**OFFICIAL NOTICE AND AGENDA**

of a **Joint** meeting of the **Nursing Home Operations Committee and the
Marathon County Mount View Care Center Committee** to be held at **North Central Health Care
1100 Lake View Drive, Wausau, WI 54403, Board Room** at **7:00 p.m.** on **Tuesday, July 11th, 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.

1. Call Meeting to Order
2. Public Comment for Matters Appearing on the Agenda
3. Approval of the May 31, 2017 Mount View Care Center Meeting Minutes
4. Educational Presentations/Outcome Monitoring Report
   a. Presentation of the Operational Analysis and Strategic Plan by the Firm of Clifton Larson Allen
5. Policy Issues Discussion and Committee Determination to the County Board for its Consideration
   None
6. Scheduling of Future Meetings and Identifying Agenda Topics
   Next Joint meeting scheduled for Wednesday, July 26, 2017 at 7:00 p.m.
7. Announcements
8. Adjournment

_____

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: __07/06/17__  TIME:__4:00 p.m.__

# MOUNT VIEW CARE CENTER (MVCC) COMMITTEE
**MINUTES**

**Wednesday, May 31, 2017 at 7:00 p.m.**
**Mount View Care Center, First Floor Dining Room, 2400 Marshall St, Wausau WI**

| Attendance: | Present | Absent |
|---|---|---|
| John Robinson, Chair | X | |
| Katie Rosenberg, Vice-Chair | X | |
| Tim Buttke | X | |
| Allen Drabek | X | |
| Deb Hager | | EX |
| Jack Hoogendyk | X | |

**Others Present:**    Brad Karger, Michael Loy, Bill Metter, Kim Gochanour, Brian Kowalski

1. **Call Meeting to Order**
   Meeting was called to order by Chair John Robinson at 7:00 p.m.  John received several complaints on the speed of his recovery and he credited aquatic therapy as a key factor to his personal success.

2. **Prior Meeting Minutes**
   **MOTION BY ROSENBERG; SECOND BY DRABEK TO APPROVE THE MINUTES OF THE APRIL 26, 2017 MEETING.  MOTION CARRIED.**

3. **Educational Presentations/Outcome Monitoring Reports**
   A.  The Regulatory Environment that MVCC Operates Within
       1.  Recent Survey Results
   *Discussion:*
   Kim Grochanour reviewed with the committee a Power Point presentation regarding MVCC's survey history, pre-survey preparation, issues monitored in a survey, correction plans, quality measures and reports:.
   - CMS, the federal agency that oversees Medicare and Medicaid, contracts with State Government to conduct nursing home surveys.
   - Key areas that are monitored include:
     1. Infection Control
     2. Resident care plan
     3. Physical environment
     4. Nursing standards
     5. Dining/Food preparation
     6. Accident prevention
     7. Caregiver misconduct
   - Problems identified must have a corrective plan submitted within 10 days.
   - "F-tags" involve Medicare and Medicaid requirements.  Most surveys center on F-tags and not near as much on State tags which involve State regulations
   - In preparing for a survey reviewing the progress made on past citations is critical.
   - Additionally, other factors are reviewed:
     - ☐ Resident Council concerns
     - ☐ Complaints
     - ☐ Top 10 survey citations in Wisconsin
     - ☐ Other area nursing home citations
   - Violations can be self-reported.  Inspectors will ask:
     - ☐ When did you know?
       - ☐ What did you do about it?

- The cost of compliance with regulations is significant. We estimate that 30% of our nurses' time is invested in documentation.
- You can quickly compare survey results and quality measures of area nursing homes on Medicare.gov.
- All violations are not equal. Surveyors will group violations into categories based upon severity/harm and scope.
  - A finding that presents immediate jeopardy to resident safety/health and is widespread, pervasive throughout the facility in a category "L".
  - A finding that presents no actual harm and no potential for more than minimal harm and is isolated, one or very limited number of residents affected in a category "A".
- Resident Rights include:
  - Privacy and confidentiality
  - Access and visitation
  - Free choice of physician
  - Informed of health status
  - Management of finances
  - Send, receive and open mail
  - Access to telephone
  - Access to stationary
- CMS Nursing Home compares Five-Star ratings of nursing homes measures quality in these areas:
  - Health Inspection
  - Quality measures
  - Staffing
  - RN staffing

We most recently (3/31/2017) have been assigned 5 stars in RN staffing. Four stars in quality measures and staffing. Two stars in health inspections and three stars for overall quality.

The 5 star report is important because it is relied upon by potential customers and referral sources in making a placement decision among alternatives.

B. Financial Update on MVCC

*Discussion:*

The primary reason that we contracted with Clifton, Larson, Allen (CLA) to conduct an operational analysis and strategic plan is that MVCC struggles financially.

The County provides MVCC a 1.7 million dollar allocation from tax levy and we receive federal supplemental payments to mitigate losses, but even with both in place, we had significant losses in 2014-2016. These losses occurred because of changes in census, plus reimbursement levels for many services that are well below our costs. All this would be much worse without the profits generated by the ventilator program.

Simply changing census or service lines is complicated by the inability to recruit staff.

Much of the current financial situation was anticipated by Wipfli when they evaluated the need for building renovations.

At the July meeting committee members will hear a report from CLA which includes a plan to move MVCC forward operationally and financially.

4. **Policy Issues Discussion and Committee Determination to the County Board for its Consideration** - None

5. **Scheduling of Future Meetings and Identifying Agenda Topics**

Committee members felt that they had learned enough from staff about nursing home operations and decided to cancel its June 25 meeting in favor of two July meetings:

<div align="center">
July 11, at 7:00 p.m.

July 26, at 7:00 p.m.
</div>

At these meetings, CLA will present its report, findings and recommendations.  The NCHC Nursing Home Operations Committee will be invited to participate in both meetings.

6. **Announcements**:  Prior to adjournment Bill Metter expressed appreciation for the thoughtful approach that the MVCC Committee had taken to learning about nursing home operations and he is looking forward to working with the committee in charting a new future for the facility.

7. **Adjournment**
   **MOTION BY BUTTKE; SECOND BY ROSENBERG TO ADJOURN THE MEETING.  MOTION CARRIED.**  Meeting adjourned at 8:35 p.m.

Minutes Prepared
By Brad Karger
on June 7, 2017

June 2017

# North Central Health Care - Mount View Care Center

## Financial and Operational Assessment Report

*Prepared by:*
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# GLOSSARY OF TERMS

- ❖ <u>MDS</u>- 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

- ❖ <u>QAPI</u>- 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)

- ❖ <u>ADL</u> – 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

- ❖ <u>CMS</u> – Center for Medicare and Medicaid Services

- ❖ <u>RUG</u> – 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

- ❖ <u>Medicare PPS</u> – 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

- ❖ <u>EMR</u> – 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

- ❖ <u>DON</u> – Director of Nursing

- ❖ <u>ADON</u> – Assistant Director of Nursing

- ❖ <u>RN</u> – Registered Nurse

- ❖ <u>LPN</u> – Licensed Practical Nurse

- ❖ <u>C.N.A</u>. – Certified Nursing Assistant

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# 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.

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## 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<br><br>• 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.<br><br>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.

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- 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<br><br>• Current average Medicare rate at $473 vs state median of $476<br><br>• Clinical assessment leadership and expertise is now in place<br><br>• 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.<br><br>10. Assess RUGs scores monthly to determine if they are accurately capturing all ADLs and services provided, resulting in increased daily rates.<br><br>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.<br><br>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<br><br>• 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.<br><br>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

- 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

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.

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<br><br>• 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.<br><br>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<br><br>• Legal opinion restricts the ability to assess a fee per county resident and would require a set percentage or absolute amount of expected costs<br><br>• 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.<br><br>22. Counties throughout the country are struggling to manage health care costs both internally and externally.<br><br>23. The risk of creating a commission for MVCC is greater than the potential reward. We believe the |

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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 | | County/ Wisconsin | Potential Improvements |
| --- | --- | --- | --- |
| | MVCC | Median | 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:
  o Hospital Readmissions
  o Emergency Department Visits
  o 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.

## Occupancy and Payor Mix
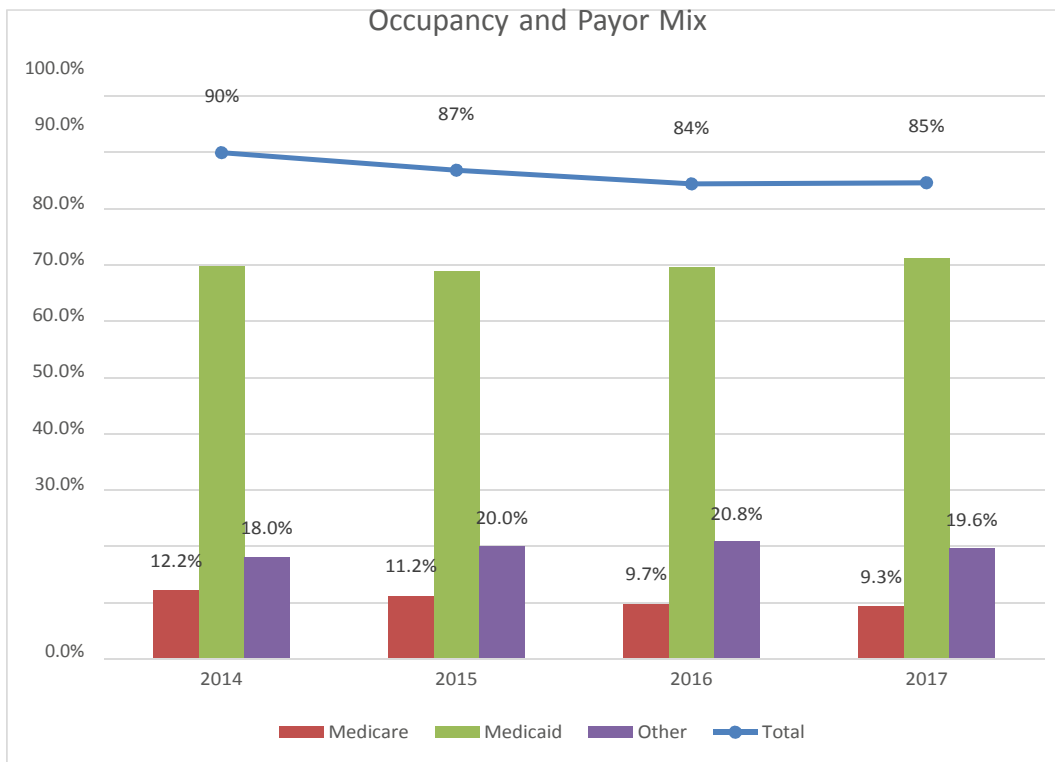


We also noted that while Other census days (private pay and insurance) have stayed relatively constant, Medicare census days have declined being replaced by Medicaid census days. Based on our discussions with staff, this change is partially related to Medicare referrals that were not admitted due to 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.

**Discharge Trend**

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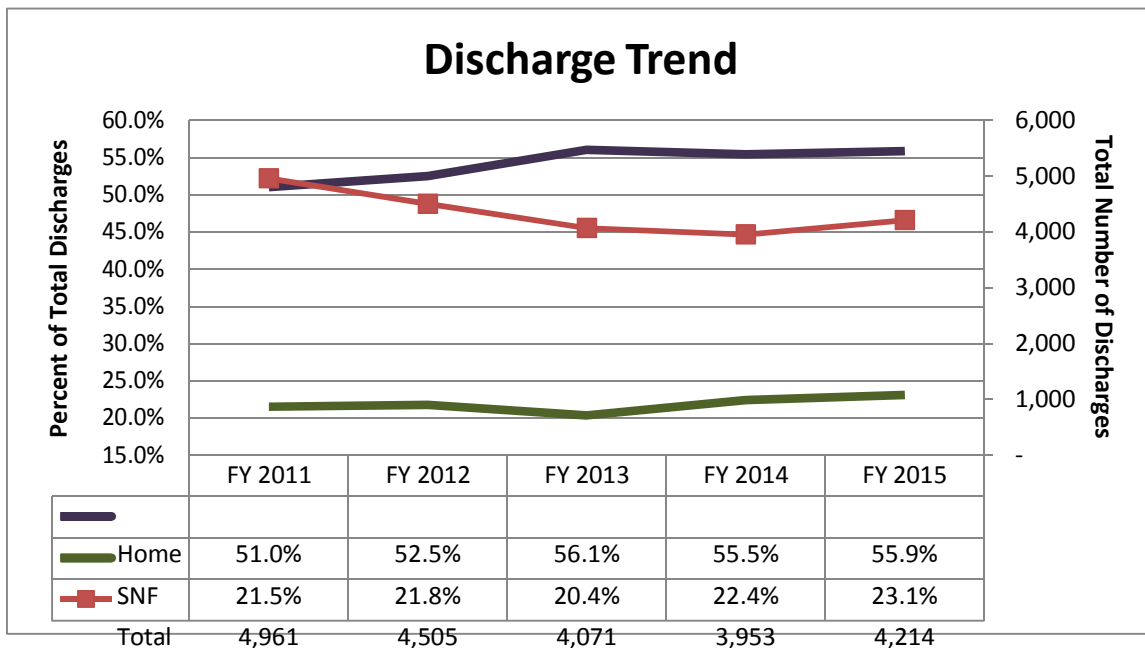
Other discharge destinations in 2015 were other acute care facilities (17%) and deaths (5%.)

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.

**Five Star Rating Analysis**
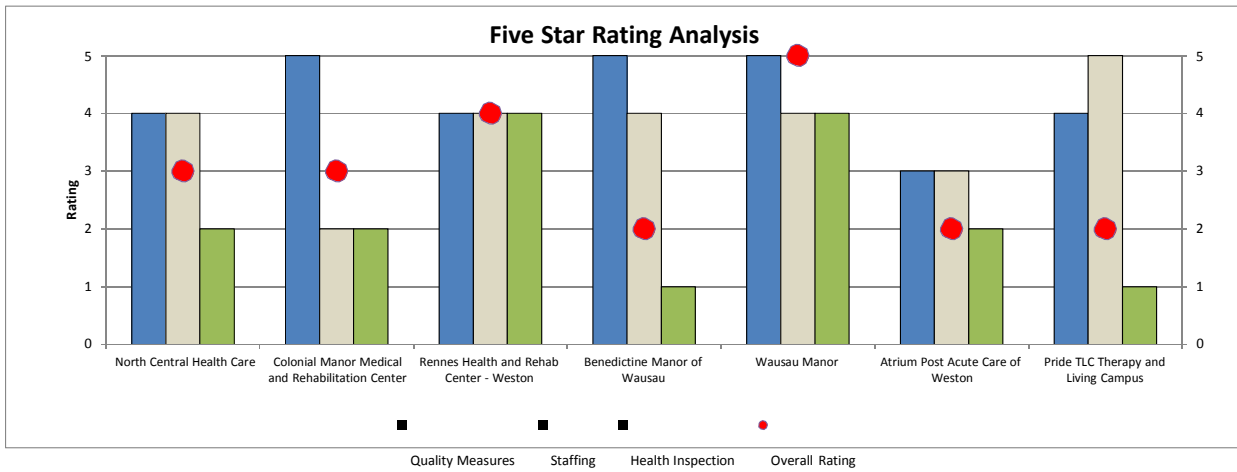


As can be seen in the chart above, MVCC is still positioned well in the market according to the 5 star rating system. It should be noted that all competitors other than Rennes Health and Rehab and Wausau Manor have a health inspection rating of 2 stars or less. Rennes and Wausau Manor have upcoming inspections 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:

**Hospital Readmission %'s for the SNFs in the Peer Comparison Group**
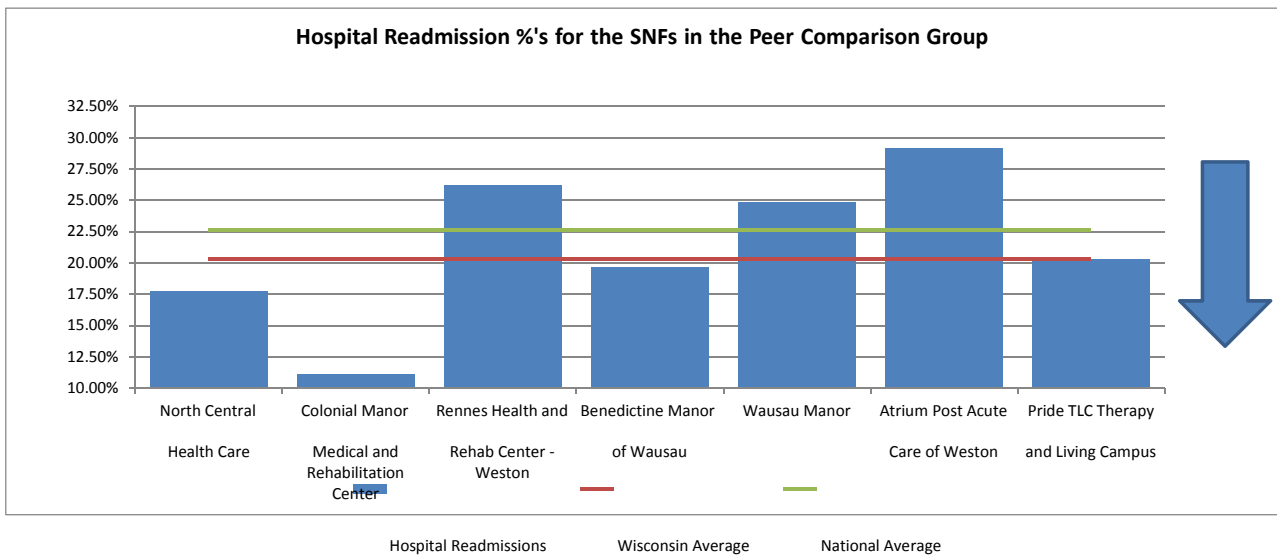
**ED Visit %'s for the SNFs in the Peer Comparison Group**
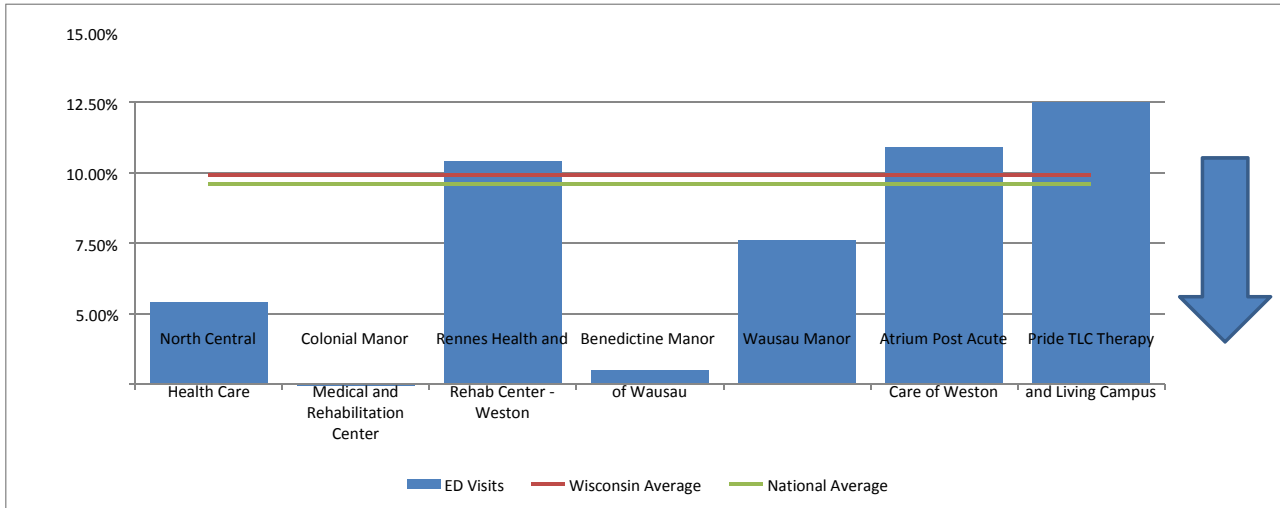


**Discharged to the Community %'s for the SNFs in the Peer Comparison Group**
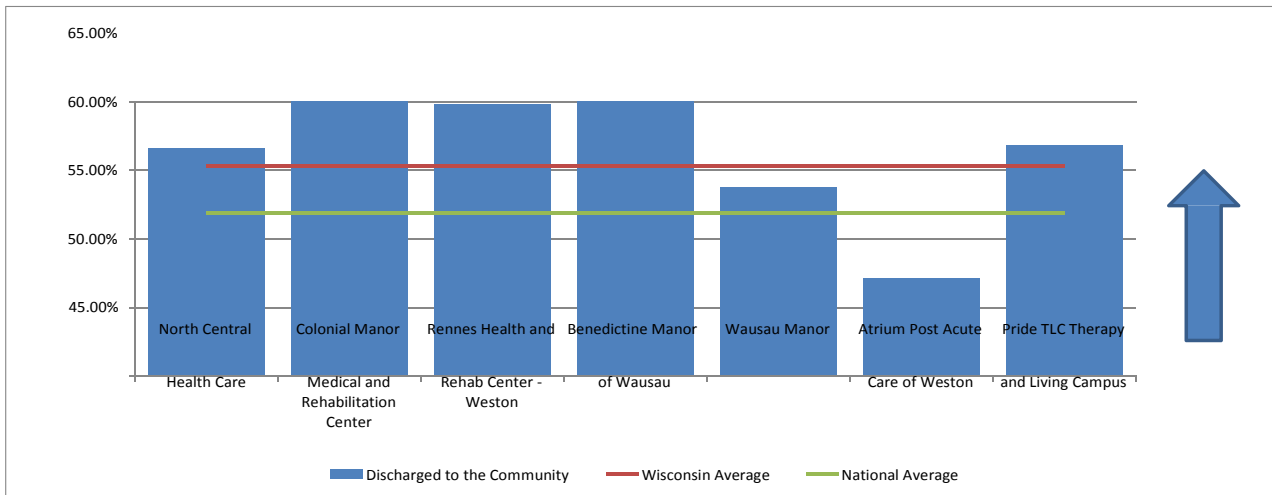


In each of these cases, MVCC is performing above most of its competitors as well as the national and state averages. Continued focus on these measures should be maintained and improved where possible. Ongoing discussions with Aspirus and other referring hospitals should also be a key focus.

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 .70compared 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**
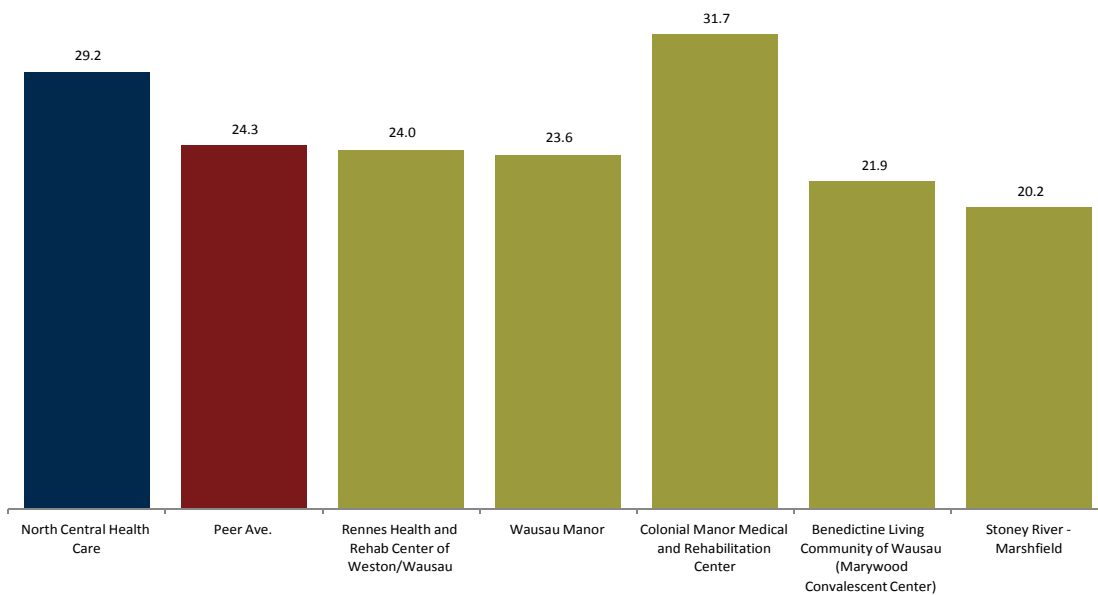


## Referrals

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.)

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# 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 |

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| 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% | | 51% | 100% |
| Long Term Care | 10% | | 81% | | 100% |
| Legacies | 20% | | 72% | | 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 |

<u>Recommendations:</u>

- 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:



| Mount View Care Center | ($000s) | Years 2017 - 2026 | Strategic Financial Planning Model |
| --- | --- | --- | --- |

**2017 PERFORMANCE** — Basis = 2016 Actual

($2.7M) / -9.9% 2017 Operating Margin

**REVENUE AND EXPENSE INFLATION**

| Skilled Nursing | 2018/2019 | 2020+ | Legacies | 2018/2019 | 2020+ |
| --- | --- | --- | --- | --- | --- |
| Medicare | 1.00% | 1.00% | Medicaid | 1.00% | 1.00% |
| Medicaid | 1.00% | 1.00% | Private | 3.00% | 3.00% |
| Private | 3.00% | 3.00% | Medicare | 1.00% | 1.00% |
| Other | 1.00% | 1.00% | | | |

| Expenses | | | | | |
| --- | --- | --- | --- | --- | --- |
| Labor Exp | 3.00% | 3.00% | Non-Labor Exp | 3.00% | 3.00% |

Total in Base Year = $20M    Total in Base Year = $9M

**CONTRIBUTIONS**
$00 Contributions (2018)
$00 Contributions (2019+)    2.0% Inflation (2019+)

**INVESTMENT RETURNS**
0.00% Overall Returns (2018 - 2020)
0.00% Overall Returns (2021+)

**CAPITAL SPENDING**

**Net Inflationary Spread (%):** -1.4%  -1.4%  -1.4%  -1.4%  -1.4%  -1.4%  -1.4%  -1.4%  -1.4%

**NOR %:** -9.9%  -11.6%  -13.2%  -15.0%  -16.7%  -18.4%  -20.1%  -21.9%  -23.7%  -25.5%

**EBIDA %:** -8.4%  -9.9%  -11.5%  -13.0%  -14.6%  -16.2%  -17.8%  -19.4%  -21.1%  -22.7%

| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |

**Days Cash On Hand:** 0  -40  -83  -130  -179  -231  -286  -344  -404  -466

| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Average Age of Plant** | 27.5 | 25.9 | 24.6 | 23.5 | 22.6 | 21.9 | 21.2 | 20.7 | 20.3 | 20.0 |

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:

**REVENUE AND EXPENSE INFLATION**

Net Inflationary

| -1.4% | -1.4% | -1.4% | -1.4% | -1.4% | -1.4% | -1.4% | -1.4% | -1.4% |

| Skilled Nursing | 2018/2019 | 2020+ | Legacies | 2018/2019 | 2020+ |
|---|---|---|---|---|---|
| Medicare | 1.00% | 1.00% | Medicaid | 1.00% | 1.00% |
| Medicaid | 1.00% | 1.00% | Private | 3.00% | 3.00% |
| Private | 3.00% | 3.00% | Medicare | 1.00% | 1.00% |
| Other | 1.00% | 1.00% | | | |

| Expenses | | | | | |
|---|---|---|---|---|---|
| Labor Exp | 3.00% | 3.00% | Non-Labor Exp | 3.00% | 3.00% |
| Total in Base Year = $18M | | | Total in Base Year = $9M | | |

**CONTRIBUTIONS**

$00 Contributions (2018)

$00 Contributions (2019+)        2.0% Inflation (2019+)

**INVESTMENT RETURNS**

0.00% Overall Returns (2018 - 2020)

0.00% Overall Returns (2021+)

CAPITAL SPENDING

Routine Capital = $630 in 2018 to $706 in 2026

Yrs 1 - 5    (2.5% of Rev.) / (136.1% of Dep.)

Yrs 6 - 10    (2.5% of Rev.) / (95.8% of Dep.)        Set Baseline

**NOR %**

| 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|---|---|
| -4.6% | -6.2% | -7.9% | -9.5% | -11.1% | -12.8% | -14.5% | -16.1% | -17.8% | -19.5% |

**EBIDA %**

| 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|---|---|
| -3.1% | -4.6% | -6.1% | -7.6% | -9.1% | -10.6% | -12.1% | -13.7% | -15.2% | -16.8% |

**Days Cash On Hand**

19

| 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|---|---|
| | -5 | -33 | -65 | -101 | -140 | -182 | -227 | -276 | -327 |

**Average Age of Plant**

27.5  25.9  24.6  23.5  22.6  21.0  21.2  20.7  20.3  20.0

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 |

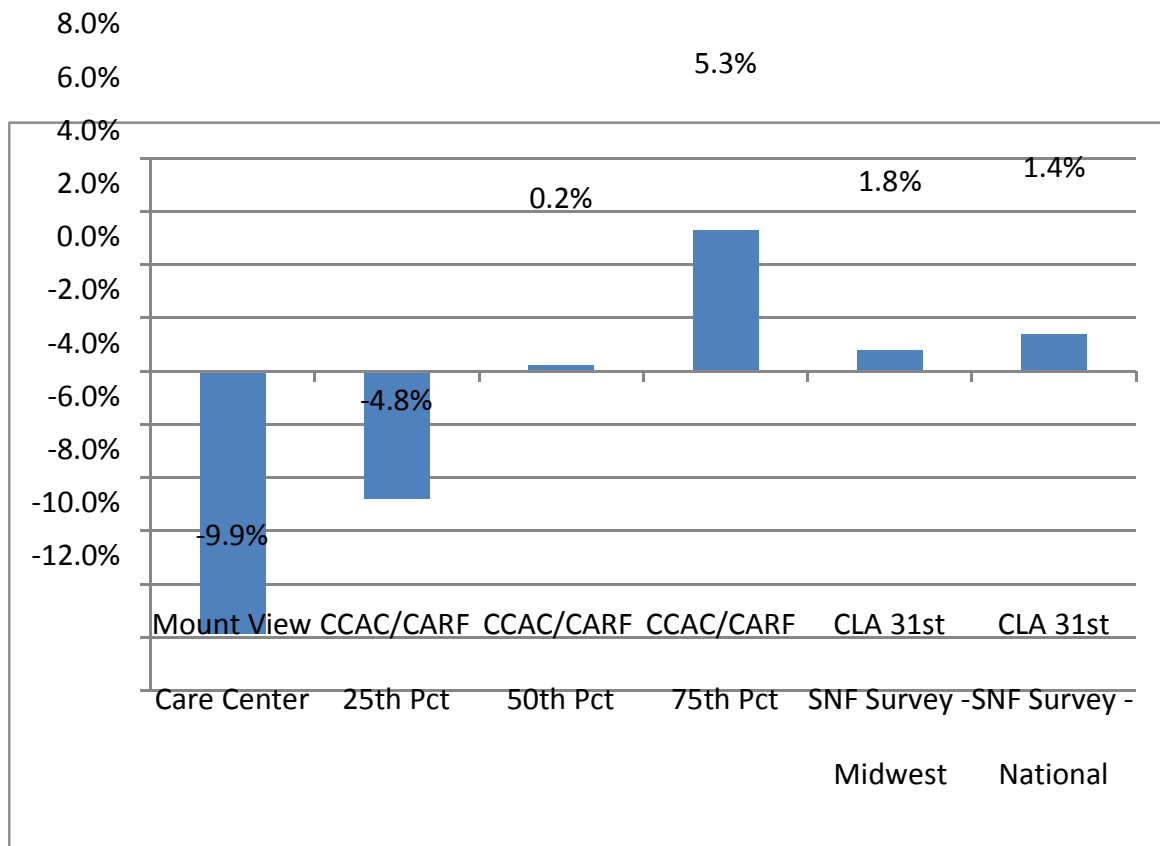The results of the review are represented in the following graphs:

**Operating Ratio**
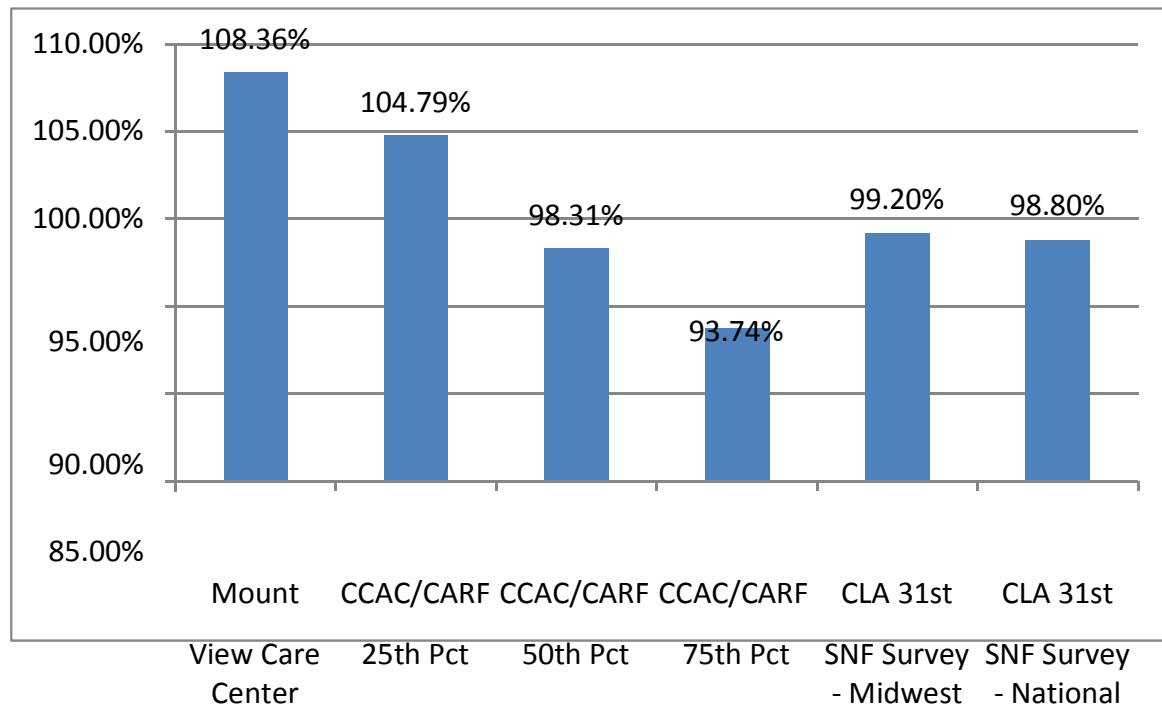


A lower Operating Ratio indicates better cost control related only to service delivery and a stronger performance.

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):
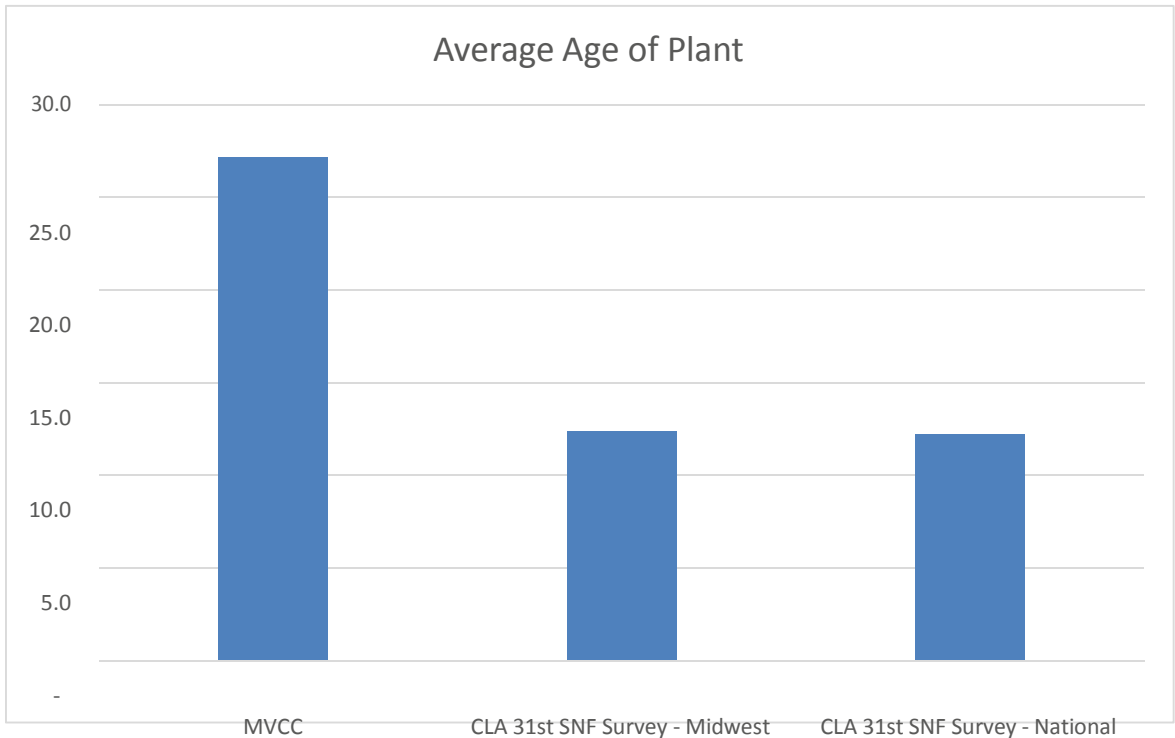


Nursing and senior living facilities have consistently used various debt options to expand and renovate their facilities and grounds.  Governmental units also issue bonds on income producing ventures.  MVCC currently has a solid foundation of service and a strong reputation. MVCC has several options 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**

## 2016 Medicare ADL Breakdown
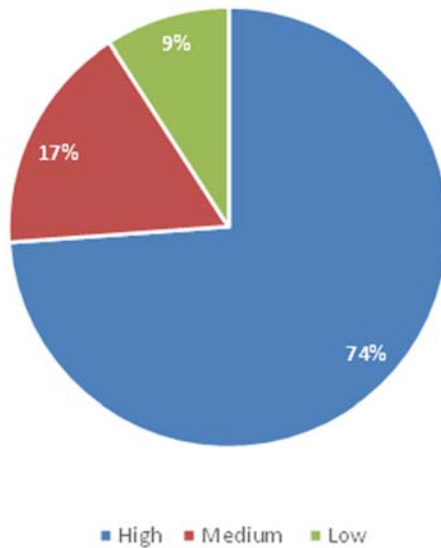


The 2016 RUG distribution placed 74% of Medicare resident days in High ADL categories. Residents in the Low and Medium categories require far less CNA assistance than those in the High categories which is reflected in the current staffing hours per patient day ("HPPD") as noted below. These calculations 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.
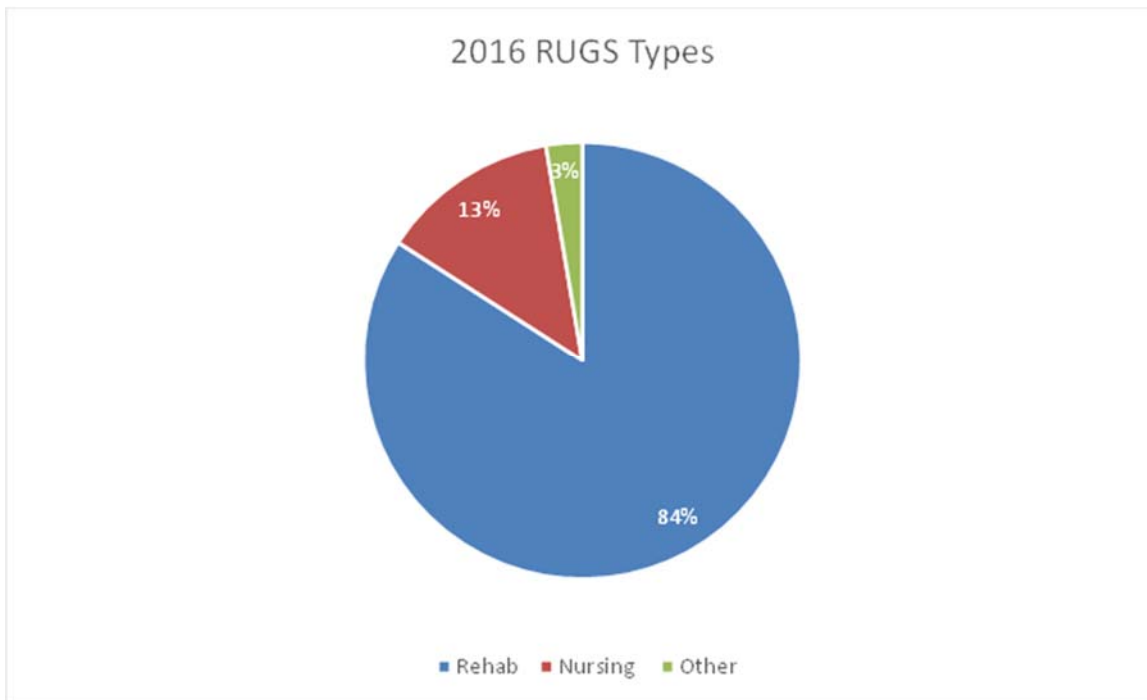
**RUG Category Percentages**

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.

## 2016 RUGS Types



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:

| Average Census | Nursing Administration Per Organizational Chart | |
|---|---|---|
| | Hours Based on Budgeted FTEs | |
| | 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