

- County-where the facility is located
- State- Wisconsin

CLA relies on the data in assessments as the "certified" source of skilled nursing expense and revenue information.

NCHC files a combined Medicare Cost Report which includes MVCC, however MVCC does not file a separate Medicare Cost Report for its specific costs and residents. Therefore, MVCC costs per day, wage rates and other metrics used were calculated from the 2016 Medicaid cost report filed by MVCC with the State of Wisconsin. A summary of the review findings follows as a reference point for some of the observations and recommendations included in the report.

MVCC reported costs vs. County Medians:

- Medicare days of 7,183 are the highest in the peer group above and are 160% higher than the county median of 2,760 Medicare Part A days. While MVCC is larger than its main competitors, the number of Medicare referrals relate to the quality of care of a facility as Medicare is typically a preferred payor.
- The reported Medicare PPS average rate of $473.18 is higher than the county median of $463.23 but lower than the state median of $476.41.
- Medicaid days of 51,352 are over 3 times the average of the peer group of 16,794 days as are overall days of 73,917 vs. the median of 23,287.
- Average Length of Stay (ALOS), estimated at 29 days, is close to the median of 32 days but significantly lower than the average of the peer group median of 38.2 days reported to CMS. The ALOS is expected to decline over time.
- Benefits are significantly higher in 2016 at 48.3% of Payroll vs. a median of 17% for all nursing homes in the county. Governmental Homes statewide achieved a median of 44% as published by LeadingAge Wisconsin.

Average hourly wages are high overall as noted by the following:

Department	MVCC	County Median/Peer Group
Nursing	$20.52	$19.19
Plant and Maintenance	$23.39	$18.70
Laundry	$14.20	$9.96
Housekeeping	$13.58	$12.01
Dietary	$14.89	$12.87

Social Services	$25.15	$20.36

- Staffing hours per resident day outside of Nursing are close to the county medians in most departments other than Plant and Maintenance at .25 vs. .12 and Dietary at .86 vs. .73. Other General Services are also high at 1.13 vs. 0.20. Other General Services for MVCC includes Volunteer Coordinator hours, Activities hours and Transportation hours which may not have been consistently reported on the peer group cost reports.
- Direct Nursing Hours overall are significantly higher at 5.49 vs. 4.71.
- Occupancy at 92% (calculated using 220 beds) is stronger than the county median of 76%.

Analysis of calculated per diem revenue and daily costs

Revenue and Direct Costs are captured for each nursing unit: Legacies, Long Term Care and Post Acute Care. At times, Long Term Care residents are place on the Post Acute Unit. Post Acute Care revenue is also captured in each unit when costs may be captured in the Post Acute Care unit if the services are provided there. Post Acute Care costs are combined for the ventilator residents and the short term rehab care residents.

CLA reviewed average rates paid for all payors and allocated costs and revenue per day to each unit based on these rates. CLA made an estimate of cost allocations in the Post Acute unit between ventilators and short term rehab residents in relation to the nursing and respiratory therapy hours staffed in each unit.

Medicare costs outside of the routine costs were estimated based on overall Therapy, Pharmacy and Ancillary gross profit percentages since these revenues and costs are captured in separate departments.

This process creates a high level estimate of gross profit per day for each type of resident and payor combination as noted below. The gross profit percentage and per diem gross profit amounts calculated may be misestimated where there is a low percentage of days in certain payor-care type combinations and where costs are spread more evenly over the more diverse populations. Results for 2016 are as follows:

Number of Days Per Unit	Self Pay	Insurance	Medicaid	Medicare	Total
Vent	272	1,283	5,459	827	7,841
Short Term Care	625	1,188	2,292	4,199	8,304
Long Term Care	2,292	1,068	17,808	782	21,950
Legacies	7,108	1,548	25,791	1,375	35,822

Percentage of Days per unit	Self Pay	Insurance	Medicaid	Medicare	Total
Vent	3%	16%	70%	11%	100%
Short Term Care	8%	14%	28%	51%	100%
Long Term Care	10%	5%	81%	4%	100%
Legacies	20%	4%	72%	4%	100%

Green shading represents areas where the percentage of days are lower indicating possible misestimate (due to outliers) of the gross profit calculation. Red shading represents Medicare days which were a low percentage for the unit indicating a possibility that costs required to care for these residents were captured outside of the unit's direct costs. Due to the low number of days spent in these categories, the allocations and calculations of gross profit are not significant in total to the overall financial results.

Gross Profit Per Day	Self Pay	Insurance	Medicaid	Medicare
Vent	$ 278.43	$ (184.41)	$ 184.43	$ 56.90
Short Term Care	$ 15.98	$ (76.08)	$ (107.90)	$ 61.23
Long Term Care	$ 122.65	$ 30.59	$ (1.23)	$ 167.91
Legacies	$ 118.57	$ 26.51	$ (5.31)	$ 163.83

Gross Profit Percentage	Self Pay	Insurance	Medicaid	Medicare
Vent	42.5%	(96.0%)	32.9%	10.1%
Short Term Care	5.6%	(39.6%)	(67.3%)	13.3%
Long Term Care	43.2%	15.9%	(0.8%)	36.4%
Legacies	41.7%	13.8%	(3.3%)	35.5%

The green and red shaded calculations are noted once again. The blue shaded calculations are reasonably calculated based on allocating all therapy and ancillaries across all residents on the Post Acute Care Unit.

Insurance payors represent 7% of all days served and since the total insurance revenue was spread evenly across all units, we expect that the Vent Unit and Short Term Care Unit performed better than calculated but may have still produced a negative gross profit.

The Medicare revenue per day and percentage is approximately $10 above the average of the peer group, however, it is $3 below the state median. The ventilator unit and complexity of residents that are cared for at MVCC suggest that this rate should be even higher.

Gross Profit per Resident day is between $14 and $19 higher per day than the county median of $42.17. Higher Routine Costs are offset by lower Therapy costs. Therapy cost estimated at $82.56 per day is significantly lower than the county median of $136.23 per day creating the majority of this difference. Based on our review and discussions with staff, therapy is available 6 days a week rather than 7 days, yet most people are not receiving therapy 6 days a week. The RUGs distribution supports this pattern and a more aggressive therapy program may both aid residents and increase average Medicare RUG rates. Pharmacy Costs are above the County and State medians by $3.78 to $7.45 per day based on the blended post acute care revenue and cost allocation noted above.

Medicare Ancillary Costs per Day			
Cost Type	County Median	State Median	Blended MVCC
Therapy	$136.23	$119.61	$82.56
Pharmacy	$43.14	$39.53	$46.98
Ancillary	$7.32	$5.12	$2.17
Total	$186.69	$164.26	$131.71

Recommendations:

- We recommend that MVCC create a more focused marketing plan to test the attraction of more Medicare residents after renovating the unit and implementing a bed management system. Each additional Medicare resident (and reduction in Medicaid residents) will improve financial performance by approximately $22,000 per year at the current revenue and estimated cost levels, but this margin can increase through other initiatives noted within this report.
- We recommend that MVCC further evaluate the Medicare program and MDS coding process (see Nursing department review)
    - Review coding/documentation to make sure MVCC is receiving credit for the services actually delivered
    - Arrange financial reporting systems to track revenue and costs by payor source within each unit (Legacies, Long Term Care, Ventilators, Short Term Care) for better analysis and profitability management

Nursing facility cost comparison

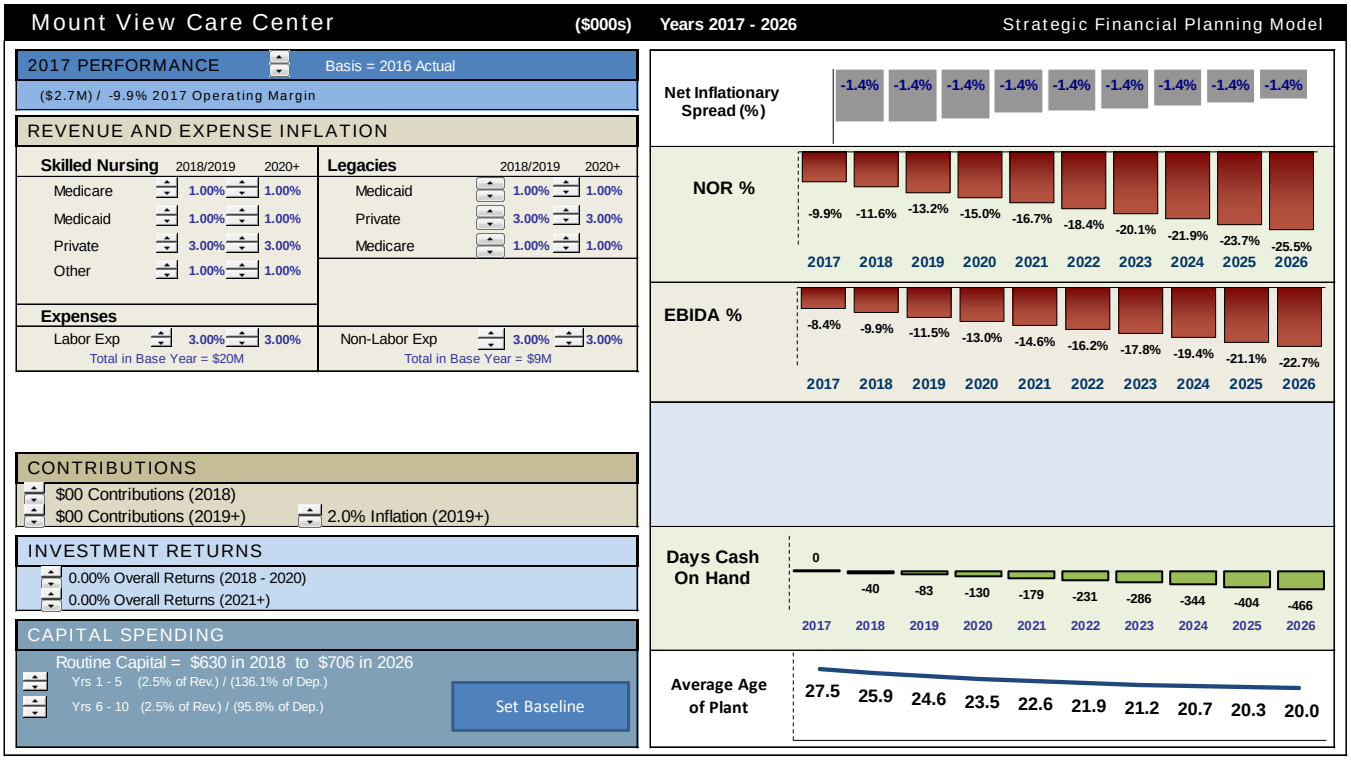
CLA reviewed the operating costs by categories from the 2016 Medicaid cost report for MVCC and compared the data with the 2016 CliftonLarsonAllen 31st Nursing Facility Cost Comparison. This report represents data from approximately 14,000 nursing facilities, including for-profit and not-for-profit in stand-alone and affiliated type organizations. Nursing staffing ratios from this report were utilized to benchmark the nursing staffing as well as other staffing ratios.

Summary of findings:

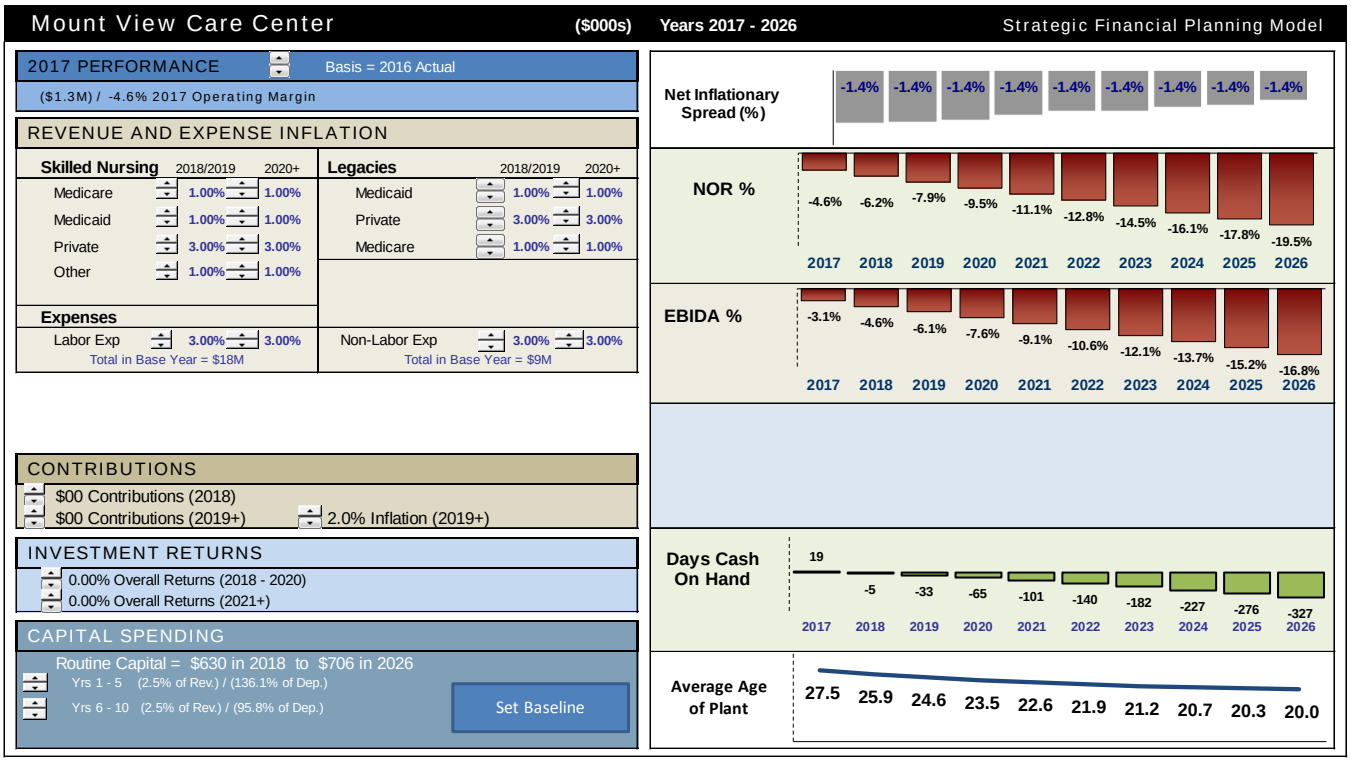
- All support departments other than Social Services and Laundry have recorded hours per resident day that were higher than the Midwest median
- All support departments recorded average hourly wages that were higher than the Midwest median
- Nursing care hours and per day costs are well above the Midwest medians
- Plant Maintenance is double the median in hours per resident day and Plant Maintenance costs per resident day are $2.95 above the median
- Housekeeping costs per resident day are $1.74 above the median
- Housekeeping average wage rate is $3.00 higher than the median
- Dietary costs per resident day are at $21.48 vs. $17.19 at the median
- Dietary average wage rate is $3.15 above the median

Financial ratios

A 10 year forecast of operating results was prepared with the assumptions noted below based on 2016 audited financial statements:



CLA noted that the employee benefits cost as a percentage of salaries was approximately 48% in 2016 and 37% in 2015. The additional 10 year forecast below assumes that the benefits cost will return to approximately 37% in 2017 and future years:



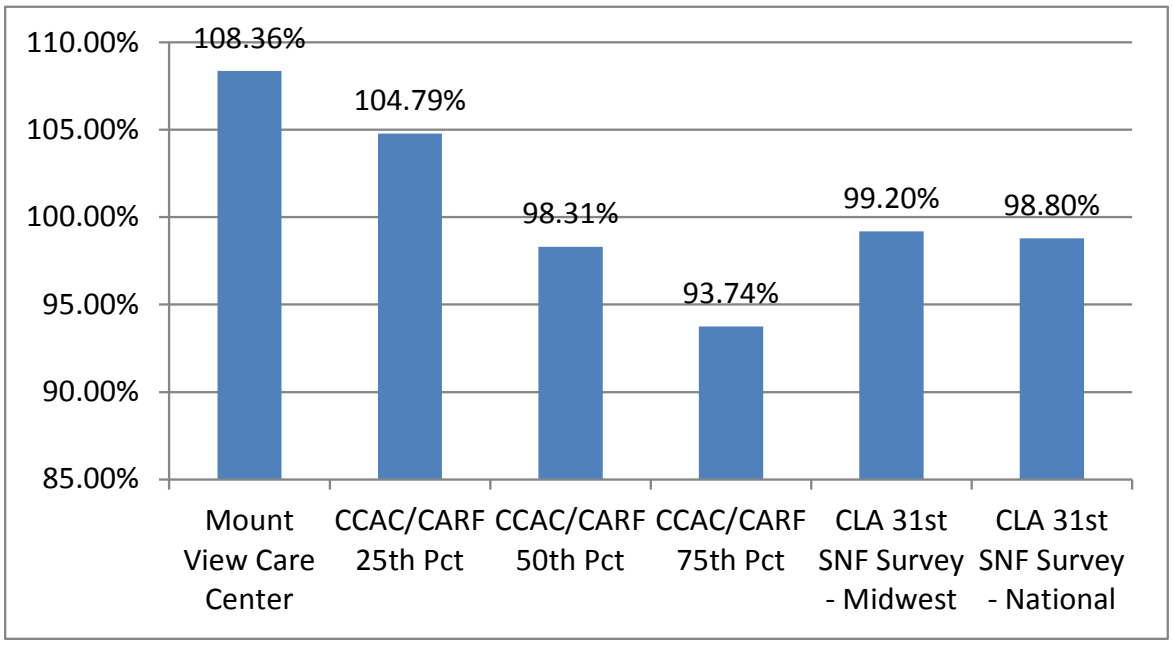
In each forecast, the need for additional tax levy will grow in proportion to the negative Net Operating Return percentage. CLA conducted a review of commonly used financial ratios, within continuing care comparing those of MVCC with the 2016 ratios of CARF-CCAC, a recognized accreditation commission, and the CLA 31st Nursing Facility Cost Comparison.

The ratios are calculated with the following formulas:

Total Operating Expense minus Amortization and Depreciation Expense
Total Operating Revenues minus Amortization of Deferred Revenue
Operating Ratio
Income or Loss From Operations minus Contributions
Total Operating Revenues
Operating Margin Ratio
Total Excess Revenues over Expenses
Total Operating Revenues and Net Non-Operating Gains and Losses
Total Excess Margin Ratio

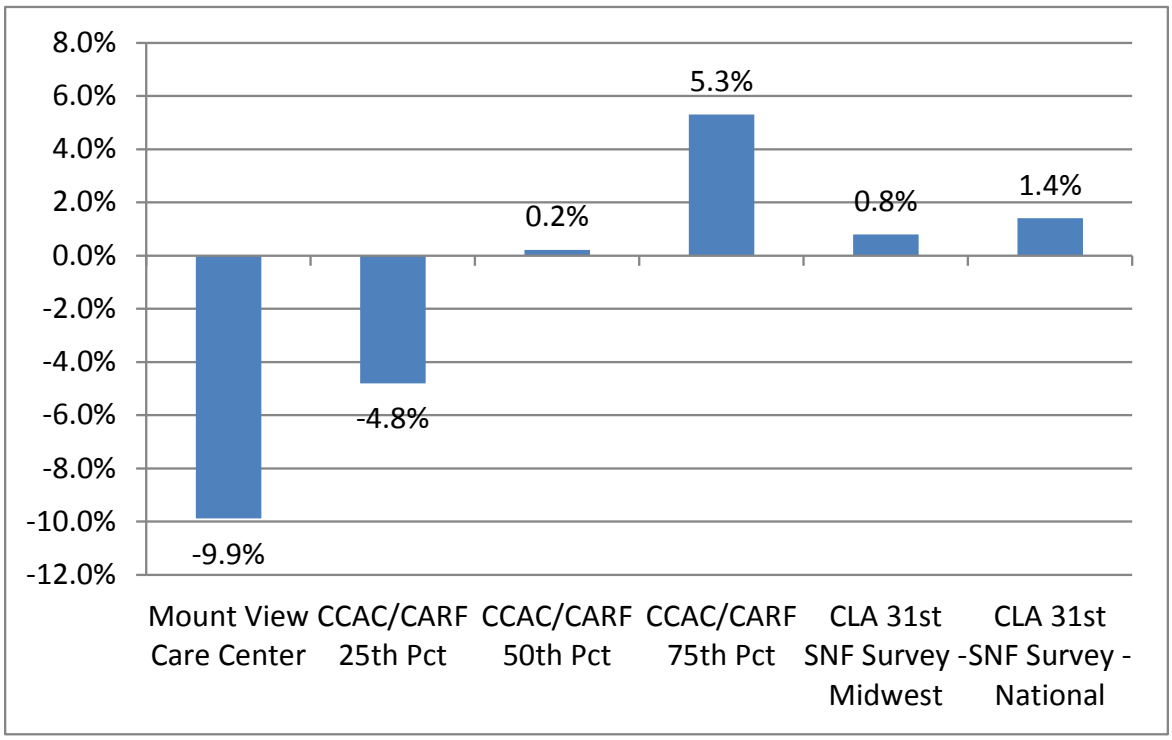
The results of the review are represented in the following graphs:

Operating Ratio



A lower Operating Ratio indicates better cost control related only to service delivery and a stronger performance.

Operating Margin Ratio



A higher Operating Margin Ratio indicates better control of all costs (including building and debt costs) in relation to earned revenues.

Both ratios indicate that MVCC's costs are higher with a significant portion related to the cost of employee benefits (medians benchmarked between 14.4% and 22.3% throughout the country.) If the pension portion is removed from employee benefits in 2016, the cost is still high at 35.3% which greatly affects the financial performance of MVCC in comparison to the rest of the industry.

CLA noted that none of the overall NCHC non-operating investment income and gains on capital dispositions ($124,480 in 2016) or the contributions for capital assets ($190,518) were allocated to MVCC. As such, the Excess Margin Ratio noted above would be the same as the Operating Margin Ratio. The benchmarks indicate that nursing and senior living communities add an additional 2% of revenue at the median through these components within the industry. This would represent an additional $320,000 of funding for MVCC if the median was achieved.

ASSESSMENT OF SELECTED DEPARTMENTS

Leadership

CLA interviewed the senior members of the Management Team. Leadership is experienced and have provided many years of service in health care, senior living and county services.

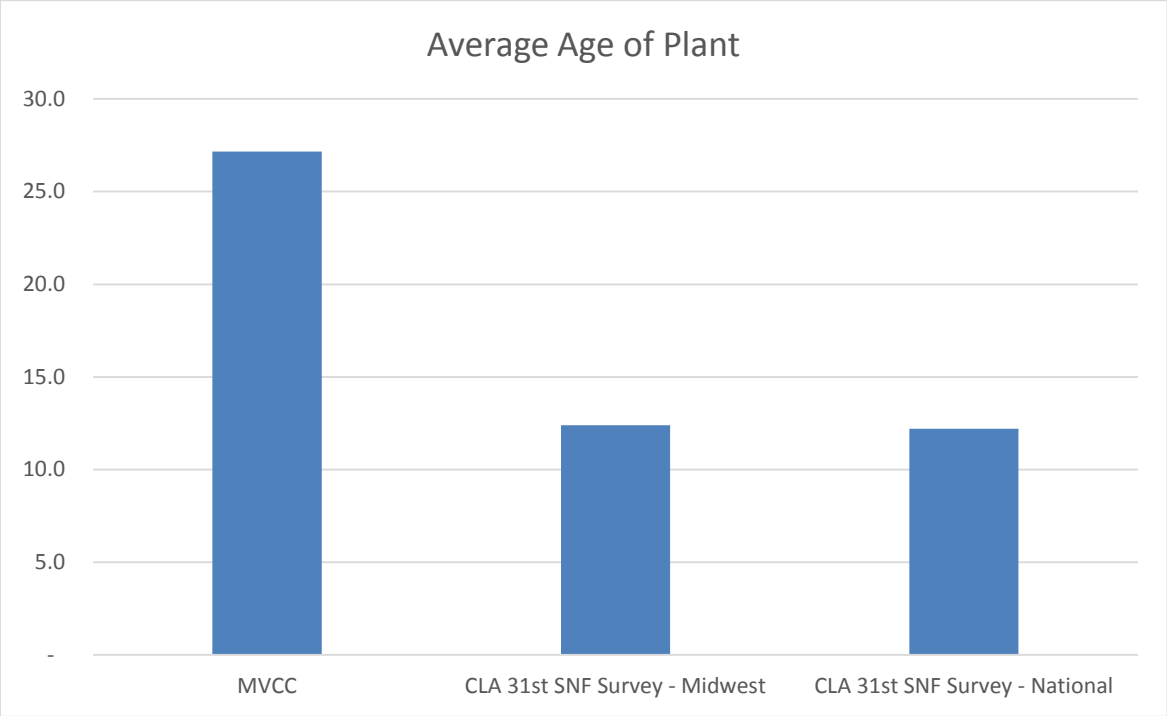
Overall, leadership identified the following as the most significant challenges they are facing:

- Staffing and attrition related to a lack of quality healthcare personnel in the market. Attrition has improved recently
- Low Medicaid reimbursement rate for the largest population of residents
- The need for redevelopment of several physical campus areas to stay competitive
- Managing admissions, referrals and beds
- Old technology in both administrative and personal care areas of the operations (i.e. call systems, care documentation, etc.)
- Deciding whether organizing a commission for operation of the nursing home among several counties would be a beneficial strategy
- Marketing perceived to have been treated more like public relations causing confusion in the market. Many county residents still think the property is a sanitarium
- Vent unit expansion may allow for investing in an oxygen farm to improve operations and possibly reduce costs per day

Plant Operations and Maintenance

The Average Age of Plant Ratio measures the average age of a facility by estimating the number of years of deprecation has already been realized for a facility by dividing accumulated depreciation by depreciation expense. A higher value may indicate that a facility is in need of remodeling or renovation and that the facility should be evaluating its current level of reinvestment and financing options for these projects. In the past 10 years, the senior care industry has seen a steady trend of shorter timeframes between renovation projects as facilities have aged in the US and consumers have expected spaces which are more modern. Based on our experience, as this ratio reaches 16 years, a facility begins to look out of date to prospective residents and their families.

The Average Age of Plant Ratio for MVCC at 27.2 years is more than double the medians for both the Midwest and the Nation (Source: CLA 31st Nursing Facility Cost Comparison):



Nursing and senior living facilities have consistently used various debt options to expand and renovate their facilities and grounds. Governmental units also issue bonds on income producing ventures. MVCC currently has a solid foundation of service and a strong reputation. MVCC has several options to increase the admission of higher profitability Medicare and Private Pay residents in order to offset the high Medicaid population currently in residence. Refurbishment of the building as well as key technology infrastructure is needed in order to restructure the resident population mix.

A prudent issuance of debt is a common method of financing these renovations. The CLA 31st Nursing Facility Cost Comparison Report notes that the median Debt Service Coverage Ratio in the Midwest is 1.8 and the median Debt to Equity Ratio is 65%. MVCC has the ability to repay a large portion of renovation costs through an increase in the capital cost component of the Medicaid rate which has been estimated by management to fund 70% of possible debt payments. It is more than likely that the projected revenue increase from additional short stay residents would allow MVCC to meet and even exceed these median ratios.

We recommend that a new renovation planning project be launched as soon as possible with an updated feasibility study performed to project the ability to pay back the debt required and to improve overall results of MVCC.

Information Technology

Direct IT Costs in 2016 represent 2.4% of revenues overall. While benchmarking IT costs has been limited, the senior living industry typically spends 2 – 3 % of revenues on these services so this is within range. Conventional wisdom indicates that most senior living facilities are not spending enough on IT costs, however, this is also related to the lack of reimbursement from both governmental and private payor sources.

The reinvestment in information technology has the potential to radically improve both care and efficiency at MVCC. We noted four main areas that should be considered for additional investment along with revising processes around the new technology. These four initiatives will require outside assistance and a well thought out roadmap for implementation since the timeline to implement these initiatives may be substantial:

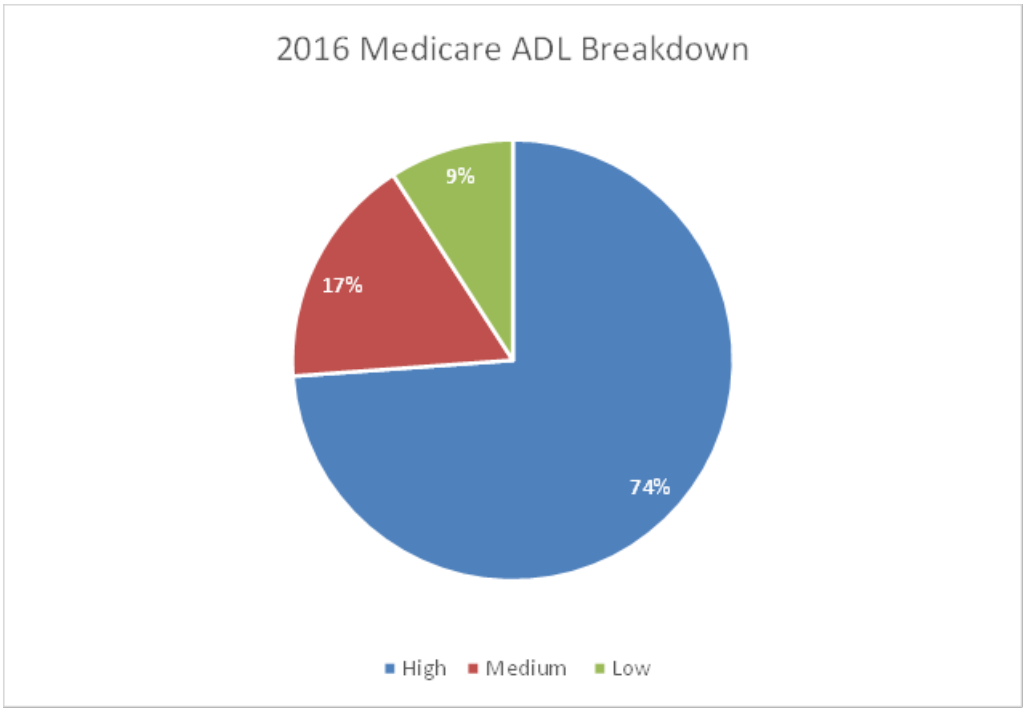
- Upgrade the wireless infrastructure to allow for additional mobile device use
- Implement a modernized call light system with options to contact other staff quickly when needed
- Implement a new culinary information system to increase the options for person centered care in an efficient manner
- Implement an updated ERP system including additional kiosks for nursing staff to easily capture the care they are giving to residents

Clinical Nursing

For the purposes of this report it is important to understand that “acuity” is the care provided by the licensed and registered nurses and that “intensity of care” refers to the care provided by the certified nursing assistants.

Correct MDS scoring and supporting documentation is vital because it not only determines reimbursement, it is the basis for CMS to calculate the Quality Indicator scores, the basis for developing resident plans of care and measuring the residents’ improvement and decline. Per Tracy McConnell, MDS coordinator, the current Medicare Advantage plans also use the RUGs scores as the basis for payments. One Medicare Advantage plan used at MVCC provides an expected score up front but this is adjusted with a final RUGs score through a reconciliation process. Staff performing these assessments need to ensure that they are as thorough and accurate as possible as MVCC is at risk for the entire length of stay based on these assessments.

Activities of Daily Living



The 2016 RUG distribution placed 74% of Medicare resident days in High ADL categories. Residents in the Low and Medium categories require far less CNA assistance than those in the High categories which is reflected in the current staffing hours per patient day ("HPPD") as noted below. These calculations and observations are indicators for the determination of nursing licensure skill mix (relative percentages of RNs, LPNs, and CNAs) percentages for determining the staffing plan for the units.

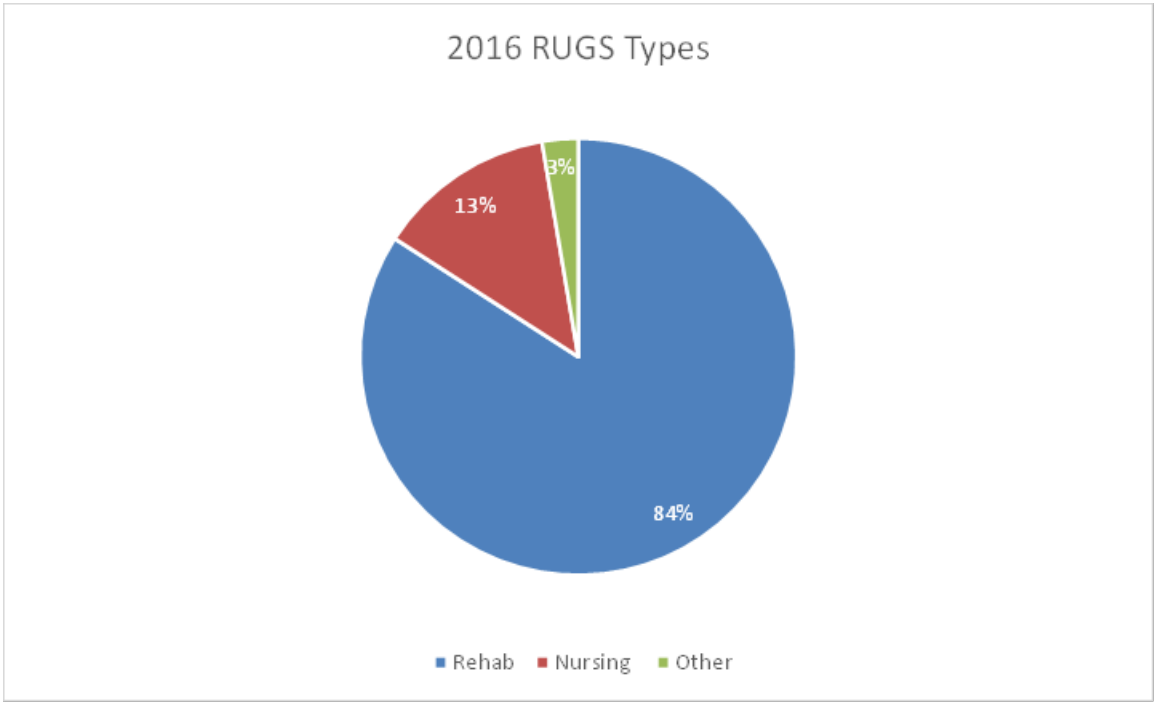
The significant percentage of days in the High category indicate that residents are not improving in regaining ADL functions overall during their short term stays. While the complexity of the ventilator residents contributes to the High ADL scores, a more balanced distribution in the Medium category is still expected since more than half of the post acute resident days are Medicare short term stays outside of the ventilator resident population. MDS coding as well as nursing protocols can be adjusted appropriately to improve the distribution and decrease staffing needs over time.

RUG Category Percentages

RUG categories are indicators of the acuity of the residents. Residents in the Rehab category receive therapy and may have some chronic conditions, but generally are planning to return home.

Residents in the Nursing category may have diagnoses such as: chronic obstructive lung disease, ventilator residents who are short of breath and on oxygen, diabetes with daily insulin injections and insulin order changes, complex wounds with dressing changes, Parkinson's disease, or residents with treatments such as dialysis, blood transfusions, IVs, IV medications, or chemotherapy. These residents require frequent nursing assessments and monitoring during each shift and at times of medication administration.

The Other category includes residents that may have behaviors that require additional nursing time to provide care, manage mood swings and refusal of care.



Based on the ventilator residents and complexity of cases observed in short stays, we would expect to see a much higher percentage in the Nursing category and in the Extensive Services (ES2 and ES3) categories. The Rehab category at 84% is very high and coupled with the fact that the ADL scores are also high, the documentation does not indicate that patients are improving enough to be successfully discharged to the community or another facility. Since the calculated cost of therapy services from the Medicare cost calculation is low as compared to median benchmarks, rehab services appear to be prevalent but not extensive enough for the population observed (i.e. more therapy minutes appear to be needed for residents to see greater improvement.) This percentage may also be low because documentation and MDS coding may be missing or inaccurate. For instance, the Rehab Plus Extensive Services category RUGs represent 2.2% of the total days which would be expected to be higher due to the complexity of the ventilator residents alone. These RUG categories do not appear to be maximized and may be miscoded CLA noted that steps are being taken to improve coding and care planning by a key MDS coordinator and along with increased cross education for staff, these distributions are expected to improve over time. As the distribution over various RUGs categories changes, the average daily reimbursement rate should also increase.

All direct care staff should be continually trained on the required documentation so that the intensity and amount of care provided can be scored properly on the MDS. With accurate capture of the provision of care, it is likely

that the case-mix scores can be increased with a positive impact on reimbursement as well as more proactive planning for staff needs and costs.

Staffing Observations

Current staffing on skilled nursing as detailed in the first three months of 2017 provide the following hours of direct care per patient day (HPPD) along with benchmark information from the CLA 31st Nursing Cost Comparison Report, the 2015 State of Seniors Housing Report and the County Median from Medicare Cost Reports.

Our observation is that purely Long Term Care units staff at a range between 3.2 to 3.7 hours of direct care per day.

Long Term Care

Hours Per Patient Day

Level	MVCC	Industry	Proposed	Potential Reduction
Licensed Nurses	1.17	1.05	1.03	0.14
C.N.A.s	2.93	2.45	2.46	0.47
Total	4.10	3.50	3.49	0.61

Legacies

Hours Per Patient Day

Level	MVCC	State of Senior Housing 2015	Proposed	Potential Reduction
Licensed Nurses	1.10		1.05	0.05
C.N.A.s	3.42		2.30	1.11
Total	4.52	2.40	3.35	1.17

Post Acute Care

Hours Per Patient Day

Level	MVCC	County Median (includes Rehab)	CLA 31st SNF Report - Midwest	Proposed	Potential Reduction
Licensed Nurses	2.29		1.33	1.42	0.88
C.N.A.s	3.90		2.45	3.90	0.00
Total	6.19	4.71	3.78	5.31	0.88

Ventilator Unit and Short Stay Rehab Unit Distribution

Level	Ventilator Unit	Short Stay Unit
Licensed Nurses	1.74	1.09
C.N.A.s	4.52	3.27
Total	6.26	4.36

Respiratory Therapist staffing was also reviewed:

- MVCC staffs 8.60 FTEs of Respiratory Therapists for an average census of 24-25 residents. The caseload ratio for each Respiratory Therapist is approximately 1 Therapist to 10 ventilator residents over two 12 hour shifts.

- Data and review of hospital ventilator unit therapist ratios published by the California Society for Respiratory Care state that the median ratio in the acute setting of a hospital is 1 Therapist to 5 residents and that 80% of the hospitals staff at 1 Therapist to 8 residents or lower.

- CLA has observed that ventilator units in Skilled Nursing Facilities staff between a caseload of 10 – 12 ventilator residents per therapist during the day and that these units tend to run at 3.75 to 4 hours per day including Respiratory Therapists.

MDS Coordinator Observations

There are three full-time MDS staff. In most care centers, a census of 45 in post-acute care could be handled by one MDS staff member, however, the high Medicaid population also requires more MDS preparation than in most organizations. At MVCC, the MDS staff is also involved in more than completing the MDSs. Other duties they perform include:

- Writing all of the resident care plans, though they are training other disciplines to participate in the writing of these plans
- Writing all the Care Area Assessments which are completed for all comprehensive assessments
- Attending resident care conferences
- ICD-10 coding
- Monitoring residents on psychoactive medications and coordinating the gradual dose reduction with the care staff, pharmacist and the physician
- Monitoring weight gain and loss

These are functions that are part of different nursing administration roles in other facilities. The MDS coordinators at MVCC are additionally responsible for covering all aspects of case management for Medicare Advantage programs and managed care programs. This involves dealing with case managers at the respective insurance organizations, getting pre-authorization, determining what is covered for the stay, what the approved length of stay is and continuing to send documentation throughout the stay for continued skilled coverage. This process can be time consuming, especially when the managed care/Medicare advantage census is high. Average insurance census was 13.9 and 12.3 residents per day in 2016 and 2017, respectively.

Process Observations

Admissions and MDS process

- The Admissions process was reviewed noting that several referrals were not admitted that could have increased RUGS rates and Medicare admissions. Bed lock issues and a concern by nursing staff on their ability to administer the care needed were cited as the main reasons for these denials.
- Tracy McConnell in the MDS office is certified and believes that with better documentation and a greater focus on MDS coding, revenue can be increased by $600,000 annually. Managing short stay patients properly is a critical factor for increasing revenue per day at MVCC.

- MDS staff is in charge of Utilization Review which can be performed by non-clinical staff to be more efficient.
- MDS staff have been more involved recently in C.N.A. education and should continue to increase the proper recording of ADLs.
- Currently MDS staff are attending every resident care conference (care plan meetings) which is not best practice nor best use of MDS staff time.
- Tracy is working to reinstitute a restorative program and will hopefully start with a walk to dine program soon.
- On the MVCC organizational chart the MDS department reports to nursing yet it typically reports to non-clinical administration for better prioritization of revenue and billing.

Workflow

- The computer/documentation system is slow and cumbersome and poses a number of problems with productivity.
- Staff feel that the decisions are being made from the top down without any input from staff on the floors.
- Some portions of the medical record are still recorded on paper and some are scanned into a different system (laserfiche) than the system being used for daily documentation.
- IT staff are not onsite at the building to assist with the numerous problems that arise with current systems.
- There is not an option for residents to have a telephone in their rooms so personal calls to and from the residents go through the nursing desk which can be time consuming and does not allow for patient privacy and dignity
- C.N.A's complete the vital signs for the shift they work and they manually give them to the nurses who then enter them into the computer which is an inefficient use of nursing time.
- Wall mounted kiosks for the C.N.A's to document care were eliminated in the past.
- A common observation and discussion with nursing staff related to the fact that C.N.A's are currently using laptops to document ADLs but they are the same laptops that the nurses use around the building which often results in a loss of the wireless signal and downtime.

Systems and processes

- The new onboarding method for C.N.A's is very successful and has already shown increased percentage of staff retention. C.N.A turnover had been around 63% with the new orientation this has decreased to 24%. New training for licensed nursing staff should be implemented in the future to improve retention as well.
- The onsite pharmacy is beneficial and convenient however staff have requested a pharmacy cost/evaluation as they feel some of the charges are high or are being charged incorrectly. Current spending on consultation fees is $11,000 a month which is high.
- The onsite lab and phlebotomist are beneficial and could be expanded. Periodic evaluation versus outsourcing should be performed to ensure that it remains cost effective.

- The volunteer program is quite robust and can be used for additional projects. This also represents a strong level of community support.
- The pay structure for the C.N.A's is in a positive range for both attraction and retention, however licensed nursing staff ranges should be reviewed. The perception is that licensed nursing pay rates are $5 below standard in the area but the reported medians are lower than current licensed nursing rates of pay.
- Human Resources has recently begun performing exit interviews which should be continued and reviewed often for trends in the tight labor market.
- HR has converted most requirements to electronic recording including an online application process and a "step one survey" for entry level staff (C.N.A, housekeeping, kitchen, activities etc.). Some applicants get rejected from this process which becomes more efficient for the organization and should be continued. Staff education should be improved on these processes as many employee referrals come from current staff and misunderstanding this process has caused some concerns when applicants are rejected without being called back. Including a call back upon automated rejection would also aid in this communication and understanding.

Staffing

- Due to labor issues, 4 hour shifts have been offered to allow for a better chance of providing proper coverage which have been successful and positive.
- Staff was being mandated to work overtime for a while because staff would not voluntarily pick up shifts when there were holes in the schedule. Keith (nurse/scheduler) and Kristen (assistant administrator) meet weekly to be proactive in filling gaps. They work to allow staff to have their day off and they do not allow anyone to work 16 hours in a row. In most cases, staff may be required to work an additional added (usually half) shift, but morale has improved. They indicated this has been working fairly well but it is time consuming.
- There has been a vacancy in the Director of Nursing position for several months. A previous DON has recently been rehired who has a lot of experience and the ability to make some great changes. CLA met with her and agree that this is a positive step for the nursing staff.
- Overtime has increased because the nurses do not leave promptly at the end of their shift. Staff indicated this is directly related to the inefficient computer system causing documentation requirements to take longer than necessary.
- Based on our discussions, a dedicated staff development coordinator (SDC) is not available to assist with training nurses for annual competencies.

Other

- Due to the closing of the Reflections unit, some long term care residents are in beds on the rehab unit that cannot be transferred off because there are not any open beds elsewhere in the facility. The process of managing beds should be reviewed and beds should be segregated for long and short term care to ensure that more short term beds are available to improve payor mix. Limiting short term and ventilator beds to a distinct area and not allowing these beds to be used for long term care would be beneficial.

- There are a large number of bariatric patients on a regular basis but not enough bariatric equipment to always accommodate these patients. The bathrooms are too small to accommodate these patients as well.
- The therapy room is outdated and antiquated. MVCC offers outpatient therapy but does not have a separate therapy entrance.
- Difficulty in obtaining prime rehab candidates relates mainly to the facility appearance, even with the beauty of the exterior surroundings. Two competitors in the area have buildings with high end finishing and they tend to get the higher quality rehabilitation patients.
- Medication technicians are not currently employed resulting in a greater use of licensed staff than is needed.
- The therapy contract with Aegis was executed in May 2015 with a standard rate of 94 cents per minute which is within the benchmark range of 90 cents to $1.10 per minute. Productivity reports are not received from the current therapy provider. Therapy staffs six days per week and could be broadened to include seven days as best practice to maximize rehabilitation for short term residents.
- Concerns were discussed related to the new Requirements of Participation ("Megarule") which have not been fully evaluated for needed implementation.
- Overall, staff believe that marketing to hospitals is lacking. A nurse liaison could be considered to help with obtaining and evaluating for better admissions.

Legacies (3 dementia units)

- The showers in Evergreen Place are very small and outdated. It is difficult for caregivers to provide assistance to the residents due to the cramped quarters and creates a safety risk.
- The dementia units' staff C.N.A's are also recreational aids and spa aids. When staffing is low the spa aids get pulled to work the floor fairly often.
- The dementia units have closed-in nursing stations behind thick walls of glass. Remodeling these is likely to improve the space, however, a locked medication storage solution would also be needed.
- This unit can also be used as an overflow unit for short term therapy patients through proper planning and bed management.
- There are private rooms on this unit but shared bathrooms which is a big complaint of residents and family members.
- There are 5 vent capable facilities in the state. Recently, more admissions were turned down that CLA believes could have been accepted. Admission decisions have been delegated to the floor nurses who were reportedly uncomfortable and did not have time to properly evaluate the admissions.

Southern Reflections (2nd floor unit)

- This unit is currently closed due to staffing concerns and a desire to reduce beds at MVCC.
- Staff have indicated if a remodel moves forward it would make the most sense to start here since it is already closed.

Nursing Administration

The benchmark that CLA has developed for Nursing Hours Per Patient Day in Administration including all supervisors/managers, MDS and admission nurses, unit clerks, medical records and is .50 hours.

MVCC is within the range of the benchmark with the 2016 average census of 202 as well as at a lower census of 185 more recently experienced as noted below:

	Nursing Administration Per Organizational Chart Hours Based on Budgeted FTEs	
Average Census	202	185
	Hours per Week	
DON	40.0	40.0
Unit Supervisors	120.0	120.0
MDS Nurses	120.0	120.0
Staff Enrichment Coordinator	40.0	40.0
Infection Control	20.0	20.0
Admissions Coordinator	40.0	40.0
Scheduler	40.0	40.0
Unit Clerks	156.0	156.0
Logistics Worker	32.0	32.0
RN Supervisor PM	56.0	56.0
	664	664
Nursing Administration HPRD	0.47	0.51
Benchmark	0.50	0.50

Average census could drop to 170 before administration staffing would be outside of an appropriate range of the benchmark.

Dietary

Food costs per resident day and per meal are above the benchmarks. Raw Food costs were also higher. Dietary costs are allocated from a shared kitchen for all service lines provided by North Central Health Care. We reviewed the allocations based on meals served which are reasonable. MVCC also has several dining venues and a shared employee and guest café which can make accounting complex. At least one of these dining rooms provides an onsite chef offering a personal choice menu for residents at one meal per day. While this type of person centered care and choice fits the mission of NCHC and is certainly a key industry goal, overall cost management needs to accompany this trend as reimbursement has not been increased for providing this service.

Other common problems in senior living dietary departments include inventory management, food cost management and efficient delivery of meals. MVCC should review their procedures for these areas annually and involve vendors to aid in management and cost control.

With information gathered in interviews, from payroll and staffing and from financial reports, CLA calculated productivity, meal counts total dietary and raw food costs per meal and resident day.

- Overall, productivity is lower than the typical benchmark of 4 to 5 meals served per productive staff hour
- Dietary food costs per meal and per day are also higher than the benchmarks by 50.1%
- Raw food costs are higher than the benchmark by 15.7%

The actual results as compared to benchmarks noted above indicate that the cost of preparing and serving meals is affecting the financial performance of the dietary department more significantly than the raw food costs.

The following chart presents the findings from these calculations:

Meal Count Calulations	MVCC	Benchmark
Daily Production Hours	200.9	
Average Meal Prod/day	651	
Meals per labor hour	3.24	4 to 5
Dietary Costs/Meal	$8.60	$5.73
Dietary Costs/Day	$25.81	$17.19
Raw Food Cost/Meal	$2.54	$2.20
Raw Food Cost/Day	$7.63	$6.59

Notes:

- Dietary Revenue was not used to offset costs in these calculations
- The Medicaid cost report noted 221,000 meals served in 2016 while CLA estimated 237,615 meals served based on average census and employee meal estimates provided by management. 237,615 meals were used in the calculations above
- In 2016, the allocation percentage based on meals prepared was 74.5% for MVCC versus other programs

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Quality Executive Summary
July 2017

Organizational Outcomes

People

- **Vacancy Rate**
  The vacancy rate decreased in the month of June to 10.9%. We did have 18 new employee's start in the June orientation. The July orientation had an additional 21 new employees start.

- **Employee Retention Rate**
  Employee Retention Rate is currently at 85.1% which is exceeding the NCHC target of 75-80%. In June the retention rate decreased by just under 2%. One significant event for retention is that the Nursing Home had 0 terminations, both voluntary and involuntary, in the month of June.

Service

- **Patient Experience**
  There was a slight downward movement in the number of surveys returned and the percent of patients ranking their overall experience at a 9 or 10 (10 point scale) at 68.3 % in June which does not achieve NCHC's target of 77-88% and is the lowest result to date. Year to date, through the end of June, is 74.3%, just short of the minimum target of 77%. However, July is showing some improvement. Individual programs achieving the target of 77-88% in June included: Lakeside Recovery (MMT), Merrill Telepsychiatry, Aquatic, Birth to Three, Community Treatment, Wausau ADS, Antigo ADS/Prevocational, Wausau Prevocational and Residential Services. Programs continue to integrate specific actions based on the priority analysis data specific to the program and it is showing improvement.

Clinical

- **Nursing Home Readmissions**
  The rate of readmissions to the hospital within 30 days in June was 10.3% bringing YTD rate to 11.6%, within target and benchmark. All acute care transfers are reviewed to identify areas for improvement

- **Hospital Readmissions**
  The rate of readmissions within 30 days is within the target range for the month of June at 10.9%. Year to date is slightly above target at 11.9%. All readmissions continue to be reviewed as we continue to strive to make this decrease. Readmission within the 0-10 day range has decreased but will continue to be monitored as the Outpatient and Community Treatment teams continue to work on best practices for continuum of care standards and to avoid readmission to the hospital within the first ten days.

- **AOD Relapse Rate**

  The rate of patients who complete treatment programing in either our AODA Day Treatment or Medically Monitored 21 Day program who reuse substances within 7 days in the month of June was 100% but this is only one person reporting at the 7 day follow-up. Year to date continues to exceed target at 16.8%. This is significantly better than industry benchmark 36-40%.

Community

- **Access Rate for Behavioral Health Services**

  Access rates remain below target year-to-date. Analysis indicates Outpatient and Community Treatment programs continue to struggle to meet target. The month of June, Outpatient was at 77% and Community Treatment was at 16%. Community Treatment continues to hire additional case managers to compensate for the communities increased need for their services. Outpatient continues to struggle in Lincoln and Langlade Counties where both locations are struggling to recruit therapists to meet the need.

Finance

- **Direct Expense/Gross Patient Revenue**

  Year to date expense to revenue ratio is steady at 61% within target of 60-64%. The month of June was at 60% which is at target. Extreme focus this year on cost management by individual departments has been the impact.

Safety Outcomes

Patient/Resident Adverse Events

Rates for June are 3.2 adverse events/1000 patient days/visits. Year to date rate is 4.0/1000 patient days/visits remains below 2016 overall rate. Noted improvement in the overall number of falls and medication errors in the month, the Nursing Home decreased number was the contributing factor.

Employee Adverse Events

Rates for June were .03 adverse events/1000 employee hours. June had significantly less adverse events at 3, compared to previous 5 months average of 10.8 per month.

Program-Specific Outcomes-*items not addressed in analysis above*

The following elements reported are highlights of focus elements at the program-specific level. They do not represent all data elements monitored by a given department/program.

Human Service Operations

- **Outpatient Services:**

  Initiated monitoring of immediate follow-up for post-hospital patients to ensure smooth transition and reduce risk of readmission. Improvement has decreased during the month of June to a 69.6% success rate which remains well below target of 90-95%. A collaborative action team to revise discharge planning and ensure smooth transition has been established which included both Outpatient Services and BHS Hospital Leaders.

- **Inpatient Behavioral Health:**
  Outpatient and Inpatient share the measure of access to services at hospital discharge. The concentration has been to make appointments as soon as staff know an approximate discharge date, to ensure a short and smooth transition to Outpatient from the Hospital.

- **Community Treatment:**
  Access within best practice timeframes continues to be significantly below target. A process improvement team has been established to address this. To help reduce the wait time for entering the Community Treatment Program, they have increased staffing to ensure all those who need services are able to receive those services.

- **Lakeside Recovery (MMT):**
  The rate of patients who complete the treatment program who reuse substances within 7 days year-to-date is 7.1%, significantly better than industry benchmark 36-40%. The month of June showed 100% relapse rate; this is with only one follow-up response from graduates within the month.

- **Aquatic:**
  Year to date rate of consumers working on pain management has shown a decrease in their pain levels currently is 90.9% which is within their target of 90-95%

- **Birth-3:**
  A system to measure availability for early intervention was established to ensure access and positive financial productivity. June was below target at 364 with their goal of 481-491 per month. They are continuing to look at opportunities to increase this number the number of appointments and increase access to clients. With new staff coming on in the month of July, this number should begin to increase.

- **Residential and Pre-Vocational Services:**
  It has been identified that employee vacancy rate in residential services is a critical issue. The year-to-date is above the targeted goal at 18.4% with a target of 6-9% or below. Contributing factors were due to a retirement and a termination in the month of June. To date in the month of July there have been 3 terminations and expect this number to grow for the month. Actions being taken include improvements in recruiting strategies, onboarding, and retention.

Nursing Home

Occupancy Rate based on a 220 licensed beds is at 85.4 %. Some impacts on census include: In February, Long Term Care decreased its available beds due to staffing issues and low LTC referrals. This did cause a bed lock when residents on Post-Acute Care needed to transfer residents to LTC. Reviews of long term bed needs are being discussed. Also the nursing home is looking at the financial burden, it is scrutinizing referral payer sources ensuring payer plans cover cost of stay and ordered medications costs are not exceedingly high.

Support Departments

- **Communication and Marketing:**
  Year-to-date, a 12.7 % increase in the number of "hits" on the NCHC employment page has been achieved with a target of 15%.

- **Health Information:**
  Health Information has achieved a 92.1 % completion of health records within 25 days post-discharge exceeding target set at 80-85%.

- **Nutritional Services:**
  Nutritional Services is hitting their target of 90-95% with a score year to date of 94% of patient/resident satisfaction rating with food temperatures year-to-date.

- **Pharmacy**:
  Dispensing error rates are below target at .09% with a target of .081-.90%.

- **Volunteers:**
  Continues to progress toward target to recruit 35 or more new volunteers in 2017. They currently have a total of 23 new volunteer's year to date through June.

- **Adult Protective Services:**
  The percent of at-risk investigations completed and closed within 30 days is currently at 63% year to date. This is below their target of 70-80%. Process improvements continue.

- **Demand Transportation:**
  Double occupancy per trip numbers have been steadily increasing and in June was within target at 46. The average year to date is 36 per month. Continued process improvements are underway.

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QUALITY OUTCOME DASHBOARD

DEPARTMENT: NORTH CENTRAL HEALTH CARE

FISCAL YEAR: 2017

PRIMARY OUTCOME GOAL	Continuous Improvement Target	Benchmark	⇧⇩	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD	2016
PEOPLE																	
Vacancy Rate	**5-7%**	**N/A**	⇩	13.1%	13.1%	10.3%	10.6%	13.2%	10.9%							**10.9%**	**7.1%**
Retention Rate	**75-80%**	**N/A**	⇧	98.0%	95.3%	93.6%	90.2%	87.0%	85.1%							**85.1%**	****
SERVICE																	
Patient Experience: % Top Box Rate	**77-88%**	**N/A**	⇧	69.0%	70.6%	76.7%	77.2%	79.7%	68.3%							**74.3%**	****
CLINICAL																	
Nursing Home Readmission Rate	**11-13%**	**17.3%**	⇩	15.2%	14.8%	0.0%	13.3%	12.5%	10.3%							**11.6%**	**11.5%**
Psychiatric Hospital Readmission Rate	**9-11%**	**15.5%**	⇩	4.8%	21.8%	11.3%	10.4%	12.3%	10.9%							**11.9%**	**10.9%**
AODA Relapse Rate	**36-40%**	**40-60%**	⇩	20.0%	12.5%	11.1%	0.0%	18.6%	100.0%							**16.8%**	****
COMMUNITY																	
Access to Behavioral Health Services	**90-95%**	**NA**	⇧	73%	61%	67%	72%	69%	73%							**69%**	**80%**
FINANCE																	
***Direct Expense/Gross Patient Revenue**	**60-64%**	**N/A**	⇩	66%	62%	62%	59%	56%	60%							**61%**	**65%**

KEY: ⇧ **Higher rates are positive**

⇩ **Lower rates are positive**

*** Monthly Rates are Annualized**

Target is based on a 10%-25% improvement from previous year performance or industry benchmarks.

NCHC OUTCOME DEFINITIONS

PEOPLE	
Vacancy Rate	Total number of vacant positions as of month end divided by total number of authorized positions as of month end.
Retention Rate	Number of employees onboard on January 1st who remain employed divided the number of employees onboard on January 1st.
SERVICE	
Patient Experience: % Top Box Rate	Percent of level 9 and 10 responses to the Overall satisfaction rating question on the survey. *Benchmark: HealthStream 2016 Top Box Data*
CLINICAL	
Nursing Home Readmission Rate	Number of residents re-hospitalized within 30 days of admission to nursing home / total admissions. *Benchmark: American Health Care Association/National Center for Assistive Living (AHCA/NCAL) Quality Initiative*
Psychiatric Hospital Readmission Rate	Percent of patients who are readmitted within 30 days of discharge from the Inpatient Behavioral Health hospital for Mental Health primary diagnosis. *Benchmark: Medicare Psychiatric Patients & Readmissions in Impatient Psychiatric Facility Prospective Payment System, May, 2013, The Moran Company*
AODA Relapse Rate	Percent of patients graduated from Lakeside Recovery MMT program and/or Day Treatment program that relapse within 7 days post discharge. *Benchmark: National Institute of Drug Abuse: Drugs, Brains, and Behavior: The Science of Addiction*
COMMUNITY	
NCHC Access	% of clients obtaining services within the Best Practice timeframes in NCHC programs. • Adult Day Services - within 2 weeks of receiving required enrollment documents • Aquatic Services - within 2 weeks of referral or client phone requests • Birth to 3 - within 45 days of referral • Community Corner Clubhouse - within 2 weeks • Community Treatment - within 60 days of referral • Outpatient Services * within 4 days following screen by referral coordinator for counseling or non-hospitalized patients, * within 4 days following discharge for counseling/post-discharge check, and * 14 days from hospital discharge to psychiatry visit • Prevocational Services - within 2 weeks of receiving required enrollment documents • Residential Services - within 1 month of referral
FINANCE	
Direct Expense/Gross Patient Revenue	Percentage of total direct expense compared to gross revenue.

Plan of Action Tactics	Accountability	Start Date	Measures of Success	Interim Updates	Status	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Appointment of RCA Members	Counties	Dec-16	Appointment	Appointments - Marathon County: Supervisor E.J. Stark, Deputy Administrator Lance Leonard; Lincoln County: Nancy Bergstrom Corporation Counsel; Langlade County: Robin Stowe. E.J. Stark resigned prior to starting and Mararthon County appointed Chief Deputy Chad Billeb in his place. Meeting dates are set for 2017.	Completed												
Appointment of NCCSP Board Members	Counties	Jan-17	Appointment	Marathon County Appointments have been recommended and confirmed Sheriff Scott Parks and County Supervisor Robinson resigned from the NCCSP Board in early 2017. Marathon County has appointed Theresa Wetzsteon, Marathon County's District Attorney in place of Sheriff Parks. The seat vacated by Supervisor Robinson was filled by Supervisor Rick Seefeldt.	Completed												
Annual Audit	NCCSP	Jan-17	Acceptance of annual audit by NCCSP Board and Counties	The audit was presented to the March 30, 2017 NCCSP Board meeting. Members of the RCA were invited to the audit presentation and provided copies of the audit documents. The RCA accepted the audit at their April 27th agenda to formally close the annual audit process.	Completed												
Policy Governance for the NCCSP Board	NCCSP	Jan-17	Policy Governance Manual Approved	A policy governance approach is recommended for the NCCSP Board to consider to delineate authorities of the NCCSP Board delegated to the CEO and decisions vested with the NCCSP Board. This approach will also provide a definition of Board end statements which align with the direction from the RCA. The Board will need to reconsider the Committee structure, especially as it relates to any potential governance change with Mount View Care Center. The Board held an Educational Presentation on policy governance at the March meeting and endorsed moving forward with exploring a Policy Governance approach. The Board held a retreat in June to start the work on the purpose of the board and its end statements. The Board will continue this work at the end of each Board meeting for the coming months with a target completion date of November.	Open												
Prepare Local Plan	NCCSP	Jan-17	Adopted 3 Year Local Plan	The Agreement requires the NCCSP Board to develop a 3 Year Local Plan to meet the needs of the Communities it serves. This project will have to be done in coordination with the RCA to establish a vision for an end product. At this time the work on this item has not begun.	Open												
Nursing Home Governance	NCCSP	Jan-17	Decision by Marathon County of the future of MVCC and a decision by both Marathon County and NCCSP on a management agreement with NCCSP	The operational and financial assessment of Mount View Care Center was delivered on July 1. Both the NCCSP Nursing Home Operations Committee and the Marathon County Mount View Care Center Committee met jointly with the consultants on July 11th and will do so again on July 31st. We are currently preparing for the next meeting with the consultants on July 31st to start the 3-5 year strategy discussion. The next meeting with review a strategic action register which will become the work plan based on the recommendations from the operational assessment. We expect the MVCC Committee to make recommendations to the full County Board sometime mid-Fall.	Open												

Plan of Action Tactics	Accountability	Start Date	Measures of Success	Interim Updates	Status	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Pool Management Governance	NCCSP	Jan-17	Decision by Marathon County on the future of the pool and on a future management agreement with NCCSP	The full County Board will vote in September on the project which will require the 3/4ths super majority support of the County Board to move the project forward. Currently, the CEO is working on behalf of the North Central Health Foundation with Steve Anderson to develop the community fundraising campaign. The target for the campaign is $3 Million that would need to be largely raised/pledged prior to the project starting early next year if all steps are successful. We are also working with both State and Federal legislators to identify any potential grant funding. NCHC is preparing to operate the current pool operations throughout 2018.	Open												
Create "arms-length" financial relationship between NCHC and MVCC	NCCSP	Jan-17	Separate financial statements and legal status	The CFO is currently working on the financial statements and budget to enable 2017 financials to be completely separate between the 51.42 program and MVCC. Further consideration will be made on doing the same for the Community Living developmental disability programs.	Open												
Review of Bylaws	NCCSP	Jan-17	Adopted Amended Bylaws	The Board adopted an update to the Bylaws to make them contemporary with the new Tri-County Agreement at their January meeting.	Completed												
Develop Training Plan for each County	NCCSP	Feb-17	Adopted Annual Training Plan	Administration contacted each of the three County administrations to identify training needs on accessing and using NCHC services along with general support for skill enhancement for individual county departments sharing in the responsibility for our managed population. The process was initiated in a request to each County's Corporation Counsels. No requests were made at this time but NCHC will be open and willing to fulfill any future requests not contemplated at this time. There will likely be some direction from the RCA on annual training expectations as part of their performance expectation responsbilities.	Completed												
CEO Selection Plan and Recommendation	NCCSP	Feb-17	Adopted CEO Recruitment Plan	The NCHC Executive Committee received feedback from the RCA in June on both the job description and recruitment plan for the CEO selection process. At the July NCHC Executive Committee meeting the Committee took the feedback and put together their vision for the position, recruitment plan and job description for the CEO selection process. This information was shared in a joint meeting with the RCA on July 18th. There remains much disagreement about the scope of the CEO position and what distinguishes it from other County Human Services Directors that would justify the current compensation plan. It appears that additional justification is needed to substantiate the existence of the CEO position and the scope of what NCHC is. The CEO was tasked with working with the Deputy County Administrator to develop an anaylsis of these issues to provide support for the RCA members to justify what makes NCHC different than other County Departments that would allow them to adopt the current compensation plan and to endorse the initiation of a search process.	Open												
Facility Use Agreements	NCCSP	Mar-17	Signed agreements with each of the three Counties	This initiative has not begun.	Open												

Plan of Action Tactics	Accountability	Start Date	Measures of Success	Interim Updates	Status	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Develop Conflict Resolution Protocol	NCCSP	Apr-17	Board adoption of Conflict Resolution Protocol	The NCCSP Board reviewed the draft policy at their April meeting. Once reviewed it will be forwarded to County Administrations for each of the three Counties for input prior to final adoption of the NCCSP Board. Langlade and Lincoln Counties have provided input thus far. The policy is slated for action but is currently still be drafted with County input.	Open												
County Fund Balance Reconciliation	NCCSP	Apr-17	Fund Balance Presentation	Presented to the NCCSP Board for acceptance on March 30th.	Completed												
Annual Report	NCCSP	May-17	Annual Report Release	The Annual Report was presented to the NCCSP Board and will be prepared for release following the May meeting. Presented the annual report to Langlade County. Hard copies were sent to all members of the three County Boards .	Completed												
Review of Personnel Policies	NCCSP	Sep-17	Appropriate Policies Identified and Adopted	The NCCSP Board reviewed the Employee Compensation Policy and Administration Manual at their April meeting. The NCCSP Board adopted the policy and plan. The full plan was forwarded to the RCA in July who will now review and adopt the policy and plan, with any recommended changes, prior to August 15th, and send the adopted policy back to the NCCSP Board for implementation.	Completed												
Programs and Services Report	NCCSP	Bi-annually	RCA Accepts Report	The RCA will need to define the structure, substance and timing of this report.	Open												
Financial Review	NCCSP	Bi-annually	Meeting held between the County Finance Directors and CFO and follow-up items addressed	The CFO has reached out to each of the Finance Directors in the time before and following the audit to check-in. Nothing of significance to report.	Completed												
Annual Budget	RCA	Feb-17	Adopted Budget within Budgetary Direction of the RCA and NCCSP Board	The RCA has provided the 2018 budget guidelines and priorities. These were shared with the NCCSP Board and will be incorporated into the 2018 Budget development. The Budget is currently in active development and is slated to be delivered to the NCCSP Board in August for recommendation to the RCA.	Open												
CEO Annual Work Plan	RCA	Feb-17	Adopted Work Plan	This documet serves as the work plan document.	Completed												
CEO Compensation Plan	RCA	Jun-17	Adopted Plan	To coincide with the CEO recruitment process but is required at least annually. The RCA will review this plan in July and will recommend a plan to implement to the NCCSP Board in August.	Open												
Bylaws of the RCA	RCA	Feb-17	Adopted Bylaws	Finalized at the February meeting	Completed												
Determine "Substantially Modify" Criteria and Application Structure	RCA	Feb-17	Agreed upon guidelines and Application process	Definition and adoption done at the February RCA meeting. The CEO and committee members will brief each of their committees/boards on the resolution of this item. The NCCSP Board reviewed this policy and guideline at their March meeting.	Completed												
Non-CEO Employee Compensation Plan	RCA	Mar-17	Adopted Plan	Compensation plan and policies sent to the RCA members for review and consideration. Will review in July and forward back to the NCCSP Board in August for Implementation.	Open												
Capital Improvement Policy	RCA	Mar-17	Develop comprehensive CIP Policy for NCCSP and RCA adoption	No activity on this intiative to report.	Open												
CEO Appraisal Process Design	RCA	Mar-17	Written Assessment Process and Documents	No activity on this intiative to report.	Open												
Performance Standards	RCA	Mar-17	Adopted Annual Performance Standards	The draft list of Performance Outcomes and Expectations continues to be developed. A substantial bulk of the work has been completed with continued refinement expected as this will be a working document going forward. A list for implementation will be determined in August or September.	Open												

Plan of Action Tactics	Accountability	Start Date	Measures of Success	Interim Updates	Status	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Reserve Policy Review	RCA	Apr-17	CFO will meet with County Finance Directors annually to review Audit and Financial performance relative to reserve policy and status		Completed												
Selection of NCCSP Auditor	RCA	Apr-17	RFP and seleciton of auditing firm	Four firms responded to the RFP and were interviewed by NCHC in July. A recommendation to sign a three-year agreement with WIPFLI was provided to and adopted by the RCA at their July meeting.	Completed												
Tri-County Contral Annual Review	RCA	Oct-17	Revision Recommendation to County Boards if necessary	No activity on this intiative to report.	Open												