PRESENTED TO: and

DATE: March 23, 2020

PROJECT:

STATEMENT OF NEED

To assess the current operational health of through discovery, observation, and review of team communication and organizational business process. The scope of work will include:

1. Department head/key facility leadership interviews and scope of work review
2. Regional leadership interviews on facility standing
3. Review of facility key performance indicators in operational, clinical, and business development categories.
4. Identification of immediate areas of opportunity for enhanced performance.
5. Provide recommended action and supporting tools to drive positive performance.

GOAL

Provide baseline analysis of to serve as a catalyst for strategic business change. The intention is to provide a recommended foundational framework for enhanced competency, output, engagement, and performance norms for the center.

This engagement is a qualitative intervention. The opportunity for stakeholders lies in embracing the narrative, which means appreciating and accepting the trends elicited from the subjective realities presented and embarking on a journey for corrective action and innovation.

OBJECTIVE

To position with both short and long term gains in operating performance through the delivery of a comprehensive recommendation on critical indicators.

METHOD

Employee responses and organizational data were analyzed to identify common patterns and trends within the organization. The trended perceptions/assumptions along with gap analysis, represent the implicit culture, e.g., operating norms. The emerging inherent culture was analyzed with current theory to identify critical environmental processes within the organization that impacts positive performance, as understood by this specific leadership population within the context of long-term & post-acute skilled nursing.

FINDINGS AND RECOMMENDATIONS

The assessment of also began with parking in the wrong location due to signage. It allowed the Everest team the opportunity to see the beauty of the Independent Living foyer, however, which did not prepare us properly for the disparity in the upkeep of the skilled center physical plant. With census at close to occupancy, it became immediately apparent that with a light renovation, census payer type and recruitment would improve. We asked the Campus ED about this disparity upon arrival, and he expressed that with the volume of the AL/IL, he believes the SNF is often an afterthought. The condition of the physical plant, in comparison to the rest of the campus, is notably neglected however, there is a pending renovation that will quickly impact that first impression to align with the quality care and staff they showcase.

Everest Renovation Recommendations:

Date: It appears that the renovation has been pending for quite some time. The constant movement of the start date is causing a bit of unease with the staff. Not having any action on needed upgrades poses a risk to the established staff confidence and loyalty in both facility and organizational leadership. Everest recommends making a final decision on the scope of work and beginning a small project within Q2 of 2020.

Signage: Consideration of transitional care signage and more prominent PR style signage to display all offerings at the entrance of the facility should occur. This addition will assist in promoting the full scope of service offered to residents.

Everest recommends moving the SNF entrance as part of the expected renovation. There is limited common space on the SNF side, so utilizing the Assisted Living entrance as a "main entrance" to the building frees up more common area on the SNF side, and creates an intentional and obvious integration of that part of the campus to any would-be customer. An added benefit is the ability to utilize one reception desk for both units, resulting in staff cost savings/efficiencies.

Aside from the opportunities tied to aesthetics, the center would benefit from considering a name change for the skilled unit as a branding tactic, catalyzing the narrative behind transitions of care and positively differentiating the AL from SNF. This recommendation will be discussed again later in the document.

Before our arrival, the Everest team was impressed by the thoroughness, completeness, and accuracy of the documents requested. Specifically, the materials that represented day-to-day facility operations. The presentation is in contrast to the reports received from the facility. Everest found that was able to produce the data quickly, which shows actual center use of the information or, at a minimum, an understanding of the data's importance to the center. We found that the information provided was more than simple answers to the questions. It included graphics to illustrate data and summaries. There were also copies of minutes that were current for meetings such as QAPI, which shows the meetings are occurring routinely.

Once we arrived, we validated that the reporting presentation was due to the leadership strength of the Campus ED. We saw this via the immediate conversation that occurred regarding the center upon arrival. The SNF Nursing Home Administrator (NHA) was not on site when we arrived, due to his pre-arranged schedule with the facility to arrive at 9 am daily. This schedule allowed us time to get into a few detailed questions with before the morning meeting. We assessed during this time and throughout the day that he has a solid knowledge of skilled nursing operations. Not only because of his experience as a Nursing Home Administrator, which is also the case for the campus ED at , but because of the level of detail that he could articulate around business operations at the clinical, financial, and business development levels.

Everest recommends a flexed schedule for the NHA. Consider a plan that allows a split week, such as two days arriving before 8 am and three days arriving after 9. This schedule should encourage ownership of "start of business" matters that can drive leadership discussions in the morning meeting.

When the NHA arrived, we were surprised to find that he did not lead the morning stand up meeting, the campus ED led the meeting. If this fact is due to having all service lines present, we would have expected a separate SNF agenda to review or a separate SNF morning meeting to occur after. NHA did not contribute any items of substance to represent the SNF service line. The Everest team was again not sure if this was a prescribed occurrence to manage our site visit, but even if so, the traditional areas discussed in a skilled morning meeting did not occur. We did observe the SNF NHA utilizing a morning meeting template at , so we assume one exists. We are confident that if the use of a morning meeting template were common practice at , would have utilized it during our visit.

In addition to the flow and function of the morning meeting not being specific to the content of the SNF, the managerial participants did not present information relevant to facilitation of operational information flow. Census was unquantified by payer sources, and there was no review of grievances and concerns, no evaluation of care plans, and no ancillary department review other than anticipated activities. A review of these items occur daily in traditional SNF settings and is essential because it is the opportunity for the Administrator to have the autonomy of his role and function as the SNF leader. It sets the stage for control of his labor, expenses, ancillary services, and the ability to give input on admissions. The end result is a tightly and effectively ran morning meeting.

As a result, Everest recommends for all SNF's within the portfolio to adopt a standard morning meeting template and incorporate the importance of follow up on critical items to the NHA. Follow up reports can occur organically throughout the day or formally via an end of day stand-down meeting. This type of leadership structure is essential for the NHA here, since he does not arrive at the facility early enough to do morning rounds or have department head check-ins before the meeting start time.

A full assessment of NHA competency was not able to occur until midway through the site visit, and when completed, presented with similar opportunity as described in the assessment in regards to the need for Skilled Ops Training. , however, has

been the NHA at for multiple years. He presented to us, and we later validated the fact that he doesn't have the full support of the campus ED or the Director of Nurses. He feels the relationship he has with the Director of Nurses is strained and therefore compromises his authority within the center. There is a perception that people can go directly to for SNF ops needs instead of going to him, which undermines his authority. The Everest team asked directly about his contribution to creating his leadership cadence within the facility and owning certain areas that are vital to the health of the center. When answered this question, and others that directed ownership back to his chair, he became very adamant in his decision to keep his head down, do the job that wants him to do, and not rock the boat. The Everest team assessed some of these style comments as passive-aggressive and a shift of blame.

The most impressive assessment of the facility is the tenure of staff. This fact was a highlight of the morning meeting. The Everest team had the chance to ask the group why they stay at and what it is about the center that separates it from the competition. Everyone discussed the teamwork that occurs within the facility and the positive work environment that exists there. They all seem to contribute to it equally. This work environment is likely to provide a significant contribution to census stability. Longevity has equipped this facility with the success of engaged, trained, and capable staff. The staff were pleasant and observed to give excellent customer service to residents and visitors to the facility.

Everest recommends purposefully utilizing the individuals with tenure and elevated skill set at as mentees, preceptors, trainers, and positive promoters at the facility.

Everest also recommends the creation of a public relations campaign for promoting the positive work environment within the center. This campaign is for recruitment of staff on job board platforms such as Facebook, Indeed and GlassDoor.

I. Revenue Generation

Net Operating Income:

Revenue growth can have a significant impact on the financial health of the facility. The following will contribute to the bottom line Net Operating Income for the facility if implemented appropriately.

Everest completed a per patient day (PPD) analysis of major expense categories to determine how the two subject facilities compare to a broad-based look of the industry. The example TTM's are in comparison to a 75+ facility control group. In many areas, costs appear relatively consistent with the control group, with some outliers noted below.

The campus is slightly more problematic to review because of the combined nature of the financials. The same dynamic likely exists concerning the PPD for Pharmacy and Rehab. If we use only SNF days to produce the PPD for Pharmacy, it would be $16; for therapy, it would be $60. We strongly recommend tracking the cost of ancillaries provided on the SNF unit only, which would allow you to better understand the actual costs of providing these services to *only* those patients. In other words, if possible, uncouple the SNF financials from the campus overall financials. Doing this will allow SNF ownership to key factors and encourage financial independence.

Plant Ops appears high, but the same dynamic exists relative to the size of the campus and the costs inherent in maintaining that type of setting.

See attached modeling for further details.

Currently, there appears to be limited tools to measure the operation. The center does not have measurable expense control metrics which is compounded by the inability to quantify expenses. The facility lacks spend-down tools and standard expense reviews. There is an opportunity for a reduction in the following ancillaries at minimum:

- The center is renting lift chairs from the therapy department
- Oxygen throughout the facility unused and running
- Oxygen not stored appropriately
- Medical supplies are unorganized
- Wound care supplies in spas unused

Net Operating Income: NOI missed by approximately $700K. The recent census growth, if sustained, will significantly help profitability in 2020.

Accounts Receivable:

The business office at the facility performs all billing tasks. Other than a few old private pay balances, the private pay A/R is remarkably clean. The Business Office Manager has a process to get payment plans where necessary. The facility recently began using the Ability Ease All Payer, and other than some initial payer set up issues, had good things to say about this software and the efficiencies it is providing.

The Humana/MNS/NaviHealth issue is delaying over $150K of balances at this facility. There are also approximately $50,000 in Medicare Part A balances currently not collected that require follow up. Medicare typically pays in the month after provided service. This fix will also allow associated coinsurance to be billed/collected. The reason for the breakdown is due to Humana's claims being delayed in payment due to a Tax ID Number (TIN) issue mentioned above. Authorizations need to be obtained under the MNS TIN, as that is the TIN that is also used in billing. This matter is largely resolved due to the persistence of the BOM working with the parties involved and older claims are starting to pay. New claims should largely be unaffected.

- Our experience with NaviHealth and Humana is that disconnects tend to reappear even after apparent resolution, so we recommend that the facility continue to pay close attention to the issue in case new denials appear from the TIN disconnect.

Managed Care RUGS has $50,000 over 180 days old. These claims should have high priority in collections. Medicaid and Hospice have strong collections after review of information provided.

DSO: The SNF runs an approximate Days of Sales Outstanding of 60 days where the industry standard is between 35-40 days. Collection of the outstanding Medicare/Managed/Humana claims would get the facility in the 40-day range.

Food costs are relatively high on a PPD basis, but the combined nature of the financials makes it challenging to determine if the SNF is running high in actuality vs. paper. Everest recommends tracking the allocation of food to the SNF to see if cost is truly an issue or just buried in the overall number.

The ability to achieve goals will tie directly to the performance of the Region Team. While the regional support team was present during our site visit, they expressed multiple times that the need for their on-site assistance at the center is infrequent, and therefore the team does not often see regional or executive-level leadership. This lack of presence is a missed opportunity for the organization. Top-performing facilities can see even greater success than low performers when the development of talent within the center is a continuous focus for the leadership team. The return on investment at a top-performing center can provide a quicker achievement of agreed-upon goals in half the time taken at a low performing center.

Everest recommends a minimum of quarterly on-site visits from each discipline to focus on next level strategy and opportunities to lead the organization in SNF performance.

Census:

is a 45 bed facility with a census of 41 at the time of our visit. The facility recognizes the importance of using LTC patients to help supplement their census where it makes sense. Even with a higher than average Medicaid patient load, the facility still maintained a robust quality mix. Census has improved dramatically in the past few months, and that is partly contributable to the growth in LTC census. While this is a good strategy, the Everest team believes that the center can and should focus intently on growing occupancy with an aggressive focus on quality mix.

The first opportunity for quality mix growth is the willingness to assume more clinical risk with admissions. Currently, the assessment is that the facility does not receive at least 1/3 of the referrals that a traditional skilled center would, because of the denial practices remembered by the case management department.

With over 60 competitors within 20 miles of the center, and a healthy amount of top tier hospital systems with a competitive amount of discharges to skilled nursing levels of care, has an immediate opportunity to reposition its clinical differentiation with the hospital referral sources.

See attached hospital data and executive summary set titled " Market Insights"

The diagnosis treated at per the PCC diagnosis reports do not match the heaviest discharging hospital diagnosis. This statement is true regarding the type of patients they treat at the hospital and the patient type they discharge to skilled levels of care. An immediate impact can be made with a simple shift to focus clinical development on cardiac patients and orthopedic patients that have multiple comorbidities. These comorbidities delay the speed of patient improvement which will traditionally cause the need for at least 15 – 30 days of skilled nursing service along with physical rehabilitation. Not only will this increase your length of stay, but it will also increase nursing driven reimbursement tied to PDPM.

A contributor to the Everest assessment of clinical risk aversion comes from observing team member communication about active referrals. These team members include Administrator, DON, campus ED, and Director of Admissions. The team should also note that initially, during the conversations, the s team did not believe that their admitting practices were not in favor of patients with higher clinical acuity. Especially since the team is proud of their openness to accepting Medicaid patients. Medicaid payer types are typically not complex, which is why they are not utilizing a skilled benefit. The care may be heavy on the individual providing ADLs, but the work does not require an enhanced clinical skill set.

During discussion with the Director of Nurses around her admission practice, she indicated that the team would take any patient that does not require 24 hour RN coverage, such as TPN. The conversation shifted to discussing patient types and the last time they've treated certain diagnoses. We reviewed IV antibiotic usage, trachs both stable and at least 30 days old, decannulated trachs, and isolation patients. The DON stated that these patient types hadn't been in the facility for a while, and before they would accept for admission, she would want to make sure that the staff received the training to care for the patient. When I asked if she accepts the patient and then quickly arranges the training for the direct care team before arrival, she stated that they typically do not work that fast, and by the time they get the training scheduled, the patient has already been placed. Then, by the time a similar referral is received again, the training that was done will need to be redone, either due to the turnover of staff or not using the skill since the last completed training. By the end of the discussion, the DON as well as the other individuals who believed they were taking clinical risk initially, recognized that the facility could do more to widen their scope of patient referrals.

Everest recommends a clinical training program in 2020 that focuses on increasing clinical competencies with a routine review of items learned quarterly. These competencies can then be provided to the business development team as a referral generator at the hospital

systems as they promote the new training completed by the center. This strategy will open up the referral flow to the center and allow the trained skills to be utilized and honed.

Everest also recommends for each of these more clinically complex patient referral types, utilization of a PDPM rate predictor by the admissions team, or partnered facility nurse to show the positive revenue potential for acceptance of complex patients. This conversation can then pair with achievement goals for highly desired staff items, for example, the addition of FTEs and specific renovation of high traffic employee areas such as the breakroom. Review of patient referral type and potential PDPM rate in the morning meeting will assist in solidifying the importance of changing the facility patient milieu and allow the conversation to turn to how to use the additional revenue in service of the facility, the employees, and the residents.

Risk aversion can also be a way to protect star rating. It should be understood that when clinical risk increases, so must clinical process diligence. A clinical enhancement will require more regional support and a tight focus on documentation, care planning, and QAPI. This strategy can assist in protecting star rating integrity.

A final census recommendation is a review of discharge practices for patients that present with neurological deterioration or cognitive impairment. There were two patient cases during our visit with discharge plans in place due to deterioration in mental capacity. One was a short term to long term care conversion and the other case was a long term resident, paying privately, who was requiring more redirection. and the team discussed the inability of the staff to support long term cognitive decline that presents as wandering, increased aide work-load, or agitation. Everest believes that these items will mitigate through the elevation of SNF activities programming designed for this patient type.

Current activities director is strong, however she is shared between multiple service lines. As a result, her skilled focus and that of her assistant team needs to be improved. Most of her training is for the AL/IL patient population versus skilled residents. Skilled activities are guided by regulation and evidence based practice that ensures appropriate experiences for SNF patients that have physical and cognitive care needs.

Everest recommends a review of the activities programming tied to the following:

- Alzheimer's and Dementia
- Cognitive impairment
- Neurological disorders such as Parkinson's
- Veterans PTSD and general recognition
- Non-Ambulatory – independence programming
- Bed Bound individual care programming.

As a result of the above shift in process, along with an elevated business development strategy to be described later in this document, Everest recommends the following goal for payer and unit mix to be considered.

Bed Count: 45
Semi Private Units: 22
Private Unit: 1
Occupancy: 84%
Total Census: 38
MCR Census: 16
Managed Care: 11
Private: 7
Medicaid: 4

Please see attached Payer and Mix Recommendations PPT for further details

II. Clinical Assessment

1. Review the Centers of Medicare and Medicaid Services (CMS) Nursing Home Compare star ratings specific for
2. Review clinical processes, procedures, and competencies.
3. Review facility informatics and electronic medical records.
4. Review facility staffing, labor models, allocation of staff roles and responsibilities, and workflow analysis.
5. Observation of facility meetings.
6. Meetings with regional and facility-level staff.
7. Identification of immediate areas of opportunity for enhanced clinical performance.
8. Provide recommended action to drive positive performance and financial growth.

General Observation:

Clinical Systems:
Clinical systems are in compliance. The Everest team provided minor recommendations during the visit. Weekly at risk meeting should include the dietician to discuss the continued use of supplements and a plan to discontinue supplements when appropriate. This will have a positive financial impact. Everest recommends that the wound nurse also attend the at- risk meeting to improve documentation and communication related to current wounds and at risk residents.

Trauma informed care practices were discussed with the team related to residents with behaviors. An evaluation of PointClickCare (PCC) utilization was not analyzed; however, based on observation and discussion, there is an opportunity for increased usage. The clinical team should utilize the dashboard function on PCC and ensure outstanding items to include assessments are delegated, and timely follow up occurs. Point of Care documentation could be improved.

Clinical Programming:
Clinical programming is needed. There is an opportunity for the team to determine clinical programming needs based on market analysis to enhance their skilled revenue. This facility

could establish clinical programming related to neurological impairment to serve the current population in the center.

An enhanced activity program with dedicated personnel to the skilled area is recommended. Improving and structuring the communication with the assisted living and independent living areas is recommended to ensure services are provided to tenants if they require skilled nursing.

Short-Stay Resident:
The discussion related to short-stay residents was adequate. The team communicates sound knowledge related to the residents discussed and advocated for continued days as needed. The team should begin utilizing laptops and PCC during this dialogue. This practice will allow the team to answer specific care questions during the meeting. The current process has the team producing a paper packet outlining information regarding the residents. Everest recommends conducting a workflow analysis to eliminate paper and duplication of efforts. Continued training related to PDPM would be beneficial, especially if enhancing clinical acuity.

Staffing:
The facility is utilizing the OnShift staffing platform. Staffing does not appear to be a critical area of concern. To validate this, an analysis of turnover rates should occur. Currently, the facility employs a full-time DON, a full-time ADON, two full-time MDS nurses, and a full-time unit nurse. Everest recommends evaluating the need of the current nurse admin positions. For the current occupancy, the center is staffed heavily in this area.

Dietary Supplements:
Approximately 50% of residents are utilizing dietary supplements for greater than six months for various reasons, including weight gain and skin integrity promotion. A review of a sample number of residents indicates an opportunity to discontinue dietary supplements. The team can make this decision due to lack of documented improvement, or the resident has improved and may not need the supplement any longer. The dietician does not attend the weekly at-risk clinical meeting to discuss residents and their status. These misses have a recurrent negative financial impact.

III. **Business Development**

The Everest team had the opportunity to spend time with the new Admissions Director (AD) at . Amy has a good background in the industry and shows confidence in her relationships as well as her knowledge of hospital systems. The AD also has confidence in her ability to conduct clinical screens of patients with accuracy and has found a nice rhythm with the Director of Nurses. She also states she receives a good amount of support from the campus Director of Sales, who is her direct supervisor. Everest was not able to meet with the campus Director of Sales, as she was on a pre-planned vacation.

Most of our time was spent discussing her conversion ratio trends via the documents that provided to Everest as a part of our diligence request. hadn't seen the numbers before and was interested in understanding the data better. During this time, Everest was able to assess that has a genuine interest in adding tools and knowledge to her business development strategy with her referral sources. These documents should now be a part of normal business practice for the center after creating for the Everest site visit.

Everest recommends that the Director of Sales and Marketing add this review to her weekly calls to discuss SNF census growth strategy with .

Opportunities for growth strategies discussed included:

- Managed care conversion improvement
    - To include routing schedules to plan case managers within the hospital.
- Development of a rehab "step up" program to position referrals from IRFs in the area as orthopedic discharges are a top discharging DRG from local hospitals
- Increasing clinical differentiation in the market to grow market share and improve quality mix.

Further strategic opportunity is identified in the Market Insights document

Similar to , there is also a significant opportunity to increase PR, marketing, and events within the center. With or without a renovation, many individuals need SNF specific resources that can help them through a loved one's change of condition. Focusing on these items will be pertinent for establishing the center as a resource in post- acute care. Examples:

- Spousal support groups: Stroke, Alzheimer's and Dementia, Parkinson, Heart Disease (monthly rotation with hospital co-sponsorship)
- A resource to understanding your insurance (partner with a plan and utilize BOM) - Event
- The difference between Medicare and Medicaid – what you should know – Event
- How to handle a hospital stay – Event
- Veterans programming
- What does it mean when the hospital says I am a part of an ACO
- What to expect when my loved one returns from the hospital / snf
- Learning series of any of the above

It is important to note that the Administrator was clear on his stance that the Marketing Director has too much "power" to make decisions autonomously that do not align with the direction of the SNF. The ED and Administrator said they have the autonomy to decide upon Medicaid admissions, admissions are vetted with the possibility of long term need and denied for the potential of long term placement. The facility "cherry picks" admissions based upon financial and clinical risk. These items are referenced early in this document.

Everest believes the SNF NHA may be a potential barrier to increasing clinical acuity based on the statements above.

Everest also believes that the potential for a SNF name change to promote "transitional care" or "continuing care" could offer the perception of an elevated clinical model to referral sources.

IV. **Final Thoughts**

has the potential to be a leader in the portfolio. The following are other items to consider in project mapping center success.

Staffing: MDS is staffed with 2 at 32/hours per week. We believe the highly skilled team members could supplement the MDS staff at to help them stay current with MDS completion and submission.

Dining Experience and Ops Review: In addition to dietary expense contributing a significant PPD overage, the walk through of the kitchen presented many sanitation concerns. NHA guided the tour of the kitchen and was unable to quantify any sanitation audits, tools, or review processes. He stated that QAPI does not require anything specific to sanitation. This is a concerning statement as QAPI is designed to to both create critical thinking about specific areas as well as allow discussion for other center items that need improvement.

Notable opportunities were labeling and dating of food, storage issues, appropriate food handling, chicken thawing meat practice, organization of storage room, and inability to identify any emergency food supply. We did not have a meal at the skilled center. When asked if the food is the same in IL/AL as it is in the SNF with the appropriate dietary restriction, it was clear that more attention is paid to the IL service versus the SNF service. This is a missed opportunity as the food presented, and the chef-quality in the IL seems to be a competitive advantage that can also be used as a skilled referral driver.

Everest recommends the team explore an elevated dining experience for the skilled nursing residents. This can be led by the executive Chef of the IL who we were told is a reputable local restaurateur. The importance of meal quality is true in the skilled population and can be a strong contributor to customer satisfaction and market share capture.

Administrator in Training Program: Everest had the chance to meet 2 Administrators in Training that would become available for both the and the facilities. In our brief time and limited conversation with these two individuals, Everest recommends a more thorough and top level search for these candidates. Both individuals presented moderately with limited engagement and contribution toward the discussion of performance improvement. One of the AITs expressed a significant difference in the employee culture at versus and would be a good validation to items discussed by the Everest team.

Positive practices observed and encouraged to continue:

- Manager on duty throughout the week. The department head comes in around 10 am and stays till 7 pm. They also assist with meal service for lunch and dinner on their assigned day.
- Part-time admissions coordinator who works Saturdays and Sundays
- Positive online reviews with a resident voice component that drives process for Google reviews and follow up
- Training from Activities Director by regional support team
- Therapy contract for PDPM pricing
- Living well program – budgeted expense vs revenue should be evaluated further
- Training and implementation of OnShift for focus on overtime reduction, staffing review and reduction of bonuses. Schedule refresher with ED and NHA
- Caring partners/angel rounds – related to scale stated to be ineffective and that the team does the process informally.
- CMS is their recruitment tool.
- Drug testing with marijuana panel, recommend to reconsider